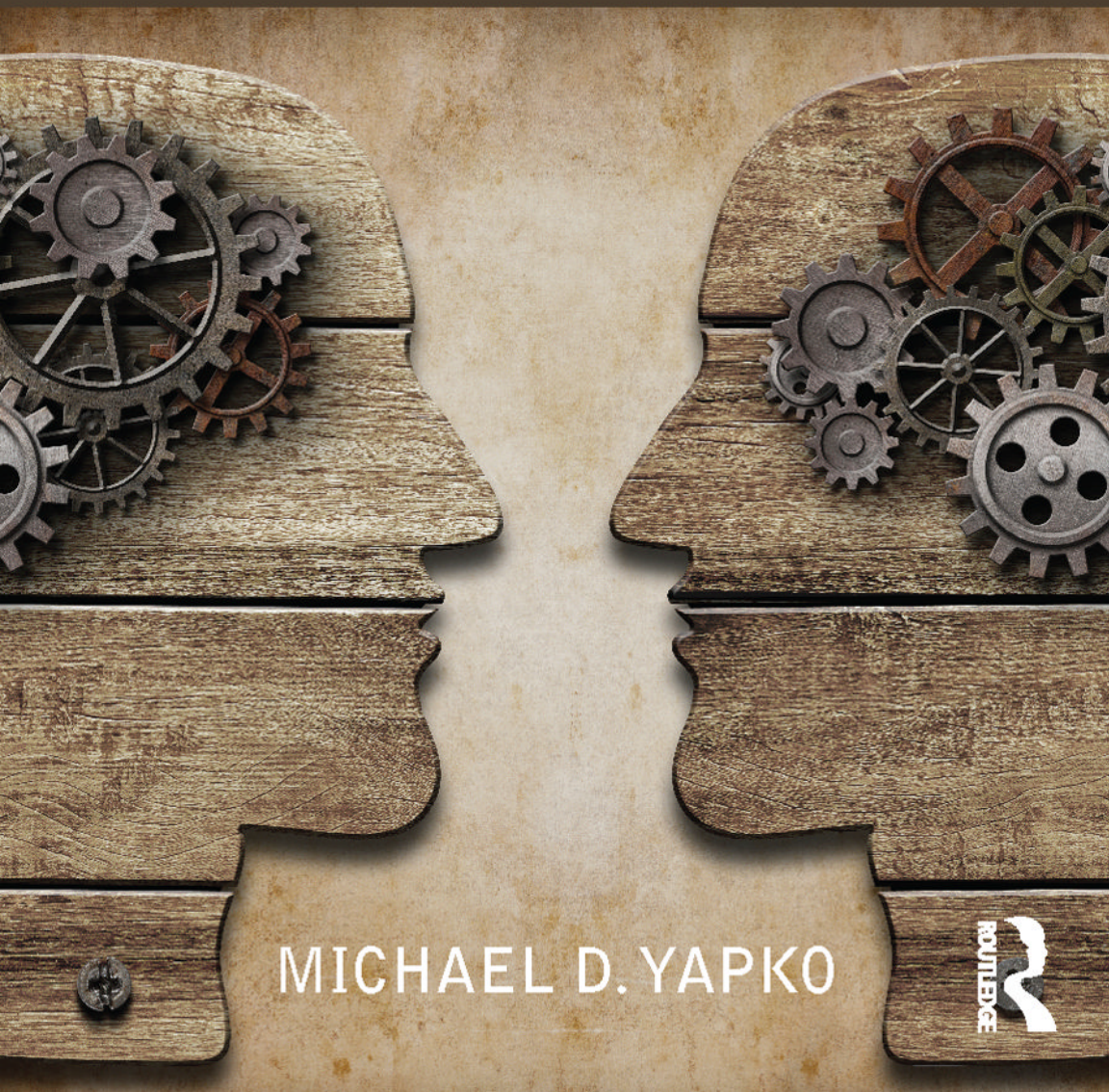
ESSENTIALS OF HYPNOSIS

SECOND EDITION



MICHAEL D. YAPKO

ROUTLEDGE

"Learning the fundamentals of modern clinical hypnosis is as simple as reading this update to a classic text. Michael Yapko has a gifted ability to comprehensively present building blocks that will edify the novice and serve as important reminders for the experienced practitioner. *Essentials of Hypnosis*, *Second Edition* is an essential primer of essential concepts. Dr. Yapko has done a great service by providing new, modern understandings in this new edition."—***Jeffrey K. Zeig**, Ph.D., the Milton H. Erickson Foundation*

"Only Michael Yapko could integrate all the complex facets of the world of hypnosis so completely in one volume. His knowledge is evident in every sentence, accurately selected with incisive precision and mindful creativity. This is a book every expert should have on his or her desk for quick and insightful reference and inspiration."—***Consuelo C. Casula**, President of the European Society of Hypnosis*

"Yapko *is* hypnosis. His accumulated knowledge, research, insights, and experience are distilled in *Essentials of Hypnosis*: one easily readable and essentially practical volume. Curious or convinced, you owe it to yourself—and your clients—to read and apply this entrancing clinical wisdom."—***George W. Burns**, Adjunct Professor of Psychology, Cairnmillar Institute, Melbourne, Australia; author of* 101 Healing Stories *and* Happiness, Healing, Enhancement

"Michael Yapko is among a handful of the best writers and clinical practitioners of hypnosis in the world. With this volume he has somehow surpassed his series of previous books on hypnosis to provide his ultimate work to date. Based on strong theory and science, this remarkable achievement provides page after page of remarkable, practical, and deeply insightful advice about how to apply hypnosis clinically. Yapko's writing is so compelling and easy to read, it might be easy to overlook that this work will be one of the most influential and innovative that has been produced on teaching even the most experienced clinicians to use this approach with their patients."—***David R. Patterson**, Ph.D., ABPP; author of* Clinical Hypnosis for Pain Control

"Whether beginning to learn hypnosis or continuing and reviewing, refreshing and renewing, learning the essentials from Michael Yapko enriches and informs like no other. This volume not only continues to provide essential critical and foundational concepts and a framework with which to grow, but also provides ongoing nurturance with wise and thoughtful responses to old and new questions that arise while we help people help themselves."—***Daniel P. Kohen****, M.D., FAAP, FASCH, ABMH, Co-Director, National Pediatric Hypnosis Training Institute; Director, Developmental-Behavioral Pediatrics; Professor, Departments of Pediatrics and Family Medicine and Community Health, University of Minnesota (Retired)*

"Michael Yapko's latest contribution to the hypnosis field succeeds as another 'must have' for one's resource library. This perfect primer distills hypnosis to the exquisitely crisp essentials, without compromising any relevant topic. Easy-to-read and clear explanations offer all the basics for the novice. The numerous practical applications will also appeal to seasoned clinicians seeking to refresh or add additional approaches and strategies to their work with their clients. This revised guide is a great companion to his comprehensive text, *Trancework*."—***Pamela Kaiser****, Ph.D., CPNP, Former Associate Clinical Professor, Pediatrics, University of California, San Francisco, Medical School; Co-Founder and Co-Director, National Pediatric Hypnosis Training Institute*

"Dr. Yapko's second edition is an important addition to every clinician's bookshelf! Dr. Yapko reduces challenging concepts to their essential elements, inviting curiosity and reducing hypnosis to its essential elements. I heartily recommend this text for any medical or mental health clinician with an interest in hypnosis."—***Dan Handel****, M.D., Chief, Palliative Medicine, Denver Health Medical Center*

ESSENTIALS OF HYPNOSIS

Essentials of Hypnosis, Second Edition provides a warm and rich introduction to the fascinating field of hypnosis by one of its leading experts. Readers may be surprised to discover that some of the most important methods in modern integrative health care have a foundation in hypnosis, and that modern neuroscience is regularly learning new things about brain functioning from brain scanning studies of hypnotized individuals. The emphasis in *Essentials of Hypnosis, Second Edition* is on the use of hypnosis as an effective tool of treatment. Thus, readers will enjoy and benefit from the wealth of clinical insights and helpful hints Dr. Yapko offers for the skilled use of hypnotic principles and methods. The essentials of this dynamic field are well captured in this practical volume.

Michael D. Yapko, Ph.D., is a clinical psychologist and marriage and family therapist residing near San Diego, California. He is internationally recognized for his work in clinical hypnosis, brief psychotherapy, and the strategic treatment of depression, routinely teaching to professional audiences all over the world. The author of more than a dozen books, including the leading hypnosis text *Trancework* (4th edition), he is the recipient of lifetime achievement awards from the International Society of Hypnosis, the American Psychological Association's Society of Psychological Hypnosis (Division 30), and the Milton H. Erickson Foundation for his innovative contributions in advancing the fields of hypnosis and psychotherapy.

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ESSENTIALS OF HYPNOSIS

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To the brilliant and courageous
hypnosis pioneers, the inspirational giants upon
whose shoulders I gratefully stand

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CONTENTS

NOTE FROM THE AUTHOR

This book provides an overview of the concepts and methods of hypnosis. It is not meant to be a complete guide to training in the applications of hypnosis and is not to be used as the sole basis for conducting an informed practice of hypnosis. Furthermore, it is assumed that anyone practicing hypnosis using the ideas and methods herein is appropriately qualified academically and legally to do so and will practice responsibly only within the scope of their training and credentialing. Neither the author nor the publisher can be held accountable for deviations from legal, ethical, and sound clinical standards of practice.

ACKNOWLEDGMENTS

My passion for hypnosis has lasted more than four decades now. It has been a rich and satisfying domain of study, perhaps because of all the unanswered questions that invite continued dedication, exploration, and discovery. I have not walked this exciting path alone. My remarkable wife, Diane, has been there every step of the way, supporting and challenging me in the best of ways. Her love and commitment to excellence are gifts I never take for granted. I am also incredibly fortunate to have the love and support of my family and great friends, and they are incredible sources of inspiration.

My very first book about hypnosis came about many years ago by developing a detailed manual for use in my training courses in hypnosis. I have had amazing students, colleagues, and teachers contributing to my education all these years, and I want to gratefully acknowledge the huge role they've played in expanding my understandings of hypnosis.

Finally I am grateful to my publisher, Routledge, for their generosity in continuing to support my work over these many years.

OTHER WORKS BY MICHAEL D. YAPKO

Books

Trancework: An Introduction to the Practice of Clinical Hypnosis (4th edition)
Mindfulness and Hypnosis: The Power of Suggestion to Transform Experience
Depression is Contagious: How the Most Common Mood Disorder is Spreading around the World and How to Stop It
Hypnosis and Treating Depression: Applications in Clinical Practice (Editor)
Treating Depression with Hypnosis: Integrating Cognitive-Behavioral and Strategic Approaches
Depression: Questions and Answers
Hand-Me-Down Blues: How to Stop Depression from Spreading in Families
Breaking the Patterns of Depression
Suggestions of Abuse: True and False Memories of Childhood Sexual Trauma
Hypnosis and the Treatment of Depressions: Strategies for Change
Brief Therapy Approaches to Treating Anxiety and Depression (Editor)
When Living Hurts: Directives for Treating Depression
Hypnotic and Strategic Interventions: Principles and Practice (Editor)

Audio Programs

Focusing on Feeling Good: Addressing Depression with Hypnosis
Calm Down: Addressing Anxiety with Hypnosis
Managing Pain with Hypnosis
Sleeping Soundly
Better Focus, Better Life, Vol. 1: Paying Attention with Intention
Better Focus, Better Life, Vol. 2: Transcending the Usual

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INTRODUCTION

The very first principle to guide you in learning about hypnosis is, "What you focus on, you amplify." Hypnosis is all about developing focus and using it to enhance people's lives, including your own. What a huge difference it makes to focus one's attention on what's *right* instead of what's wrong, on what's possible instead of on unchangeable history, on what may be changeable in medical and psychological conditions previously perceived as hopeless, or to focus on achieving the goal instead of getting sidetracked by doubts or irrelevancy!

The ability to pay *meaningful* attention has never been more important than it is at this time: so much high quality information and experience that could help improve our lives is readily available to each of us, but tends to get drowned out by too many noisy and meaningless distractions. As a result, people are disconnected from themselves, disconnected from each other, and living in near-constant states of debilitating stress in one form or another. Consider how valuable it would be to be relaxed, focused, and readily connected to one's personal resources, especially when you need them to help respond wisely at life's most challenging times.

Relaxed, focused, and readily connected to one's personal resources . . . *This* is where we enter the domain of hypnosis. Describing what happens in hypnosis in general, superficial terms is easy: Hypnosis helps by providing a deliberate means of paying focused attention to what matters and mobilizing the specific skills to manage life's challenges effectively. But, *how* does focusing lead to changes in physiology and perception such that someone can overcome panic attacks or depression or have major surgery without a chemical anesthetic? Fascinating! This foundational question, and thousands more just like it, are asked by curious researchers and clinicians like myself who are dedicated to the study and practice of hypnosis. There's something very powerful going on here we'd all love to understand better as we strive to help improve people's lives—and our own as well.

Applications of hypnosis share at least one common denominator: *they serve to empower people*, sharply contradicting the popular

mythology of an imminent loss of control that makes uninformed people wary about hypnosis. My work and the work of many others draws people's attention to the opposite truth: *Hypnosis is a means of focusing one's attention in meaningful ways to achieve self-defined goals for developing the best and most adaptive parts of ourselves.*

The field of clinical hypnosis and the body of supportive scientific literature affirming its merits have grown dramatically in depth and breadth since the first edition of *Essentials of Hypnosis* appeared more than two decades ago. As a result, this second edition of *Essentials of Hypnosis* offers you a warm welcome to the field in its most current form. It provides a brief introduction to this dynamic domain of study that pays a great deal of attention to what can happen when people pay attention. I will provide a strong foundation of information, perspective, and practical methods to give you a solid understanding of and appreciation for the invaluable things hypnosis can make possible. But, I have purposely kept short and to the point the many topics covered in an attempt to live up to the defining word of the book's title: essentials.

If you're looking for a more in-depth consideration of the topic of hypnosis, I'd refer you to the updated and expanded fourth edition of my hypnosis textbook, *Trancework: An Introduction to the Practice of Clinical Hypnosis*. *Trancework* is rich with detailed examples and insights about applying hypnosis, reference citations, and thought-provoking perspectives on topics ranging from the neuroscience of hypnosis to its uses in modern psychotherapy and behavioral medicine.

Essentials of Hypnosis is divided into two major sections. The first and smaller section is about developing realistic perspectives about hypnosis, a vitally important consideration since the way you will apply hypnosis is a direct consequence of how you think about hypnosis and how you think about people. In this first section, then, I'll share a little of what key research and clinical findings suggest in terms of credible ways to think about hypnosis. Hypnosis is too often described in exaggerated ways by enthusiasts, but there are indeed some things quite special about hypnosis that warrant a high regard for its potentials.

The second and considerably larger section of the book is about the practical aspects of doing hypnosis. Structuring and delivering suggestions that hold the potential to be helpful to someone is the artistry of conducting effective hypnosis sessions. Knowing how and when to introduce positive ideas and possibilities to people who are often desperately in need of effective tools is serious-minded and vitally important work. Being a "hypnotist" is not a position to take lightly. *Essentials of Hypnosis* will provide you with many of the key considerations associated with using hypnosis skillfully.

In the Appendix, there are some valuable suggestions for specific books and articles to read if you want further information in some area.

The clinical and scientific literature continues to grow steadily and there is much you'll be pleased to discover if and when you pursue further study.

My first book on the clinical applications of hypnosis came out over 30 years ago. My enthusiasm for the field has only continued to increase over these past decades as new and amazing ideas, insights and methods evolved. It has been a privilege to help people grow in life-enhancing ways, and it has been immensely satisfying to be part of a field that has so much to offer on both professional and personal levels. I hope you will find *Essentials of Hypnosis* an inspiring introduction to this rich and exciting field.

Michael D. Yapko, Ph.D.
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Part 1

DEVELOPING YOUR PERSPECTIVE ABOUT HYPNOSIS

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1

DISCOVERING HYPNOSIS AND THE REASONS WHY ITS VALUE KEEPS GROWING

Hypnosis is an innately fascinating topic to most people. It's a phenomenon that invites lively discussion, curious speculation, and even profound philosophizing about the nature of human consciousness and the complex, often puzzling interrelationships between mind, brain, and body. Hypnosis challenges thoughtful professionals to ask questions that are difficult, if not impossible, to answer each time we watch someone perform some unusual behavior manifested by someone in hypnosis. Hypnosis continues to confound the general public who, understandably, can't readily grasp how hypnosis can be in the spotlight in cheesy stage acts, yet still be taken so seriously by prominent researchers and clinicians who study it in depth and enthusiastically declare it an effective vehicle of treatment when used skillfully by well-trained health care professionals.

Defining hypnosis would seem a good starting point for a book on the subject. This is much easier said than done, however. Hypnosis has no single agreed upon definition simply because it is difficult to precisely define something so abstract that also varies greatly with circumstances and suggested qualities of subjective experience. It's like trying to precisely define equally abstract terms such as "love" or "patriotism."

A widely cited definition is this one offered by the American Psychological Association's hypnosis division (Division 30), called the Society of Psychological Hypnosis: "Hypnosis is a procedure during which a health professional or researcher suggests that a client, patient, or subject experience changes in sensations, perceptions, thoughts, or behavior." This broad definition acknowledges the role of the person doing hypnosis, the context in which it is done, and the role of the person experiencing hypnosis. What happens in the mix of these three factors that makes it possible for someone to essentially direct someone else to have an experience that, under normal conditions, would seem,

at the very least, unlikely? For example, encouraging someone suffering pain to focus attention on allowing a comforting sense of numbness to develop in a particular part of his or her body is not typical conversation! Something very special is going on in the world of hypnosis, as I hope and expect you will discover here.

I'm a clinical psychologist, regularly treating people with a wide range of problems who are looking for advice, information, and relief. I have spent my entire professional life—more than 40 years—fascinated by hypnosis and its merits in a wide variety of health care applications. I learned early on in my career how powerful relationships can be and how powerful words can be. I've had countless opportunities to watch people do things during experiences of hypnosis that, even while I'm watching them, I'm thinking, "No way!" A clinician introduces a suggestion, say, for stemming the flow of blood to an area, and the client in hypnosis responds by doing so. Now, how does *that* happen? What does it say about that particular person, and what might it say about people in general? Not everyone can do that, it seems, but I am regularly amazed by people showing all kinds of abilities I—and *they*—wouldn't have thought they'd have. Hypnosis provides a focused context for mobilizing and using these often hidden skills, empowering the person in the process.

Studying hypnosis will likely change your understandings of people and their problems by encouraging you to look for client strengths in ways you may not have considered before. Acquiring skills in the use of clinical hypnosis will be an invaluable means for enhancing your clinical abilities. Integrating hypnosis into your treatment plans can allow you to obtain better and more lasting results in the therapy work you do. Perhaps best of all, use of hypnosis can be a way to promote self-sufficiency and independence in the people you work with, helping them to feel more in control, resourceful, and self-assured.

I wrote this book holding the assumption that you, the reader, want to learn about hypnosis in order to possibly apply it in your work with others. Thus, in this book, I will pay attention to the *clinical* context in which hypnosis is applied. By focusing on the *clinical* uses of hypnotic principles and approaches, I will be paying greater attention to the essential skills of how you engage and amplify people's attention, and how you then use your words and gestures in particular ways to help people achieve their goals. This is not to say that hypnosis is only about the skills of the clinician, particularly when it is well established that hypnosis only happens when the client is willing to engage in the experience and can get absorbed in the possibilities the therapist suggests. But, you are undeniably a full half of the relationship with your client. Thus, the skills of the clinician are a large part of the hypnosis equation, and these skills are the focus of this book.

Is there Evidence that Hypnosis Really Works?

The field of hypnosis has been directly influenced by the push in the health care system for delivering what are generally termed "empirically supported treatments," that is, treatments that have a proven value. In recent years, substantial high-quality research has been done in order to assess what, if anything, hypnosis can contribute to the positive effects of treatment. Thus, a growing body of good hypnosis research is becoming available to clinicians of all types, especially since this valuable research is no longer being published only in hypnosis specialty journals. Topnotch journals across disciplines regularly publish valuable hypnosis research.

Let's pose the question directly: Does hypnosis work, that is, is it an effective therapy? The question seems deceptively simple, as if there should be a single, clear response. Unfortunately, though, the issue isn't clear because of one confounding factor: The debate still goes on to this day as to whether hypnosis should be considered a *therapy*, or simply a *therapeutic tool* but not a therapy in its own right. There are prestigious and persuasive advocates for both positions. For those who view hypnosis as a therapy in its own right, any therapy that employs hypnosis is termed "hypnotherapy" and it strongly implies that hypnosis is the principal mechanism of intervention. Hypnotherapists view hypnosis as a style of treatment that is as well defined and as distinct in character as, say, behavior therapy.

On the other side of the issue are those who view hypnosis as a *tool* of treatment, integrated into a larger conceptual and practical framework that transcends the hypnotic procedures themselves. Rather than hypnosis or suggestive procedures being "stand alone" methods, hypnosis is used to further the aims of other, more well defined interventions, such as cognitive therapy. (It may seem like an annoying semantic issue to some, especially in the United States, but in many European countries the issue is substantial because how you define your work determines whether or not you are eligible for payment from government insurance resources.)

Whether hypnosis enhances treatment results is not dependent on resolving the issue of whether to define hypnosis as a therapy or a therapy tool. The dividing line between a therapy and a therapy tool in this case is sufficiently ambiguous to arouse debate by the experts. *What matters more is the growing body of objective evidence that when hypnosis is part of the treatment process, it generally increases the benefits of treatment*. Hypnosis has been effectively applied in the treatment of far too many conditions and disorders to name them all, but some of the best-known applications are in the treatment of pain, anxiety, post-traumatic stress disorder, depression, phobias, children's disorders, irritable bowel syndrome, and dissociative disorders.

Hypnosis can differ dramatically from the way one clinician applies it to the way another clinician applies it. This is one primary reason why some professionals don't much care for the term "hypnotherapy." It doesn't say enough about what sort of treatment the clinician is actually providing once hypnosis has begun. Thus, when one researcher concludes hypnosis did not significantly increase positive effects, or, conversely, when another researcher concludes it did, it bears more careful scrutiny by the reader to determine what kinds of procedures were used, and whether they reflected a particular style or orientation to hypnosis that enhanced or diminished the value of the findings.

So, the question, "Does hypnosis work?" is a complicated question. Is it the hypnosis itself that "works," or is it the larger treatment plan of which hypnosis is only a part that is effective? *In the most general sense, though, it can be said with confidence that hypnosis helps improve treatment outcomes*. The research shows that when a treatment is delivered without hypnosis, and the same kind of treatment is delivered with hypnosis, the addition of hypnosis enhances treatment response. This point alone justifies the time and effort it takes to learn hypnosis.

The Value of Hypnosis Keeps Growing

As the pace of life keeps getting faster for most of us, and as our attention spans collectively get shorter, it has become obvious to many researchers and clinicians that much of what ails us is the disconnect from ourselves. Too many of us don't know we're tired until we're exhausted, or that we're stressed until we're on overload, or that we're lonely until we're desperate for some attention, even negative attention. Here in the United States, we have the highest rates of stress-related illnesses of any country, but in this planetary "global village" we all share, other countries are quickly catching up to this unfortunate position of distinction.

It has never been more important to take the time to focus, to discover the richness and complexity of our inner world, and to be connected to positive and helpful abilities you thereby discovered but never knew you had. *Hypnosis provides each of us an opportunity, not a guarantee*. Hypnosis invites you to stop and go inside and focus on what's *right* with you, amplifying it and using it in new ways that not only make you feel better, but *be* better. Your quality of focus may well be the single greatest factor determining your quality of life, and that of the people you hope to help. Learning hypnosis will be a gift that keeps on giving in more ways than you could have ever expected.

2

HYPNOSIS CAN BE USED IN MANY DIFFERENT CONTEXTS

Wherever there is involvement of the person's mind in a particular problem, which is *everywhere* to one degree or another as far as I can tell, there is some potential gain to be made through the application of hypnotic patterns. With that point in mind, this chapter will consider specific contexts where hypnosis may be used to help people in meaningful ways.

Medical Hypnosis

In general, hypnosis can be a useful adjunct to more traditional medical treatments for several reasons, the first of which relates to the mind–body relationship and the role of the mind (attitudes and related emotions) in medical disorders. Hypnosis amplifies the mind–body relationship, encouraging greater healing, increased control over physical processes such as immune functions and circulation, and better coping with pain and distress.

A second reason for making use of hypnosis in the medical context is because of its emphasis, by its very nature, on the responsibility of each person for his own health and well-being. Use of hypnosis gives people a direct experience of having some control over their internal experiences, whether of pain or distress. I have worked with many people who actually cried tears of joy or relief in a session for having had an opportunity to experience themselves as relaxed, comfortable, and positive when their usual experience of themselves was one of pain and despair. Finding resources of comfort or the ability to shift perceptions of their body within themselves was a dramatic experience, and allowed them to take on a new and higher level of care for themselves.

Hypnosis in the treatment of serious diseases, as an adjunct, not a replacement, for more traditional approaches, has demonstrated the

necessity of addressing the emotional needs of the patient while mobilizing his or her mental resources as a part of treatment. This is true even for diseases that seem, and probably are, entirely organic in nature. The exact mechanism whereby a doctor can verbalize a few hypnotic phrases and effect changes in the patient's condition or physiology is unknown. In general, hypnosis is thought to strengthen the body's immunological functions and assist in fighting disease. How it does this exactly has been the focus of a relatively new field called psychoneuroimmunology. Much research still needs to be done, of course, but the lack of precise explanations for mechanisms of action should not inhibit the use of techniques that can assist in the healing of a human body. Hypnosis doesn't replace other treatments—it adds to them.

A Few Words of Caution

There are a couple of special issues associated with hypnosis and mind–body healing approaches that I'd like to bring to your attention. The first concerns the responsibility of a patient for his or her health. The goal is to positively encourage a person to use all of his or her resources to help him- or herself. *Pointing out responsibility for one's self is not meant to translate into blaming the person for his or her condition.* The second issue relates to the use of hypnosis in the treatment of medical problems. Specifically, unless you are a physician, or have the proper training and credentials to treat a person's physical disorders, you are working out of your field and are inviting trouble for both you and your patient. If you want to assist someone in the treatment of a physical disorder, it is imperative from an ethical, legal, and humane standpoint that you have the support and involvement of the appropriate medical practitioners. You cannot simply assume, for example, that a patient with migraines is "just stressed" or a child with a stomach ache is "just trying to get out of going to school." With those symptoms, and all others, the patient should have a thorough physical examination, and you should have medical backup as you treat individuals with what may well turn out to be organically induced symptoms. Call the patient's doctor directly, and ask if your treatment plan will interfere with his or hers, at the very least. Rarely, if ever, will it interfere and treatment can be coordinated between you. Knowledge of medications the patient may be taking and the physical impact of his or her symptoms is also essential to effective suggestion formulation.

The growing use of hypnosis in a broad range of medical conditions is evidence of the influence of all those who have called for a more person-centered practice of medicine. Physicians, to their credit, have generally evolved a style of practice that invites the patient to be an informed and

active participant in treatment. Hypnosis amplifies this partnership and thereby empowers patients to mobilize their own resources to supplement whatever other treatments they might also be receiving.

Dental Hypnosis

Many of the desired outcomes sought in medical contexts are also desirable in the dental setting because of the physical nature of dental work. Physical parts of the body (i.e. teeth, gums, and associated structures) are under treatment. Furthermore, attached to every mouth under treatment is a human being whose attitudes about the work being done, the dentist, and his or her self (self-image) will affect the outcome of the intervention.

Dentists are aware, perhaps acutely, that most dental patients do not mark their calendar months in advance of their appointment and wait with eager anticipation for the big day to arrive. Far more common is the patient coming for treatment who can be described as somewhere in between mildly reluctant and terrified.

Hypnosis as a means of effectively communicating with and enhancing the treatments of the dental patient has been well documented. Helping a patient reduce his or her anxiety about receiving dental treatment with a few well-chosen statements can make a huge difference in the outcome. A second good use of hypnosis in dentistry involves the use of pain management techniques. Many people either cannot or choose not to use chemical anesthesias (or analgesias) such as novocaine or nitrous oxide, and prefer to rely on their own resources when undergoing dental treatment. Hypnosis techniques for creating the experience of analgesia or anesthesia allow the patient to reduce to a more easily managed level the degree of discomfort experienced, and many are able to eliminate the discomfort altogether.

A third use of hypnosis in dentistry is for its ability to assist in directing the flow of blood. With proper techniques and a responsive patient, hypnosis can reduce blood flow to the area under treatment. The result is a less traumatic experience for the patient and greater clarity for the dentist in seeing what he or she is doing. A related use of hypnosis is for the enhancement of the healing process following treatment. Use of hypnosis techniques involving the imagining of healing (e.g. images, feelings, and sounds associated with rebuilding, repairing, and strengthening) can both shorten the recovery period and allow greater comfort during that time.

Another use of hypnosis in dentistry has been to counter bruxism, or teeth grinding. Bruxism patients can be given suggestions to develop a greater awareness of and control over the muscles in their jaws. Finally,

hypnosis to encourage better dental health practices has been successfully employed. Suggestions to increase time brushing and flossing can be given to encourage prevention of dental problems.

Many dental practices could easily incorporate hypnosis into treatment through the use of generalized relaxation recordings the patient can listen to (through headphones) during the dental procedures. Of course, better responses occur with more individualized approaches, but unusual is the dentist who has the time, interest, and means for the greater involvement in hypnosis such a practice would require.

Forensic Hypnosis

In decades past, hypnosis had frequently been used in the course of criminal investigations to refresh or enhance eyewitness testimony, whether that of a witness, victim, or suspect. In light of the considerable research evidence that hypnosis was given more credibility in the domain of memory enhancement than it deserved, a subject I'll explore in depth later when we focus directly on memory, hypnosis has lost much of its value as an investigative tool.

As a part of the investigative process, particularly when information simply can't be obtained in any other way, hypnosis may still be used when performed according to some specific practice guidelines. In such instances, hypnosis may be used to try to facilitate a person's recall in an attempt to recover details of the crime the person could not consciously remember. Often, a person's conscious mind is so absorbed in feelings (e.g. fear, fascination, confusion) during the experience of witnessing or being victimized by a crime that conscious memory is poor. Because of the dual nature of the human mind (i.e. conscious and unconscious processes), memories and details that may have been forgotten or else simply escaped conscious noticing in the first place may not have escaped the person's unconscious processing. Thus, there's a possibility—not necessarily a probability—the person might remember something in hypnosis they'd forgotten or didn't even know they knew.

Hypnosis in the Courtroom

The use of hypnotically obtained testimony in the courtroom is embroiled in controversy even now. Experts are at odds over the issue of whether hypnotically obtained testimony is valid because of the potentially detrimental effects of hypnosis on memory (e.g. intentionally or unintentionally suggested misrememberings). On one side of the issue are those who claim that the information obtained from a hypnotized person is as usable and reliable as any other information obtained from memory, and

that hypnosis does not *necessarily* distort memory. On the other side of the issue are those who claim that hypnosis invariably alters memory, that the hypnotized witness can lie while in hypnosis, and is likely to fill in missing details either with fantasy material or with information contained in the subtle leading questions of the investigator.

The issue is really one concerning the nature of memory. In a sense, both views on hypnosis and memory are correct. The conflict is a pseudo-conflict, a conflict arising because of its "either–or" nature, which is not a useful dichotomy in this case. All human memory is a distortion of experience—a memory is an internal representation of an event and not the event itself. The process of experiencing and then remembering is regulated by many factors, including values regarding what is important to notice; mood; internal or external focus; expectations; previous experiences in similar situations; and a variety of other factors that must be considered.

Memory, whether in a formally induced hypnotic condition or in the less specific condition called "life," can be reliable to a large extent, such as in "objective" experience when many people reach agreement on the object of observation. Likewise, memory in or out of hypnosis can distort experience because of the factors described earlier that comprise one's conscious and unconscious information-processing capacities. Why else can ten people (presumably not all in hypnosis) standing on a street corner all see the same accident yet their police reports offer ten different versions of what happened?

Hypnotically obtained information should be considered in the same way as information obtained by any other means, in my view. It should be considered, evaluated, and substantiated by other means. If one has a motivation to lie, though, hypnosis has no preventative powers. If one must distort or misrepresent an experience, it won't be because of hypnosis. One doesn't require formal hypnosis to fill in gaps or rely on others' leads; these processes are ongoing in all human beings. Blaming hypnosis for the memory distortions is not reasonable when the evidence is clear that memory distortion is not unique to hypnosis.

Since the laws about hypnosis in the courtroom vary from state to state in the United States, it would be wise for you to find out what the laws are where you practice. This knowledge may affect your practice in ways you can't yet imagine, such as in a case where you help someone in pain who will eventually be going to court to settle a lawsuit about the accident. Will the court consider the testimony contaminated because of the hypnosis you did and thereby dismiss the claim? It's in the realm of possibility, so you're advised to do your homework and know where you stand legally in your practice.

Hypnosis in Education

Teaching and learning are highly refined skills that require a great amount of information processing on multiple levels. Teaching is a learning experience—learning how to capture students' interest and attention (a skill necessary for the induction of hypnosis, not coincidentally), learning how to present information in such a way that the student can use it (a skill necessary for the effective utilization of hypnosis, not coincidentally), and learning how to allow students to become self-sufficient learners (a skill necessary for consolidating treatment results with hypnosis, not coincidentally) so they may be competent and motivated to learn in the absence of the teacher. Whether a teacher is teaching preschoolers or doctoral candidates, effective teaching involves these steps paralleling hypnotic patterns.

Learning is a multiple step process. For the sake of simplicity (learning theory is a complex world in its own right), effective learning must include the following basic steps: First, there must be some degree of attentiveness to the material to be learned. Second, there must be some method for bringing the material from the outside world into the internal world. One's senses (e.g. sight, hearing, etc.) are the means for gathering information from the world around us. There is nothing we experience of the external world that does not enter our conscious or unconscious mind through one or more of our senses. Third, there must be some method for organizing the information internally as it mingles with previously acquired information while simultaneously building a framework in which to incorporate future learnings. Fourth, and last, there must be some method for being able to retrieve the information from within as necessity dictates.

Does hypnosis enhance learning by enhancing memory? As you learned in the previous section, hypnosis does not seem to do much for enhancing accurate memory. Studies on using hypnosis to increase recall of meaningful as well as nonsense material generally reinforce this point.

Hypnosis as a tool has been used successfully, however, to assist in the learning process both by enhancing concentration and diminishing anxiety. Anxiety can interrupt any of the above steps (e.g. "going blank at exam time") and poor concentration can distract one from adequate exposure to the information as well as disrupt its internal organization.

Many creative teachers at all levels are using hypnosis in their teaching, encouraging students' creativity and guiding students with relaxation procedures, for example. Many students are developing themselves with self-hypnosis exercises, learning to manage anxiety and increase their ability to notice and organize their subject of study. Hypnosis in the educational context, whether formally or informally used, can enhance teaching skills, creativity, and student performance.

Sports Hypnosis

Engaging in athletics with any degree of intensity involves a large measure of physical control and mental concentration. Hypnosis as a tool can effectively provide both. For the athlete, having precise control over one's body is essential to outstanding performance. Athletes often describe what they call "muscle memory," the body's keen awareness of how each limb, each muscle must be positioned in order to perform successfully. The physical control through the amplification of the mind–body relationship can help an athlete push his or her body to the upper limit of his or her talents. The requirement for intense concentration is obvious, and hypnosis as a technique for narrowing one's attentional focus to the task at hand is a powerful tool to have available.

In addition to building concentration and physical control, hypnosis can help in better managing the considerable stress inherent in competing. Furthermore, building positive expectations and positive self-talk can enhance performance dramatically. Often, the troubled, slumping athlete has mental images of failure, which all too easily get translated into real failure. Building positive images through hypnosis and self-hypnosis can turn an athlete's performance around completely. Certainly, hypnosis does not provide extra talent to the athlete; it simply amplifies the talent the athlete has, giving greater access to as much of his or her talent as possible. A lot of athletes appreciate that, as you can well imagine.

Hypnosis in Psychotherapy

As a psychotherapist by training and in practice, I have developed a profound appreciation for the possibilities hypnosis has to offer in the treatment of behavioral and emotional problems.

How do you know where to step in and offer help in a client's world? There are currently more than 400 different forms of psychotherapy described in the literature, and all of them have the potential to be helpful to someone (just not *everyone*). All of the various therapeutic approaches work in a general sense. The skill is in knowing what will work with *this* specific person.

The person seeking help has quite likely already tried to consciously change (perhaps through sheer willpower or by seeking greater self-understanding from reading self-help books or by having consulted other mental health professionals) and failed to do so. The resources the person can get to consciously aren't the ones that have resolved matters for them. In simpler terms, the perceptual frame the person has used to solve the problem hasn't been helpful; the solutions are more likely to be outside the person's usual experience of him- or herself. Hypnosis helps people "step outside" their usual experience of themselves, allowing new

associations to be formed in their inner lives (whether on cognitive, emotional, behavioral, and/or physical levels). *Hypnosis by itself cures nothing. It's what happens during the hypnosis that has the potential to be helpful to people.*

Hypnosis in psychotherapy can be used in at least two general ways: (1) to suggest symptom relief; and (2) to teach specific skills (e.g. cognitive, behavioral, relational) that can help someone better cope with and resolve ongoing underlying issues and problems as well as deal with their presenting symptoms.

How someone uses hypnosis clinically is a direct reflection of his or her own beliefs about what constitutes appropriate clinical practice. A view of people that appreciates each person's uniqueness would preclude you from approaching each client in the same "cookbook" way. Likewise, a view of people that assumes people seeking help are "sick" and need to be made "well" would preclude you from making use of the wealth of their personal resources that would be available to another clinician who views people as uniquely special and potentially powerful in their ability to make use of their innate resources in new ways for growth.

3

THE MYTHS ABOUT HYPNOSIS AND WHY COMMON SENSE MATTERS

In the practice of clinical hypnosis, the opportunity for dealing with misinformation is constant. Most misconceptions people hold—whether clinicians or their clients—are predictable, which can make their identification and rebuttal easier. There is no doubt that well-educated clinicians conduct better quality hypnosis sessions and well-educated clients outperform those who are either uninformed or misinformed.

Involving clients in direct discussion about their beliefs and expectations for the hypnotic and psychotherapeutic experience is necessary to make certain they are knowledgeable enough to make sensible treatment decisions. Since the client's understanding of the therapy process may be inaccurate, incomplete, or both, the ethical and competent professional can provide the person with as much information as he or she may require in order to be fully involved in the process in a cooperative and positive way.

Finding out What the Client Requesting Hypnosis Believes

Only by engaging the person who directly asks for hypnosis in discussion can you discover how much he or she knows and simultaneously use the opportunity to support or challenge the person's beliefs. Some basic questions that have been useful for me to ask are: Have you ever had experience with hypnosis before? Was it personal experience or was it something you saw, read, or heard about? What impression did you form? What leads you to believe it might be helpful to you?

If the client *has* had personal experience with hypnosis, good questions to ask might include: What was the situation in which you experienced

hypnosis? Who was the hypnotist and what were his or her qualifications? What was the explanation given to you about hypnosis at the time? What was the specific technique used with you? Was it successful? Why or why not? How did you feel about the experience? What is the basis for your seeking further experience with hypnosis? Such information will be vital in helping determine your approach. Asking a lot of questions can be threatening and tiresome to the client, and so must be done gently; aggressive interrogations under a bright light are not recommended.

If the person *has not* had personal experience with hypnosis, good questions to ask might include: What is the basis for your requesting hypnosis? Have you heard about clinical applications of hypnosis before? How have you heard hypnosis may be used? Do you know anyone personally who has experienced hypnosis? What did he or she tell you about it? What is your understanding of how hypnosis works? How specifically do you believe it might be helpful to you? Have you seen hypnosis demonstrated? If so, in what context? In asking some or all of these questions, you can elicit the client's experiences and attitudes concerning hypnosis. Misconceptions can be dealt with, unrealistic fears and magical wishes can be alleviated, and a positive belief system can be established.

Asking about specific hypnotic techniques the client may have previously experienced is very important. If he or she experienced a process that was ineffective or even unpleasant, then your using a similar technique almost guarantees a similar failure. Unless you specifically ask about prior experience, you run the risk of duplicating past negative experiences. Why? The client's associations to that approach are negative. If you want to create a positive experience with hypnosis, it makes good sense to do something different.

If the client has not had personal experience with hypnosis before, but is only indirectly familiar with it through entertainment media or the experiences of an acquaintance, it becomes even more important to discover his or her beliefs and attitudes. Second- and third-hand stories about hypnosis from "knowledgeable" friends have a tendency to get distorted and can sometimes be as misleading as the entertainer's version of hypnosis. Many clients who seek hypnosis are fearful of the "mind-control" potential, but seek the associated "magic wand" for the "instant results" they've been told are possible. "Instant results" (i.e. single session interventions) *are* sometimes possible, in fact, but the larger issue here is to help unrealistic people avoid the "magical thinking" that complex problems can be solved instantaneously through hypnosis.

The Issue of Control

If someone were to come to you, take you by the hand and say, "Come with me," would you go? Or, would you first demand to know where you are being taken? Try this simple exercise on a number of people you know in varying degrees of closeness. It should highlight to you the recognition that different people respond differently to direction and uncertainty, an important observation relevant to doing clinical hypnosis. The issue of "control" surfaces immediately. In fact, the client's fear of losing control of him- or herself is the single greatest obstacle you are likely to encounter in your practice. In one form or another, almost every common misconception is grounded in this fear. Unless you acknowledge and deal with it in a sensitive and positive way, it will undoubtedly hinder or even prevent the attainment of therapeutic results. The belief that hypnosis has the power to take self-control away has been fostered in ways mentioned previously, and until one has had the experience of therapeutic hypnosis in a positive atmosphere of caring and professionalism, the fear is a real one.

Stage hypnosis and variations of it found in the entertainment media seem to be the biggest culprits for making control an issue of such huge proportions. The typical viewer of a hypnosis stage act has no idea how the hypnotist can "make" seemingly normal volunteers do all those strange and silly things on stage before an audience. The erroneous conclusion is that the hypnotist has some mysterious power that can make people do things they would not ordinarily do.

Clinicians need to be sensitive to the issue of control and respond to it in some meaningful way, either directly or indirectly. Avoiding the issue of control can increase the anxiety of an already uncertain client, and may generate a force ("resistance") that works against the aims of treatment. If a client fears an imminent loss of control, the typical result is a "power struggle" with the clinician. Would *you* want to be hypnotized if you thought you would lose control of yourself? The sensible goal in therapy is to do all you can to avoid a power struggle and define the relationship as a cooperative one. After all, there is really no way to win a power struggle with the client. To defeat your very best efforts, all he or she has to do is . . . *nothing*!

The importance of providing choices in the hypnotic encounter cannot be overemphasized. Hypnosis has occasionally been accused of making good people do bad things, but such accusations do not consider realistically the choices the individual made (or *didn't* make, which is also a choice). *At any given time, a person in hypnosis is in a position to choose to lighten, deepen, maintain, or end the experience*. You cannot be forced to focus your attention, dissociate and respond, the core components of hypnosis.

Common Myths and Common Sense

Listed in the remainder of this chapter are many of the most frequently encountered misconceptions about clinical hypnosis. Some of these are more common to clinician-practitioners, and others are more prevalent among clients. Following each is a discussion containing ideas that can help you clarify the issues related to the misconception. As you become more familiar with hypnosis, and you find yourself talking more about hypnosis to others, responding to these and other misconceptions will gradually become quite automatic for you.

Common Misconceptions Among Clinicians

Misconception: Hypnosis Can't Harm Anyone

It is not hypnosis itself that may cause someone problems, but difficulties may arise due to misdiagnosis, the inappropriate content of a session, or the inability of a clinician to effectively guide the client. The same conditions exist in *any* helping relationship where one person is in distress, vulnerable, and seeking relief. An inexperienced or uneducated helper may inadvertently (rarely is it intentional) misdiagnose a problem or its dynamics, offer poor advice, make grandiose promises, impose an anti-therapeutic point of view, or simply waste the person's time and money with ineffective treatment. It's the primary reason why many experts advocate for hypnosis being used only by qualified health care professionals.

Misconception: Hypnosis is a Good Thing

Your quality of life is largely dictated by what you tell yourself about yourself and the world around you. How does it affect your mood, behavior, and physiology when you tell yourself, "Life is so unfair!" Likewise, how does it affect you when you tell yourself, "I can do this!" Each person has countless thoughts each day, ranging from profound to (mostly) mundane. Which ones you focus on, which ones you absorb as true, can generate symptoms ("I'm afraid to fly because what if the plane crashes?") or, conversely, can generate healthy choices ("I love the freedom to be able to hop on a plane and go anywhere in the world I want to go!"). *Suggestions can be used to either help or harm* and in that respect hypnosis isn't innately a good thing. Hypnosis has the *potential* to be *very* good as a tool to help people when it is applied skillfully.

Misconception: Suggestions Given in Hypnosis Bypass the Conscious Mind and Go Directly into the Unconscious

This explanation is stated so commonly in the hypnosis community that too many people have simply accepted it as true. Saying it a lot does not make it so. It suggests hypnosis involves programming someone who is unaware of what is being said. There is much we don't understand about how a suggestion is converted to a response, but leading people to think you can sneak in suggestions "below the radar" is a misrepresentation of what hypnotized people actually experience. In fact, as the neuroscience demonstrates clearly, when people are in hypnosis they most definitely hear the suggestions being given and respond to them only to the extent that the suggestions fit and the person is willing to respond to them. People can be every bit as critical, perhaps even more so, about the suggestions they're given in hypnosis as they may be out of hypnosis.

Misconception: Hypnosis Necessarily Involves a Ritual of Induction

For as long as your attention is directed in an absorbing way either inwardly on some subjective experience, or outwardly on some external stimulus (which, in turn, creates an internal experience), and you are responsive to suggestions to alter your experience in some way, you can reasonably be said to be in hypnosis. It should be apparent that hypnosis does not have to be formally induced through some ritualistic procedure in order to occur. Likewise, the various hypnotic phenomena can and do arise spontaneously even when no induction has taken place. You may recall times when you were deeply absorbed in doing something, and only afterward did you notice you were injured or bleeding. That is an example of a spontaneous anesthesia, one of the classic hypnotic phenomena to be discussed at length later. It helps to be able to recognize hypnosis as a more common phenomenon than most people realize, and thereby take it out of the realm of "strange" or too far removed from everyday experience.

Misconception: Hypnosis is Simply Relaxation

Relaxation feels good, but it is, at best, simply a stepping stone in the direction of facilitating more complex hypnotic experiences, such as an age regression (experiential memory) or an anesthesia. No one would simply do a relaxation process and then expect the client to undergo a painless surgery. Hypnosis involves the deliberate structuring of experiences such as anesthesia that go well beyond simple relaxation.

Misconception: Hypnosis is a Specific School of Therapy

Clinical hypnosis is a therapeutic tool that is not aligned with any one theoretical or practical orientation. So, what of the term "hypnotherapy?" Does it mean anything? It implies therapy delivered hypnotically and, as you have already learned, hypnosis can enhance treatment effects. There *is* something special about hypnosis that warrants giving it a unique position in the realm of treatment. But should it be considered a distinct form of therapy?

There are nearly as many approaches to the use of hypnosis as there are clinicians who use hypnosis, and inevitably they use it in a way that is consistent with their beliefs about therapy and the way they believe therapy should be done. So, for some clinicians, hypnosis is integrated with cognitive-behavioral approaches, and for others it is integrated with psychodynamic approaches. For some, it is integrated with mind–body healing approaches, and for others it is integrated with preventive approaches. Whatever belief system and style of therapy you currently practice will likely continue to be meaningful to you as you discover ways to enhance what you already do by applying hypnotic approaches.

Misconception: Hypnosis Can Be Used to Recall Accurately Everything that Has Happened to You

Clinicians need to understand how memory works in order to best utilize this most important aspect of the individual. Some have compared the mind to a computer in which every memory is presumed to be accurately stored and available for eventual retrieval under the right conditions. The computer metaphor is highly inaccurate, however, and has the potential to be hazardous if a misinformed clinician operates on that premise. The research on memory makes it abundantly clear that the mind does *not* take in experience and store it in exact form for accurate recall later. In fact, memories are stored on the basis of perceptions, and so are subject to the same potential distortions. People can "remember" things in vivid detail that did not actually happen. Likewise, people can remember only selected fragments of an experience, or they can take bits and pieces of multiple memories and combine them into one inaccurate memory. Memory, simply put, is not reliable; if you are looking for "truth," you are unlikely to find it in memory.

Can a memory be considered more reliable because it was obtained through hypnosis? Can hypnosis be used to uncover the truth of what actually happened in someone's past? The answer to these two critically important questions is no. The effects of hypnosis on memory will be explored in greater detail later. Suffice it to say here that hypnosis does *not* increase the probability of accurate recall.

Common Misconceptions Among Clients

Misconception: Hypnosis is Caused by the Power of the Hypnotist

Hypnosis involves focusing on some stimulus such as the clinician's words or the client's own internal associations. When used formally, hypnosis usually involves a relaxation process as well. You cannot force someone to concentrate or relax; thus, entering hypnosis is a personal choice. The hypnotist directs the client's experience, but only to the degree that the client permits it. It is a relationship of mutual responsiveness.

Misconception: Only Certain Kinds of People Can Be Hypnotized

In theory, almost anyone can be hypnotized to one degree or another, whether directly or indirectly. In practice, however, there is a spectrum of responsiveness in people ranging from what are generally termed "low" hypnotizables to "mid-range" hypnotizables to "high" hypnotizables to "very high" hypnotizables, sometimes referred to as the "hypnotic virtuosos." These are designations based on responses to test items (such as the ability to generate an arm levitation or shoo away an imaginary fly) in the formal, standardized tests of hypnotizability researchers studying hypnosis are likely to employ.

Clearly there are some people for whom going into hypnosis is easier than others. What that means exactly is the subject of considerable debate within the field. Does it mean the person has some inherent gift (e.g. a genetically, neurologically, or psychologically defined capacity for hypnosis), or might it mean that the test protocol used to assess hypnotizability somehow overstates the significance of a high test score for the person? There are experienced and bright people arguing for each side. This issue will be explored in greater depth in Chapter 6 when we consider the factors that give rise to hypnotic responsiveness.

Misconception: Anyone Who Can Be Hypnotized Must Be Weak-Minded

This misconception is based on the belief that in order for a hypnotist to control someone, the individual must have little or no will of his or her own. Modern "scare stories" about evil hypnotists who control people and force them into doing terrible things play on this misconception. As discussed earlier, the average person does not understand how the hypnotized person can be in control of him or herself while demonstrating unusual behaviors at the direction of the hypnotist.

Misconception: Once One Has Been Hypnotized One Can No Longer Resist It

This misconception again refers to the incorrect idea that a hypnotist controls the will of his or her subject, and that once one "succumbs to the power" of the hypnotist, one is forever at his or her mercy. As you now know, nothing is farther from the truth, since the hypnotic process is an interaction based on mutual power, shared in order to attain some desirable therapeutic outcome. If a client chooses not to go into hypnosis for whatever reason, then he or she will not.

Misconception: One Can Be Hypnotized to Say or Do Something against One's Will

This is among the most controversial issues in the field of hypnosis. It raises many complex issues about notions of free will, personal responsibility for one's actions, boundaries in the therapeutic relationship, the potential for abuse of one's position, and other such issues related to professional and personal conduct. In theory, the clinician offers entirely benevolent suggestions that the client can freely choose to either accept or reject. In practice, however, this is far too simplistic to be entirely true given what we have come to know about the phenomenon of iatrogenesis (i.e. client symptoms either caused or aggravated by treatment), the exploitation of naïve or vulnerable clients, and the hazards of working with people who are sometimes psychologically quite disturbed. But, these circumstances represent the exceptions and are atypical of therapeutic environments where clinicians strive to be supportive and helpful.

Misconception: Being Hypnotized Can Be Hazardous to Your Health

This misconception is a strong one in raising people's fears about hypnosis. The process of formal (i.e. structured and openly labeled as such) hypnotic induction is an absorbing process in which one's concentration is directed—perhaps to an idea, or to a voice, or to an internal experience, but always to *something*. There is a slowdown of physiological functions (e.g. breathing, heart rate) and typically the person's body is relaxed. Such physical responses are healthy, effectively reducing stress and discomfort.

Misconception: One Inevitably Becomes Dependent on the Hypnotist

Clinicians know that the ultimate goal of responsible treatment must be to help each client establish self-reliance and independence whenever

possible. Rather than foster dependence by indirectly encouraging the client to view the clinician as the source of answers to all of life's woes, hypnosis used properly helps the person in distress to turn inwards in order to make use of the many experiences and resources the person has acquired over his or her lifetime that can be used therapeutically. Consistent with the goal of self-reliance and the use of personal power to help one's self is the teaching of self-hypnosis to those you work with so your clients can continue to work independently and grow in your absence.

Misconception: One Can Become "Stuck" in Hypnosis

Hypnosis necessarily involves focused attention, which may be either inwardly or outwardly directed. The hypnotic experience is fully controlled by the client, who can initiate or terminate the hypnosis session whenever he or she chooses. It is literally impossible to become "stuck" in a state of concentration. As a parallel example of absorption, can you imagine anyone getting "stuck" reading a book?

Misconception: One is Asleep or Unconscious When in Hypnosis

Hypnosis is not sleep! Observed from outside the experience, someone in hypnosis may physically resemble someone who is asleep, showing minimal activity, muscular relaxation, slowed breathing, and so on. However, from a mental standpoint, objectively measurable in a variety of ways, the client is relaxed, conscious, and *alert*. Ever-present is *some* level of awareness of current goings-on, even when in deep hypnosis. In the case of spontaneous hypnosis, as well as in the condition of so-called "alert hypnosis" where the person has his or her eyes open while engaged in some focused task, conscious awareness is even more marked. Physical relaxation need not be present in order for hypnosis to occur.

As you may have come to appreciate from this chapter, hypnosis carries with it a considerable amount of tired, old baggage. I hope you now have a clearer understanding of some of the most important characteristics and issues associated with hypnosis, and how to better inform the people you hope to help with the corrections to whatever misconceptions they may hold. Clients do better when they're well educated about the treatments you employ.

4

MODELS OF HYPNOSIS

How You Think about Hypnosis Determines How You'll Use It

Over the years there have been many different perspectives offered by clinicians and researchers in an attempt to characterize the phenomenon of hypnosis. As you might predict, these viewpoints often differ sharply. Each of these perspectives considered individually has played a role in both illuminating and confounding our understandings of hypnosis. In general, theories have a paradoxical effect: They catalyze understanding by helping one discover meanings and relationships in an otherwise apparently random universe, and yet theories can often confound matters by limiting one's observations to only what the theory allows for. The theories of hypnosis that have been developed over the years are each useful in their own way for describing one or more aspects of hypnosis, but none can be considered the final word in fully describing either the process or experience of hypnosis.

Let's briefly consider the essence of some of these models.

The Neodissociation Model: Hypnosis as a Dissociated State

The neodissociation model set forth by legendary hypnosis researcher Ernest Hilgard, Ph.D., has exerted a profound influence on the field. Most clinicians first learn about the phenomenon of dissociation in terms of pathological conditions, such as Dissociative Identity Disorder. However, dissociation represents a human capacity for separating or compartmentalizing different elements of subjective experience. This capacity to detach from aspects of experience, such as pain in your body or anxiety-provoking thoughts, can be helpful in a variety of ways when utilized skillfully.

Hilgard's neodissociation model is based on the view that humans have multiple cognitive (thought and information processing) systems capable

of functioning simultaneously. These are arranged in a hierarchy under the control of an executive system, called an "executive ego" or a "central control structure." Cognitive subsystems may include habits, attitudes, prejudices, interests, and other latent abilities. The executive system is tasked with monitoring and formulating responses to ongoing subjective experience. In the condition of hypnosis, the various cognitive systems can function autonomously, effectively dissociated from one another to a significant degree.

The research sparked by the neodissociation model has been extraordinary in both volume and quality of findings and has led to some of the most important understandings within the field of hypnosis, especially in regards to unconscious influences on people's responses to suggestion and the view of hypnotizability as a variable but stable trait across individuals.

Hypnosis as a Passive or Permissive State

In this theoretical perspective, special emphasis is given to what is presumed to be the passive role of the client, whose position is defined as one of responding to the directives of the clinician. Is hypnosis a state of passivity or arousal? It's *both*. This primarily intrapersonal model explores the active–passive paradox of hypnosis that has confused and divided clinicians about what is happening in the subjective experience of the client.

One of the ways to describe a clinician's style of hypnotic intervention is in terms of the degree of authoritarian or permissive suggestions employed. An authoritarian practitioner is characterized as one who is direct and commanding. The stage hypnotist is a classic example of the authoritarian approach, evidenced by such common direct suggestions as, "You are going to close your eyes when I count to three." A permissive style is one that emphasizes possibilities without making specific demands on the client, as in a suggestion such as, "*Perhaps* you'll be more comfortable if you let your eyes close."

The authoritarian approach of some clinicians is the basis for this theory's description of the demeanor of the client in hypnosis as a passive, permissive one. Specifically, a permissive client is characterized as one who permits the clinician to direct his or her experience, seemingly expressing no will of his or her own. The client is expected to fully respond to the suggestions of the clinician, and no initiative on the part of the client is either expected or deemed necessary. Superficially, the hypnotic interaction may thus seem to be one of the clinician being the active one and the client the passive one. Discussed earlier, however, was the notion that if you allow another person to guide your experience,

the person in control is the one who has the power to "allow" the actions of another. The role of the client, therefore, is *not* a passive one. Rather, it is an active one in the sense that it is the client's ability and responsibility to respond, in whole or in part, to the suggestions of the clinician that makes hypnosis happen. And, a response is inevitable, since even no response is a response!

If a clinician adopts a permissive style in guiding the client, a style that may be less direct and is certainly less demanding, the client is defined as an active participant in the process of making suggested possibilities come to life. In such a client-activated approach, the "permissive state" theory of hypnosis is no longer as plausible.

Hypnosis and Social Role-Playing

There is a considerable amount of speculation by experts as to whether there really is a condition of human experience that can be called "hypnosis." In light of advanced neuroimaging technology, is there a discrete and consistently measurable change that takes place we can point to and say, "There! That's hypnosis!"? Unfortunately, no evidence for a specific state called hypnosis has yet been found. Graphs of brain waves, measurements of biochemical changes in the body, and objective readings on the activity of the nervous system are revealing ever more about the internal workings of hypnotic experience, yet they are still ambiguous enough to prevent us from defining hypnosis in purely, or even primarily, physiological terms.

While some look for a biologically defined state of hypnosis, other theorists have adopted the perspective that hypnosis is not a discrete state separate from normal experience. They suggest that the seemingly unusual behaviors associated with hypnosis can be accomplished by anyone sufficiently motivated to so behave even in the absence of any mention of hypnosis. Hypnotic phenomena thus occur as a consequence of an interpersonal context labeled by the participants as "hypnosis." In their view, hypnosis exists only when someone is willing to play the socially prescribed role of a hypnotized individual.

Classic studies conducted by Martin Orne, M.D., Ph.D., were among the very first to address the issues of the confounds of distinguishing simulating versus "genuinely" hypnotized subjects and the demand characteristics of hypnosis encounters that could yield responses that were merely compliant rather than hypnotic. An experimental scenario might involve a group of subjects who are instructed to behave "as if" they were hypnotized and mixed with a group of subjects who were overtly and willingly formally hypnotized. A number of "experts" in hypnosis are then challenged to discover which individuals were and were not

"truly" hypnotized. Subjects who role-played hypnotic behavior were extremely convincing in their manifestations of hypnotic phenomena and were able to successfully confound the experts.

Role-playing has long been recognized by social scientists as a way of absorbing a person's attention by encouraging him or her to "get lost in the role." Many therapeutic strategies (e.g. psychodrama, behavioral rehearsals, family therapy role-reversals) regularly involve role-playing as a way of rehearsing positive responses in troublesome situations or developing empathy for another person. Initially, the client typically feels self-conscious and uncomfortable in the role, but gradually adapts to the role demands and is soon immersed in it.

Role-playing as a theoretical perspective on the phenomenon of hypnosis is useful up to the point, wherever that may be, where the artificial experience becomes genuine, a "believed-in imagining" as theorist Theodore "Ted" Sarbin, Ph.D., called it. A client or research subject may begin by making a conscious effort to respond with hypnotic behavior, but at a certain, idiosyncratic point along the way, a true hypnotic experience begins when responses become unconscious (i.e. non-volitional).

Hypnosis as a Sociocognitive Phenomenon

A dominant model in the field of hypnosis today, and growing ever more influential over time, the sociocognitive model emphasizes social roles but also focuses intently on the cognitive makeup of the individual, including his or her expectations, beliefs, attitudes, attributional style, and other such factors influencing social responsiveness. Psychologist Theodore X. "Ted" Barber, Ph.D., was especially prolific in his writings and research into the multiple factors comprising hypnotic responsiveness. Barber considered both intrapersonal characteristics of the client, such as fantasy proneness and imaginative ability, and interpersonal characteristics of the social context of hypnosis. His view is that there are four especially important behavior-determining factors regulating the hypnotic experience:

1. *Social factors* that obligate the socialized subject to cooperate and try to actualize or realize the hypnotist's expectations and explicit suggestions;
2. *The hypnotist's* unique skills and personal characteristics (including creative ideas, communicative ability, and interpersonal efficacy) and the nature of the hypnotist–subject interpersonal relationship;
3. The effectiveness of the *induction procedure* in encouraging the subject to choose to go along with the suggestions; and

4. The depth of meaning, creativity, and "force" or "power" of the *suggested ideas*.

Other prominent sociocognitive theorists have also conducted significant research on the social and contextual forces affecting hypnosis as they interface with personal variables. Much of their work has focused on the placebo effect, a therapeutic response to an inert substance or procedure, such as a sugar pill or a sham surgery, where a positive expectation clearly catalyzes a meaningful response. One prominent sociocognitive theorist, psychologist Irving Kirsch, Ph.D., went so far as to describe hypnotic suggestions as "verbal placebos." As a result of the strong support in research, sociocognitive models hold an especially prominent place in modern understandings of hypnosis and hypnotic phenomena.

Hypnosis as an Altered State of Consciousness

The experience of hypnosis has been conceptualized by some as an altered state or states of consciousness featuring absorption and shifts in perception. In this perspective, hypnosis is considered to be a unique and separate state of consciousness relative to one's "normal" state of consciousness. The hypnotic state is presumably created by the hypnotic induction process that alters the person's consciousness through the narrowing of attention to the offered suggestions. The altered state is thought to feature reduced defenses, greater emotional access and responsiveness, and greater access to unconscious processes.

This view of hypnosis as a distinctly altered state, or perhaps altered states, has historically been popular because of its recognition that people in hypnosis can experience things seemingly beyond their usual capacity. The idea of altered states of consciousness conveniently allows for that possibility, and also allows for the variable proportion of people who can experience such states as described in hypnotic susceptibility statistics.

Despite its early popularity and seeming obviousness, the view of hypnosis as an altered state of consciousness has been supported by the wide range of perceptual shifts people report taking place in their individual experiences of hypnosis. But, this view has also been challenged by the fact that unique physiological correlates (including brain "signatures") of hypnosis have not been found, and the additional fact that hypnotic phenomena can be produced without the benefit of hypnotic induction.

If hypnosis is an altered state of consciousness, what is it altered *from*? Yet, when a hypnotized person experiences his or her body as numb in response to a suggestion for developing an analgesia, that is not a routine experience. Clearly, *something* has changed, but *what* exactly changed and exactly *how* it changed largely remain a mystery.

The Reality-Testing View of Hypnosis

You use your senses to gather information from the world around you. Consciously, but more so unconsciously, you are continually engaged in the processing of huge amounts of sensory input flooding your nervous system that tells you where you are relative to your immediate environment and what is going on around you. Information is continuously coming to you through virtually all of your available senses, and all of these tiny bits of information give you a sense of where your body is, what position it is in, and how it is distanced from objects and outside experiences near and far. This is referred to as a "generalized reality orientation."

Obtaining feedback from our senses about the world around us and striving to validate its accuracy is a process called "reality testing." Proponents of this view of hypnosis claim that people are continually reality testing in order to preserve personal integrity and alleviate the anxiety of uncertainty in not knowing our position in the world. This process is generally so unconscious we take it for granted.

The reality-testing view of hypnosis theorizes that when someone is first entering and is then in hypnosis, his or her ongoing process of reality testing is directly affected, generally by reducing one's reality orientation. When someone suspends the process of obtaining feedback from the world around him or her by focusing inwardly as is characteristic of most (but not all) hypnotic experiences, the person is primarily oriented to internal experience. The suspension of objective reality testing frees the person to accept whatever reality is suggested. As research has affirmed, though, consistent with Hilgard's neodissociation perspective discussed earlier, suspending or reducing reality testing in order to accept suggestions for perceptual shifts does *not* preclude reality awareness. People in hypnosis retain the ability to monitor and, if necessary or desirable, respond to situational realities and cues.

The Conditioning Property of Words and Experiences

Three of the most advantageous properties of having evolved consciousness for us as a species are our ability to reason, ability to learn on multiple dimensions of experience, and ability to communicate about experience. Evolution has allowed us to attach words to experience and thus represent experience abstractly. Instead of our communication concretely being tied to a current need or experience, we can communicate about things that occurred millions of years ago or about things yet to come centuries from now.

Language and communication will be discussed repeatedly throughout this book. When we seek to evolve a theoretical perspective for the various

phenomena of hypnosis, the recognition of the role of your words as triggers for complex, multidimensional, non-volitional, focused, socially responsive, contextually valid experience is absolutely crucial to the attainment of sophistication with hypnotic techniques. Hypnosis encompasses so many variables, but my ultimate aim with this book is to help you evolve a framework for being able to *say something to your clients that will help*. Regardless of theoretical orientation, I know of no one who would suggest that what you say to the client is unimportant. How do mere words, those sequences of sound you produce, attain such power?

You are reading this book, specifically this page with lots of black ink marks all over it in various configurations. The patterns of configuration form what you have come to recognize (from years of learning and experience) as words. As you read each word in a fixed left-to-right sequence, line-by-line, you are taking the words and attaching them to your experience of what they represent to you. The words on this page don't mean anything at all to you until you attach a meaning to them, and the meaning can come from nowhere other than your own experience of having learned what experiences the words represent. Without your attaching meaning to the words, the words on this page are meaningless. When you see the lines and squiggles of written words or hear the sounds of words from a language that is unfamiliar to you, those markings and sounds are meaningless because you have no internal frame of reference for understanding them. *Meaning is in you, not in the words themselves*. And, since you use your own individual experience to attach meaning to a word, you can appreciate how the same word will *inevitably* mean different things to different people. The more abstract a word, meaning the more room for individual projection, the more this is true.

In the practice of clinical hypnosis, you need to be sensitive to the words and phrases you use because of the idiosyncratic nature of your client's interpretation. The phrase that works well in helping you develop relaxation, for example, may sound like fingernails on a chalkboard to your client. The word that fits well for your understanding of a particular kind of experience may represent something entirely different to your client.

Words are conditioned stimuli representing internal experience. Gestures are also conditioned stimuli arising from socialized experiences (e.g. head nods, hand gestures). In hypnosis, the conditioning property of words and experience is apparent both in the process of the trans-derivational search the client undergoes (i.e. attaching the clinician's words to experience), and the resulting physical, emotional, and sensory changes that occur while the client is mentally absorbed. These changes, subtle but present, occur quite naturally all of the time, but are accentuated in hypnosis.

The inevitable "automatic responses" that arise unconsciously as someone listens to your suggestions are collectively called the "ideodynamic" responses. A motoric, or physical, response occurring spontaneously is called an "ideomotor response." Automatic thoughts are called "ideocognitions," automatic sensory associations are called "ideosensory" responses, and automatic emotional associations are called "ideoaffective" responses.

Transderivational search and ideodynamic processes are deceptively simple but highly sophisticated characteristics of communication in general and hypnosis in particular. The inevitable role of personal experience in attaching meaning to words accounts for a great deal of the individuality and uniqueness of each person's response to hypnosis. This model does not, however, consider the relationship and situational dynamics that are inevitably a part of all hypnotic work.

Hypnosis as a Special Interactional Outcome

In older views of hypnosis, the induction of hypnosis was something a hypnotist "did to" a subject with specific incantations or prepared scripts. The late psychiatrist, Milton H. Erickson, M.D., is widely credited with transforming the clinical practice of hypnosis from such ritualistic approaches to a more refined hypnosis defined in broader interactional terms. His methods have collectively come to be called Ericksonian approaches or, synonymously, "utilization" approaches to hypnosis. Hypnosis, in this view, is a result of a focused and meaningful interaction between clinician and client. The clinician, to be successful, must be responsive to the needs of the client and tailor his or her approach to those needs if the client is going to be at all responsive to the possibilities for change the clinician makes available. The relationship is one of mutual interdependence, each following the other's leads while, paradoxically, at the same time leading.

The idea that the participants in the relationship are both leader and follower is a key point in this theoretical perspective. A client's behaviors and/or feelings are fed back to him or her verbally and/or nonverbally, thereby creating a sense in the client of being understood—the essence of rapport. Tied to verbalizations of what he or she is experiencing as true are respectful suggestions of what *can* become true. Instead of imposing on clients the clinician's belief system of what they should do, the possibility is made available to them of something progressive they can do in their own way and at their own rate. The important point here in describing this theoretical perspective is that hypnosis is considered a natural outcome of a relationship where each participant is responsive to the sensitive following and leading of the other.

Hypnosis as a Psychobiological Phenomenon

The new technologies for studying the brain and nervous system did not escape the notice of the hypnosis community. Neuroscientists have been studying the brain in response to hypnotic procedures and have made some very interesting discoveries about brain functions as a result. These findings suggest to many with a biological orientation that hypnosis is best understood as a neurological or psychobiological phenomenon.

Psychologist Ernest Rossi, Ph.D., has been an especially prolific researcher and writer in the area of the mind–body relationship in hypnosis and the physiological correlates to hypnotic experience. Rossi proposed that hypnosis was a natural part of the body's regularly alternating cycles of attentiveness and relaxation called "ultradian rhythms" that occur every 90–150 minutes. More recently, continuing his research on hypnosis and physiology, Rossi has been focused on the potential for neurogenesis as well as hypnotic influence at the genetic level.

Psychiatrists Herbert Spiegel and David Spiegel hypothesized that hypnotic abilities are the product of the interrelationship of the brain hemispheres. Together they evolved a "biological marker" assessment in the form of an eye-roll test to indicate an individual's hypnotic susceptibility.

The more we learn about the relationship between the brain and the mind, the more we learn how they influence each other in response to experience, including suggested experience. Hypnosis provides some unique glimpses into brain and mental functioning that holds great potential to redefine our understandings of how our brains work.

Closure on Perspectives

Having presented a few of what I consider to be among the most useful explanations for the phenomenon of hypnosis in this chapter, you may now have an appreciation for my earlier comments about the applicability of aspects of each, and the inadequacy of any single one as a means for understanding hypnosis. As you continue to get more involved in the actual use of hypnosis, you will discover that the complexity of people and the diversity of peoples' responses necessitate your keeping an open mind about the specific elements of each model that may be operating in an interaction at any given time. The greater the flexibility you have in making use of the many well reasoned and well researched models there are to work from, the better the response you will likely get to the work you do.

5

THE BRAIN, THE MIND, AND THE BODY IN HYPNOSIS

Insights into Mental Functions in Hypnosis

Brain research has proliferated during the last decade and continues to do so even now as newer technologies for examining neural processes continue to evolve. These allow us an unprecedented opportunity to study detailed aspects of brain functioning never before possible. These new sophisticated technologies for examining the workings of the brain hold the potential to answer many of the most basic questions about ourselves, such as what physically drives our thoughts, feelings, behavior, and what constitutes the physical basis for conscious experience and unconscious processes under various conditions.

Hypnosis in particular poses special challenges to our understandings of the brain. In hypnosis, there are cognitive, perceptual, physical, and behavioral changes that occur that generally manifest as a greater responsiveness to suggested experiences. It is a well-established fact that not everyone is equally responsive to hypnotic procedures, though. Researchers typically separate subjects into groups of so-called "high hypnotizables" and "low hypnotizables" by formally testing their responsiveness using such standardized scales as the *Stanford Hypnotic Susceptibility Scale* or the *Harvard Group Scale of Hypnotic Susceptibility*. By focusing on those who appear to have a greater hypnotic capacity, brain researchers attempt to address vital questions about the way the brain functions when in hypnosis and also when responding to suggestions delivered during hypnosis.

What makes it possible for someone to focus intently on a quiet induction process in a noisy room, perhaps even reporting having no awareness for competing sounds? How is it possible that a suggested sensation of numbness can allow some focused individuals to undergo surgery without the use of any chemical anesthesia? As neuroscientists

strive to understand the cascade of neurophysiological events that take place when one person invites another to "just relax and listen to my words," the research questions grows more complicated, and the research methods designed to answer such questions grow more sophisticated.

Something changes during the experience of hypnosis: Before the induction procedure, the research subject could focus on nothing but the pain in his or her arm. Following the induction procedure and some direct suggestions for numbness (e.g. "your arm will feel completely and comfortably numb as all the sensation seems to drain out of it"), the pain is all but gone from the person's awareness. The underlying premise in much of the brain research involving hypnosis has been that there is a specific measurable state called "hypnosis" even though it has not yet been identified and defined biologically. *Something* has changed—but *what*? Has neuroscience fully answered this basic yet very complex question for us? Currently, the simple answer is no. The assumption is that our current technologies, sophisticated as they might be, are simply not yet sufficiently advanced to fully achieve the task. That may well be true. It might also be true, however, that the qualities of attention and absorption that seem to characterize hypnosis are not different enough from other experiences to generate their own distinct biological signature.

The notion of there being a specific state of hypnosis that is neurologically distinct and measurable has been substantially revised in recent years as new understandings about the brain in hypnosis have evolved. In general, the neuroscientific hypnosis research has moved in the direction of studying attention and attentional processes, since these are the integral components of hypnosis. Rather than there being a specific, unique location for the experience of hypnosis in the brain, the direction and intensity of attention and the types of mental activities encouraged will determine which areas of the brain are likely to be actively involved. As people in hypnosis focus their attention and respond to suggestions, sophisticated scanning technologies detect and measure changes in the brain that might offer insights as to what may be occurring there.

Paying Attention to Attention

Without the ability to pay attention, we would be overwhelmed by the vast amount of information available in sensory experience at any given moment in time. When people suffer disorders that affect their ability to focus, such as attention deficit disorder, physical pain, or severe anxiety, the resulting distress and impairments tend to be obvious. Clearly, the capacity to focus in a meaningful way varies across individuals. How do variations in attentional capacities influence a client's response to hypnotic interventions? Are these variations innate to the

client or are they accounted for by variations in procedures? Furthermore, will the therapist's expectations for and subsequent treatment of clients differ based on how their capacity to pay attention is viewed?

Beyond the individual differences evident as a result of physical and mental states, there is evidence described in the hypnosis literature that suggests attention and responsiveness will vary, even at a neurophysiological level, based on the type of suggestions offered.

"Selective attention" refers to the ability to voluntarily focus on one portion of an experience while "tuning out" the rest. Focusing on a specific stimulus (e.g. words, gestures, silence, images, sounds, textures, memories, etc.) to the exclusion or near-exclusion of other ongoing stimuli is the foundation upon which hypnotic experiences rest.

There are complex factors that determine what works its way into one's awareness. These include: the degree of sensory stimulation (how weak or strong the stimulus is); the novelty of the stimulus; the person's response tendencies (arising from a complex interplay of socialization and genetics); the person's motivation to attend in the context under consideration; the person's mood; and the kinds and amounts of other sensory stimulation coexisting in the environment. This is why the cumulative effect of practice is so important; there will virtually always be multiple possibilities of things available to attend to at a given moment. In training oneself to be skilled in experiencing hypnosis or self-hypnosis, one is learning how to regulate one's attentional abilities.

The Brain in Hypnosis

So, what have we learned about the brain in hypnosis? Neuroscientists focus their research on studying the process of paying attention. Attention in the brain is correlated with activations in the anterior cingulate cortex and the frontal cortex. This is found to be true in hypnosis as well as in other cognitive tasks performed without hypnotic induction. The work of neuroscientists shows a multi-stage process of frontal lobe shifts associated with hypnosis: the instruction to focus attention, typical of getting an induction process underway, features an engagement of frontal attentional processes. Upon suggesting relaxation, an inhibition of these frontal attentional processes develops. Once the person is in hypnosis, functional brain activity is redistributed depending on what suggestions the person is given.

The most salient point is that attention is not a singular mechanism. Rather, it comprises multiple, interactive conscious and unconscious processes. The implication is that different qualities of attention will be elicited by different qualities of suggestion. It is interesting, but hardly surprising, to discover from the neuroscience that different areas of the brain regulate the different types of attention. Thus, it is predictable that

there are differences in brain activity across different types of hypnotic experiences. In the same way that one's quality of attention regulates emotion, cognition and motor activity, *one's quality of attention will necessarily activate different regions of the brain depending on the content of one's focus*.

Can life experiences, including the experience of hypnosis, change the brain? Until relatively recently, it was believed that we are born with all the brain cells we will ever have. However, the discovery of neurogenesis—the creation of new neurons (brain cells)—changed our fundamental understandings of brain physiology. The ways in which life experience can help sculpt brain functions to some extent—a capacity of the brain to change itself through a process called neuroplasticity—is an extremely exciting area of current neuroscientific research. Hypnosis has been shown to promote both neurogenesis and neuroplasticity.

Despite the gains to be made from brain research, however, there are a number of issues complicating the treatment process that clinicians should consider. These include: Can we—*should* we—attempt to define peoples' experiences, especially their problems, in only biological terms? As some suggest, should we define depression, anxiety, and numerous other disorders merely as brainwave dysrhythmias? Similarly, the drug industry has strived to define such disorders as evidence of a neurochemical imbalance requiring medications. However, the evidence is overwhelming that almost every disorder has psychological and social correlates, as well as physical ones. Likewise, the experience of hypnosis takes place in a physical context, a social (interpersonal) context, and it involves personal characteristics such as motivation to attend and expectations. Hypnosis is much more than brainwaves, cerebral blood flow, and hemispheric activation. Despite this point, clinicians should be aware that brain physiology matters, and that what could be interpreted as psychologically based symptoms may well have biological underpinnings. Medical and even neuropsychological evaluations are a sensible first step in responsible treatments.

Hypnosis in Behavioral Medicine: Amplifying the Mind–Body Relationship

Research across many scientific disciplines has made it abundantly clear that virtually *every* problem, even those that seem "purely medical," are influenced by the mood and beliefs of the patient, which have measurable effects on both the course and prognosis of the person's condition. Thus, "mind–body medicine" was born and is now in its infancy. "Behavioral medicine," the interdisciplinary study of behavioral, psychosocial, and biomedical knowledge guiding our understanding of health and illness,

has become mainstream as integrative medicine centers become increasingly common here and elsewhere around the world.

Hypnosis has had a special role to play in the evolution of behavioral medicine. From the early days in the late nineteenth century of the famed neurologists Jean-Martin Charcot of the Salpêtrière Hospital in Paris and Hippolyte Bernheim in Nancy (France), and their young Viennese student Sigmund Freud, the power of suggestion to alter and even remove their patients' presumably psychosomatic symptoms (especially among those who suffered what most would now likely diagnose as somatoform disorders) was fascinating to behold. The early pioneers in clinical hypnosis were almost exclusively physicians who used suggestion to address not only psychosomatic symptoms, but also diseases and medical conditions that were clearly organic in nature, such as pain from injury or disease.

Much more recent is the discovery of the role of hypnosis in influencing gene expression (studied in a field called epigenetics), enhancing immune system function, and facilitating a better rate and quality of physical healing. Furthermore, hypnosis has been used to encourage active participation in treatment, what many physicians might term "treatment compliance," as well as promoting other desirable self-management, health-oriented behaviors (such as quitting smoking, eating healthily, and exercising regularly).

The Placebo and Nocebo Effects in Medicine

The power of expectancy and belief, amplified through clinical hypnosis, is most dramatically on display through medicine's universal recognition of the placebo effect. The "placebo effect" refers to an inert treatment given to a patient or research subject who derives benefit from the treatment simply because he or she *expects* or *believes* that it will work. Placebo effects have been studied most commonly in the use of drugs, but have also been used in intravenous solutions and, even more dramatically, to study sham surgeries, where the patient is opened up but no actual surgical procedure is performed.

Placebo effects are easiest to demonstrate in those conditions where subjective factors are especially prominent, meaning the attitudes, beliefs, and expectations of the individual play a greater role in the types and magnitude of symptoms. Thus, when the problem has a less clear and multi-causal origin, placebo effects are likely to be larger. For example, some headaches, stomach aches, and types of back pain are more responsive to placebos than others. Depression and anxiety are also highly responsive to placebos. The patient is given an inert treatment, typically a sugar pill or "dummy" medication, that he or she believes is an active drug that will produce a therapeutic effect, and so it does.

The quality of an individual's expectations or beliefs can also have the reverse effect, unfortunately. The term "nocebo reaction" was coined by Walter Kennedy in a paper published in 1961. He chose the Latin word nocebo, meaning "I shall harm" (the functional opposite of the word placebo which, in Latin, means "I shall please") to describe an undesirable, injurious reaction to the administration of an inert treatment. Given a dummy drug, the patient generates a negative reaction based on the belief that the drug is dangerous. He or she experiences the inert drug as harmful and as the cause of unpleasant (or worse) side effects. Despite the fact that the drug is a dummy, the physiological, emotional, cognitive, and behavioral consequences, whether positive or negative, are quite real and can have a profound effect on the person.

The power of belief in influencing treatment responses has a clear and direct relationship to the use of clinical hypnosis in the medical setting. The added value of having a person's mind and spirit align with the medical intervention he or she is receiving cannot be overstated.

Applying Clinical Hypnosis to Empower the Medical Patient

Hypnosis in the medical context, what some therefore term "medical hypnosis," can be used in a number of ways. Suggestions can be offered for: (1) healing the disease or condition the patient is suffering; (2) modifying the disease or condition in some way (e.g. slowing its spread or reducing symptom severity); (3) reducing risk factors for the onset or exacerbation of a disease or condition (e.g. improving one's diet or increasing the frequency of exercise in order to prevent or better manage diabetes); and (4) enhancing one's coping skills in order to reduce one's level of distress (e.g. anxiety, depression, avoidance) associated with the disease or condition (or procedure, such as a blood draw or injection). These applications are not distinct from each other. To the contrary, any well-planned intervention is likely to encompass *all* of these possibilities to one degree or another. Each of these applications, when applied realistically so as to avoid building false hope, has the net effect of empowering the patient. The patient can discover that even if he or she can't control the problem, he or she can learn to view it differently in ways that can help make a meaningful difference.

Every disease or condition is made up of multiple dimensions (such as biological, psychological, physical, and spiritual) that affect the patient's quality of life. From this perspective, there are many possible points of entry into the patient's inner world: expressing feelings, discussing the spiritual meanings, exploring trains of thought, considering the social effects, developing coping behaviors, managing pain and other distressing physical symptoms, mobilizing skills in relaxing and focus-

ing for enhancing mind–body relationships, and so on. Where clinicians will jump in typically depends on their training and style of treatment. Fortunately, hypnosis sessions can be constructed to serve whatever specific goals the clinician has in mind.

It therefore seems fair to say that hypnosis can be used in the treatment of virtually any condition in which the patient could benefit from becoming absorbed in a more adaptive way of viewing and managing that condition. For just a few examples, there is ample evidence that hypnosis can help with: reducing anxiety and the avoidance of necessary or desirable medical procedures, pain management, facilitating healing, gastrointestinal disorders, enhancing immune system functioning, reducing stress and levels of stress hormones, breast cancer, heart disease, dermatological disorders, asthma, burns, sleep, and much, much more. The hypnosis and medical journals contain a fascinating array of studies about the demonstrable benefits of hypnosis in behavioral medicine.

6

THE GIFT OF BEING RESPONSIVE TO HYPNOSIS

Can anyone be hypnotized? The complex issue of who can be hypnotized (and, likewise, who cannot) has been researched and written about at great length by some of the most respected people in the field. The net result is the conclusion that although the great majority of people can experience hypnosis to some degree, *not everyone is equally responsive to hypnosis*. Research subjects exposed to standardized (scripted) and different forms of hypnotic induction and offered standardized and differing suggestions show variable levels of responsiveness across conditions. Thus, many experts conclude that hypnotizability, generally defined in the research as an ability to respond positively to suggested experiences, is substantially more about personal factors than interpersonal or contextual ones. But, it isn't clear what it is about someone that leads to higher or lower levels of hypnotic responsiveness.

The Social Psychology of Human Suggestibility

The responsiveness to suggestions, that is, direct and indirect messages imparting information and perspective, and the associated vulnerability to the influence of others (and to our self-suggestions as well) is the essence of human suggestibility. Is hypnosis the same as suggestibility? Can we accurately say that hypnosis increases suggestibility, and the evidence for hypnosis is an increase in suggestibility? The circular relationship between the phenomena of hypnosis and suggestibility is both apparent and confusing: Hypnosis occurs because people are suggestible, and people are suggestible because they're in hypnosis.

The relationship between suggestibility and the clinical benefits to be derived from hypnosis is an important domain of inquiry. Is suggestibility simply an individual personality trait that exists in stable form across different contexts? Or is it determined by additional factors beyond the

person's capacity to respond to suggestion, such as the salience of a suggestion or the demeanor of the person who offers it?

My response to these important questions is *both*: Suggestibility *in a general sense* is a relatively stable quality of response over time. And, in a particular context, such as a clinical interaction, suggestibility is mediated by a variety of personal, social, and situational factors that can serve to increase or decrease it in someone. The phenomenon of suggestibility will be explored in this chapter.

The field of social psychology in particular offers many valuable insights into the dynamics of interpersonal influence that are immediately relevant to the clinical context in general and to the use of hypnosis in particular. Social psychology as a field evolved out of the recognition that people will do things when they are alone that they will not do if even just one other person is around. When two or more people are together, social influence is inevitable. It's not a question of *whether* you'll influence someone. Rather it is a question of *how* you'll influence him or her.

What is suggestibility in hypnosis? It is openness to accepting new ideas, a willingness to absorb new information or perspectives. Furthermore, it is a focused capacity to translate ideas into suggested responses. As new information is acquired, depending on its subjective value, it can alter the person's experience anywhere from a little to a lot. In the therapeutic interaction, the person to be influenced (i.e. the client) is, to some unknown degree, suggestible and wants to acquire new information or experience that will reduce his or her distress. The person is unhappy with some aspect of him- or herself and seeks help from an experienced clinician who might be able to say or do something to make a difference.

Few people are completely noncritical in accepting information, and so there is an important difference between suggestibility and gullibility. Suggestibility as a trait exists because each person recognizes that he or she is limited; after all, no one person knows all there is to know about everything. *No matter how knowledgeable you are in an area, your information remains incomplete*. When we brush up against those areas we recognize we know little about, we tend to become more suggestible to the influence of others we believe may know more.

The Need for Clarity and Certainty

When people experience uncertainty, both social psychology and common sense have taught us that other people become very important as sources of information. The old saying, "When in Rome, do as the Romans do," reflects our reliance on other people's judgments and behaviors as models of what to do when faced with our uncertainty about what is proper. Thus, the principle of increased conformity in the face of uncertainty is immediately relevant to the clinical context.

If someone has attempted change and failed (who hasn't?), the suggestion may be accepted that one who is professionally trained in such matters will be able to help. The helping professional is perceived as an authority on a personal problem because he or she has been trained to recognize causes and administer treatments. The person seeking help has already accepted his own ignorance and powerlessness about the situation, and with a strong sense of hopefulness, looks to the therapist as the person who can make the hurt go away.

The quality of the relationship between the clinician and the client has been well established as a primary basis for the therapeutic experience in general and the hypnotic experience in particular. Every therapy I am aware of emphasizes the importance of the therapeutic alliance.

Clinician Power

When someone comes in for help to deal with a distressing problem, that person is making an investment in the clinician as a person of authority and, hopefully, a source of relief. Power is not typically something the clinician simply has; rather, it is acquired from the client's reaction to him or her. Thus, power is a capacity and a potential, and not a personality trait. A clinician has the *potential* to be influential, but every clinician learns the hard way through unsuccessful cases that influence is hardly a given in doing therapy. But, some clients do come to see the clinician as all-powerful and readily comply with his or her directives, usually out of the earnest hope that he or she will be able to alleviate their suffering.

When a clinician has power, from where does it come? The status of the therapist is one key factor, and his or her perceived expertness is another. Probably the greatest capacity for power, however, comes from the social role the therapist is in; the clinician–client relationship is generally not, and usually never is, one of equals. The person coming in for help must divulge personal and sensitive information to a person about whom he or she knows very little—only his or her professional status, and, for the more inquisitive, academic background and clinical training. The relationship is characterized by the clinician being the expert, the authority, and a client's uncertainty about how to solve a problem or an inability to detect personal choices; this can easily induce obedience to the authority of the clinician. Consider how extreme some forms of treatment are, and even many that are just silly, yet how willingly people comply with what they are told by the "expert" to do.

The Need for Acceptance

A person seeking professional help, or even just some information, is typically feeling deficient or incomplete in some way. A basic need people seem to have, which is the foundation of any society, is other people. When you combine a feeling of deficiency with a need for others, the drive for acceptance begins to emerge. Acceptance is something we all want in varying degrees. Is there anyone who is truly indifferent to the reactions of others? Or is there anyone who genuinely *likes* rejection? How far are *you* willing to go to get the approval of others who are important to you?

One of the fears often in the mind of clients coming in for help is, "If I open myself up to you, and let you see all my fears, doubts, quirks, and imperfections, will you like me and accept me? Or will you find me weak, repulsive, and reject me?" The potential for acceptance or rejection by the clinician is a risk the client takes in seeking help, and in light of all the evidence for the potential power of the therapeutic alliance, it is a legitimate concern. Recognizing and respecting the client's need for acceptance is an important factor to consider in addressing the issues of whether and how the client conforms to the demands of clinical intervention. How far is *your client* willing to go to get *your* approval?

Communication Style

Your style of communication is another significant factor shaping the quality of your client's suggestibility. By communication style, I refer to the manner with which you convey information and communicate possibilities to your client. There are many different styles, each having a different range and quality of impact on how receptive the client will be to the information and perspectives you present.

If a clinician wants to get a message across to a client, he or she must consider what style of communication this person is most likely to respond to in the desired way. Should the interaction be one of rationality and reason, or would an emotional appeal perhaps work better? Should the techniques used be direct or indirect? Should the position adopted be a supportive one, or a confrontational one? Would it be better to be demanding of this person, or better to approach them in non-demanding ways? Will an incongruent message ("mixed message") have greater impact, or a congruent one? The structures and styles of hypnotic suggestions will be dealt with in great detail later; suffice it to say here that there are many ways to package ideas, and no single style is going to be effective with everyone. Suggestibility is a general human trait, but what a specific individual requires in order to respond well can vary dramatically across different people.

What Individual Factors Determine Hypnotic Responsiveness?

Research into the capacity to experience hypnosis has examined many different personal variables including personality types, imaginative ability and fantasy proneness, capacity for absorption, expectancy, age, gender, socioeconomic status, and many other factors. In this section, we'll explore some of the research in these areas.

Personality Factors and Hypnotizability

Many researchers have explored the relationship between dimensions of personality and responsiveness to hypnosis. Test scores from personality inventories such as the Minnesota Multiphasic Personality Inventory (MMPI), Thurstone Personality Schedule, the Rorschach, the Thematic Apperception Test (TAT), the California Psychological Inventory (CPI), and many other standardized personality measures have all been studied relative to hypnotizability as measured by standardized tests and all have yielded similar results: No specific positive correlations exist between hypnotic responsiveness and scores on these assessment instruments. More recently, the popular "Five Factor" model for describing individual differences in personality was studied in regards to hypnotizability. The five factors include openness, conscientiousness, neuroticism, agreeableness, and extraversion. And, once again, no meaningful relationships were found to exist between hypnotic responsiveness and these personality characteristics.

Imaginative Ability, Fantasy Proneness, and Hypnotizability

People vary in their abilities and styles for processing information; some people are quite concrete (i.e. tied to the immediacy of their experience), not very imaginative, and require highly detailed descriptions of experience they have already had in order to experience hypnosis. Others are capable of high level abstraction (i.e. having experiences that are not part of past or present experience) in which imagination and fantasy can run loose in their minds and generate meaningful experiences for them. How concrete or abstract someone is in their thinking is a factor in responsiveness to hypnosis because of the subjective nature of the hypnotic experience. After all, there are no rockets that go off, no sirens that sound, no marching bands that come by waving banners that confirm "this is hypnosis!"

The experience of hypnosis can range from being a subtle one, barely distinguishable from one's usual waking state, or it can be a very profound, distinct experience characterized by certain intense sensations

and perceptions collectively identified as "hypnosis." To the concrete and unimaginative individual experiencing the subtleties of a lightly hypnotic experience, the reaction is often "I wasn't hypnotized . . . I heard everything you said." The concrete subject should generally be spoken to in parallel concrete terms of verifiable experience. Using abstract terms such as a person's "energy flow," or people's "groundedness," and other such nondescript abstractions is likely to result in an unsuccessful hypnotic experience. Some people's imaginative powers and ability to engage in fantasy, called "fantasy proneness," are very concrete, while others are more abstract. This is one more variable to consider in formulating your approach.

Absorption and Hypnotizability

The capacity to become absorbed in experience is yet another way for viewing the perceptual process of selective attention so clearly evident in hypnotic responsiveness. Absorption has been described as a capacity for selective attention, an ability to focus in varying degrees of intensity. How is this measured? Psychologist Auke Tellegen devised a popular instrument called the Tellegen Absorption Scale (TAS) to measure one's quality of absorption. The 34-item TAS questionnaire has, in fact, predicted hypnotic responsiveness in research subjects to a significant degree. An interesting finding, though, is that the TAS has only a modest correlation with established hypnotizability scales. Whatever ways that finding might be interpreted, fostering absorption in doing hypnosis benefits the process.

Expectancy and Hypnotizability

The role of expectancy in shaping responsiveness to hypnosis, psychotherapy, medicine, and life experience has been discussed previously. There is a wide variety of research supporting the notion that a person's expectations about his or her ability to respond to suggestions shapes his or her eventual experience.

Expectancy is an especially strong factor mediating hypnotic responsiveness. As I have suggested in many previous writings and described detailed procedures for doing so, imparting positive expectations to the client represents the single best focal point for doing hypnosis and the most important initial target of therapeutic intervention.

Gender and Hypnotizability

Early studies which addressed the issue of whether there are gender differences in hypnotizability yielded some data to support the belief that,

in general, women may be slightly more hypnotizable than men. Subsequently, any gender differences in hypnosis have not held up over time.

Despite the lack of difference in hypnotizability based on gender in a general sense, there is certainly good reason to take gender into account given the substantial data showing different rates of vulnerability, differential courses, and differential responses to treatments in a variety of medical and psychological conditions. Thus, in recent years, there has been a growing emphasis on acknowledging and incorporating gender differences into hypnotic procedures as well.

Age and Hypnotizability

Does an individual's age influence his or her responsiveness to hypnosis? The answer is, in a general sense of course, yes. In particular, the issue of age and hypnosis has revolved around the differences in responsiveness between children and adults. Research in this domain has typically examined hypnotic responsiveness in children using standardized test items of hypnotic responsiveness adapted to children's developmental stage. Since the test items are much the same as for adults, it becomes possible to characterize hypnotic responsiveness over the course of a lifetime.

The available evidence suggests that responsiveness to hypnosis emerges at a low level around age five, rises sharply to a peak responsiveness around ages seven to nine, begins a gradual decline in early adolescence, and stays fairly level throughout adulthood.

Children are, in general, responsive to hypnosis, but naturally require different approaches than adults do. After all, the range of personal experiences is considerably more limited, and both cognitive and social abilities are less well developed. As a counterbalance, though, children also tend to have less rigid notions of reality, a greater capacity for play, including role-play, and a higher level of responsiveness to authorities. The use of hypnosis with children is the topic of Chapter 17.

In general, age is a relatively minor consideration in assessing the capacity to respond hypnotically. Age is a factor to consider, though, in determining an effective approach for the induction and utilization that is appropriate to the age and background of the client.

Self-Esteem and Hypnotizability

Every person has a measure of self-esteem, a value they place on themselves in terms of their perceived self-worth. The self-esteem of a person can range from very low to very high. Self-esteem is not necessarily a stable trait that remains fixed throughout one's lifetime; rather it can

go up or down with experience. Yet, self-esteem is self-regulating in that it can unintentionally motivate one to work very hard at staying the same in many important ways.

The self-esteem of the client is a significant variable in his or her ability to respond meaningfully to the clinician's suggestions. Self-esteem, in part, determines what one views as possible for oneself. The little boy who says, "Mommy, I can't do math," is not likely to be reassured by a simple, "Oh, sure you can." It creates dissonance between Mom's feedback and the boy's self-image.

The principle known as cognitive dissonance is highly relevant to suggestion formulation. Cognitive dissonance refers to the psychological defenses that come into play when someone is exposed to something that contradicts what he or she believes. Information contradictory to what the person believes to be true is defended through a variety of means in order to maintain the original belief. A person with a terrible self-image who is told, "You have so much to offer," is not likely to take that message in. The real skill of hypnotic communication is in knowing how to package a communication for someone in such a way as to maximize its likelihood of becoming internalized.

Self-esteem is an entirely learned phenomenon, not a trait present at birth. Your experiences and, more important, the conclusions you draw from those experiences, determine how you will view yourself. Confronting a client's self-image directly in the form of contradicting it is rarely a successful maneuver for changing it. Instead, the client just gets the feeling the clinician really doesn't understand him or her.

Mental Status and Hypnotizability

There have been numerous studies attempting to determine whether there is a relationship between hypnotizability and the development of specific clinical disorders. Using standardized measures of hypnotic responsiveness, higher levels of hypnotizability have been associated with phobias, post-traumatic stress disorder, dissociative identity disorders, sleep disturbances featuring nightmares, and eating disorders to name just a few. An increased responsiveness to suggestion, a greater capacity for dissociation, a deeper quality of experiential absorption—any or all of these and other factors, too, may combine to serve as a foundation for various disorders. The parallel notions of a "negative self-hypnosis" or a "symptomatic hypnosis" have been valuable in underscoring the point made earlier that hypnosis is a neutral phenomenon, capable of generating a broad range of experiences, deemed either helpful or harmful depending on their outcome.

When hypnotizability can be associated (correlationally, not causally) with various disorders, does that mean you shouldn't do hypnosis with

people suffering those disorders? The answer is unambiguous: You can do hypnosis with *any* category of disorder, but each category requires its own specialized approaches. For example, the approach you would use with someone who is highly dependent and other-oriented would differ from the approach you'd use with someone socially avoidant and inner-directed. More to the point, though, *we treat people, not diagnostic categories*.

Single Factors, Multifactors, and Hypnotizability

After all the research unsuccessfully attempting to relate single factors of personality, age, or whatever, with hypnotizability, it becomes clear that hypnotic responsiveness is a function of multiple factors operating together in some as yet unknown way.

Test–retest studies of hypnotizability show a high correlation, suggesting it is a relatively stable phenomenon over time. Poor subjects seem to remain poor over time (in repeated attempts to induce hypnosis in the same person with the same or similar procedures), and good subjects seem to remain good over time. Is hypnotic responsiveness a fixed capacity, or can someone's responsiveness to hypnosis be enhanced with practice or variations in procedure?

Enhancing Hypnotizability

A practical concern of the clinician is how to maximize the client's responsiveness to the treatment. If responsiveness is viewed as innate to the client, and the style of the clinician or the quality of the relationship is considered secondary or even tertiary, then there is no need to experiment with different suggestion structures and styles. The client can simply be given a scripted hypnosis procedure to respond to. Either the client has "it," or doesn't. Similarly, in manualizing treatments, either the technique "works," or it doesn't. Clinicians are generally highly skeptical of the notion of hypnotic responsiveness just being an innate capacity. Consequently, the motivation has existed on the part of many to go beyond the data declaring hypnotizability a fixed trait in an effort to explore ways of enhancing responsiveness. They believe hypnotic responsiveness *can* be enhanced.

Looking back over the sections of this chapter, you can appreciate that there's not much you can do about someone's age or gender, but what about all the other factors? For example, can skills in imagination, and fantasy-proneness be taught? What about improving self-esteem or changing someone's expectations and mental status?

Some hypnosis experts argue quite convincingly that each of these factors is modifiable when people are given helpful information and

training. Enhancing the goals of therapy, whether delivered hypnotically or otherwise, requires a flexibility and respectfulness of the client's experience that encourages the best in the person. There are no established rules about what makes for the most influential communication or the best hypnosis. What appeals to one person will not appeal to another. The "positive psychology" in doing hypnosis is to go beyond labels, discover the unique resources of each person that can be mobilized in the service of the therapeutic goal, and build genuinely therapeutic relationships that foster responsiveness.

The gift of being responsive to hypnosis is a gift that keeps on giving. The comfort with one's Self, the flexibility in one's outlook, the richness of one's inner world, the openness to new experiences, the creativity and resourcefulness, and much more are available to discover with each hypnotic experience. It truly *is* a gift to appreciate.

7

THE CHANGES IN YOUR EXPERIENCE DURING HYPNOSIS

Hypnosis is a highly subjective experience, for no two people experience it in exactly the same way. Appreciating the uniqueness of each person you interact with is a worthy goal in general, but if you want to learn to apply hypnotic patterns effectively, it is a strict requirement. There are certain assumptions that are beyond question and are unfailing when doing clinical hypnosis. One concerns the uniqueness of each person and all that uniqueness implies about each person's individual personal history and responses being unlike anyone else's. A second assumption is that each person is going to have his or her own way of experiencing hypnosis; what specific subjective associations your communications will trigger in the client will be unknown to you until they are somehow communicated to you (unless you are a board-certified mind-reader). A third assumption concerns the multidimensionality of hypnotic experience: Whatever the client is experiencing will have cognitive, behavioral, emotional, spiritual, relational, and physical features. Which dimension(s) you choose to focus on and amplify will be a product of your own style of intervention. In this chapter, we will briefly consider many of the most common phenomenological or subjective experiences of the person in hypnosis on a variety of dimensions, divided for simplicity's sake into two broader categories: "psychological" and "physical" characteristics of hypnosis.

Psychological Characteristics of Hypnosis

Expectancy

As many of the sociocognitive theorists have pointed out, the client is encouraged to expect a change in his or her experience and to accept those suggestions that will fulfill that expectation. Many clients actively seek out hypnosis as an intervention because they have the expectation

that the experience of hypnosis will be powerful, dramatic, and effective. The mindset of the client is ideally one consistent with the aims of treatment, and building positive expectancy in order to enhance responsiveness is given deliberate attention by the clinician through the way he or she conducts the session.

Selective Attention

Selective attention is the ability to focus on one portion of an experience while "tuning out" the rest. Focusing on a specific stimulus (usually your words or your gestures as you conduct the hypnosis session) to the near-exclusion of other ongoing stimuli is a foundation of hypnotic experience upon which the other phenomena rest. Without the focus to attend to the suggestions of the clinician, not much else that's useful is likely to happen. It's why the neuroscience of attention has become so important a topic in the world of hypnosis.

The conscious mind is limited in its ability to pay attention to numerous things occurring simultaneously. We consciously notice only a relatively small part of a total experience. How do you decide which part of an experience to pay attention to? As stated previously, there are a number of complex factors that determine what works its way into one's field of attention. These include: the degree of sensory stimulation (how weak or strong the stimulus is); the novelty of the stimulus; the person's response tendencies (arising from a complex interplay of socialization and genetics); the person's motivation in the context under consideration; the person's mood; and the kinds and amounts of other sensory stimulation coexisting in the environment.

The client must gradually selectively attend to the provided suggestions and narrow his or her attention to the associations the suggestions stimulate. The client's focus is generally inward, and so although external events may be noticed and responded to, they typically account for only a small portion of the client's attention. And, while the person's conscious awareness is focused on specific aspects of their experience, unconscious processes may still respond to things outside of the person's attentional field. This is a basis for the next characteristic I will discuss: Dissociation.

Dissociation

Dissociation, in effect, means that normally integrated and synergistically functioning parts of a person are increasingly able to function autonomously. Stated more simply, while the person in hypnosis has his or her attention selectively focused on the suggestions of the clinician and whatever associations may be triggered as a result, there is a type of separation occurring between the conscious and unconscious. The

conscious tends to be occupied with the details of the hypnotic process, while the unconscious tends to actively search for symbolic meanings, past associations, and appropriate responses relevant to the suggestions received. This separation of conscious and unconscious during hypnosis is accomplished in varying degrees with different people, and is called "dissociation." Dissociation is so critical a component of the experience that it can reasonably be said that hypnosis cannot take place without *some* degree of dissociation being present. In general, the greater the degree of dissociation, the deeper will be the person's subjective experience of hypnosis. The fact that the conscious and unconscious minds can be divided and utilized as interdependent yet independent entities is thus the backbone of the clinical applications of hypnosis.

A second aspect of dissociation refers to the sense of detachment people may experience in some situations, especially traumatic ones. A third aspect of the dissociative nature of the hypnotic experience is evident in the "parallel awareness" people typically report they experience during hypnosis saying something such as, *"Part of me* was aware of you and what you were saying, and *part of me* was totally into my own experience and tuned you out."

Ernest Hilgard's "Hidden Observer"

The client in hypnosis can have multiple awarenesses, each operating on a separate level. One of these levels is a mostly objective one that has a relatively realistic understanding of the nature of the experience, a part of the person Hilgard called the "hidden observer." The "hidden observer" is separated (dissociated) from the immediacy of the suggested experiences, and can maintain a degree of objectivity about the experience. This dissociative characteristic of hypnosis allows the client to attend to and respond to suggestions with a "believed-in imagination" while simultaneously observing him- or herself go through the experience more objectively. The implication of the hidden observer is that even in deeper hypnotic experiences the client knows what he or she is doing and what is going on.

Martin Orne's "Trance Logic"

Psychiatrist and hypnosis researcher Martin T. Orne, M.D., Ph.D., claimed that one of the most important attributes of hypnotic experience is the ability to comfortably tolerate incongruities or inconsistencies in suggestions that in the usual so-called "waking" state would be disturbing. Orne termed this phenomenon "trance logic."

In clinical practice, trance logic refers to the client's lack of need to objectify his or her experience. In other words, the client can accept a

suggested reality, however illogical and even impossible it may be, as if it were the only reality. For example, if I want to do an intervention hypnotically involving the client's currently inaccessible parents (who may live in a distant place or perhaps are deceased), I can suggest to the client that he or she see his or her parents and interact with them on the issue(s) needing resolution. There may well be an element of role-playing present, but trance logic allows the client to respond to his or her parents in the "here-and-now" as if they are really there, rather than responding with an intellectual assessment such as, "How can my parents be here when they live in Europe?"

Things that don't make much logical sense can make perfect sense to the hypnotized person engaging in trance logic. This affords the clinician the opportunity to conduct clinical sessions that can be highly creative and imaginative, unfettered by a conventional sense of reality. Trance logic is a voluntary acceptance of suggestions on the part of the client, without the critical evaluation taking place that would, of course, destroy the validity or meaningfulness of provided suggestions. The opportunity to act "as if" something were real can be a gateway to deeper feelings and issues appropriate for therapeutic intervention.

Idiosyncratic Interpretations of Your Message

How a given person will respond to a word or phrase is unpredictable. Some people are more prone to act in terms of this literal meaning even when a figurative one is clearly intended. Remember, the person is using his or her own frame of reference (i.e. experience, understanding) to make meaning out of your words. The best you can do is use words carefully enough to leave as little room (or as much room, as the case may be) for misinterpretation.

Increased Responsiveness to Suggestion

The selective attention and dissociation described above can lead to an increased responsiveness to suggestion. Increased responsiveness is evidenced as a greater willingness in the client to be guided by the suggestions of the clinician, that is, to experience the perceptual shifts being suggested. Furthermore, by definition, the person in hypnosis would be more responsive to experiences that, outside of hypnosis, he or she would not be.

From a clinical point of view, when you are concerned about maximizing a client's responsiveness to your treatment, the increased responsiveness hypnosis affords makes it an especially valuable clinical tool. Why are clients more likely to respond? It may be the lowered defenses, the greater focus, the calmer attention to problem solving, the

support of the clinician, and any or all of dozens of such contributing factors.

Responsiveness is not to be confused with gullibility, or noncritical acceptance of suggestions. Contrary to the mythology, the hypnotic experience in a respectful clinical or research context actually *amplifies* a person's range of choices, including the choice to reject a suggestion that isn't desirable or relevant. The increased responsiveness to suggestion is a choice on the part of the client to be guided by someone he or she trusts and feels is benevolent in wanting to help. If the personal, interpersonal, and contextual dynamics are not favorable, responsiveness is nonexistent and the result is a poor response.

Cognitive and Perceptual Flexibility

There are different cognitive styles, that is, ways of thinking about experience. This is true not only across individuals, but also within individuals. You have different styles of thinking about different types of experiences. For example, some things you may approach more globally or "holistically," while other things you approach more specifically or in "detail." How you think naturally influences your perceptions and subsequent reactions.

Numerous researchers have studied the cognitive styles of people in hypnosis. No one style typifies the response of people in hypnosis to suggestion, and a client may use one or more of these styles during the same hypnotic session. To a considerable extent, the choice of style varies with the task complexity. The ability to move in and out of different cognitive styles, and the different perceptual experiences associated with them, as demand dictates, and as hypnosis enhances, is the essence of cognitive flexibility.

Every clinician who uses hypnosis is doing so for the express purpose of creating perceptual shifts that enhance the client's quality of life. Thus, encouraging a cognitive style that permits excruciating pain to be transformed in perception to a mere annoyance, for example, is an invaluable application of such cognitive research. Encouraging a perception of accelerated time that permits a long unpleasant medical procedure to subjectively seem to go by quickly (i.e. "time distortion") is another example. Dissociation is clearly a relevant factor as the person moves from one seemingly discrete portion of experience to another.

Physical Characteristics of Hypnosis

When you perform an induction of hypnosis on a client, how do you know your client is in hypnosis? The answer is a definite . . . you *don't*.

As you know, there is no clearly defined, unambiguous state called "hypnosis." At just what moment a person has gone from his or her usual awareness to a more focused and "hypnotized" experience is not definable with scientific precision. Instead, there are more general indicators of hypnotic absorption that clinicians can use to evolve a practiced sense of when the person is hypnotically engaged.

Observing physical characteristics of hypnosis is usually the first indicator you will have available for assessing your client's experience until you specifically ask for verbal or nonverbal feedback. Asking for feedback *during* the hypnosis session about what is going on for him or her is a good idea if you want to avoid the trap of "reading body language" (i.e. projecting your interpretations onto what someone's behavior "means").

You can be an excellent observer of your client's physical responses to hypnosis without having to interpret them. Noticing your client shifting his or her position in the chair, for example, allows you to comment on it in a helpful way: "As you adjust your position, you can make yourself even more comfortable allowing you to become even more deeply absorbed in the experience." Noticing the physical changes that take place in the client simply provides information that can be used to further the goals of treatment. You can't use the information, though, if you don't first notice it. Thus, it is valuable to practice skills in close observation of others. There are physical indicators that may be useful for you to observe; some of these are described in the sections that follow.

Muscular Relaxation

One can be in hypnosis without being relaxed, but the relaxation of mind and body is a general characteristic most people associate with hypnosis. Most hypnotic processes involve relaxation as a way of facilitating dissociation of conscious and unconscious processes. Relaxation feels good to clients, alters their experience of themselves in a relatively obvious way, and may even convince them that they have, in fact, been hypnotized. Notice the person's level of tension carried in the body and especially the facial muscles both before and during your work for comparison. When you can see muscles relaxing, clearly an internal shift is taking place.

Muscular Twitching

As the body and mind relax, often there are spasms that are wholly involuntary and are related to the neurological changes that take place with relaxation.

Lacrimation

As the person relaxes, occasionally his or her eyes may water. Some clinicians automatically assume the person is upset and shedding a tear, but that is an unjustifiable leap to a possibly (and probably) erroneous conclusion. *Whenever you are in doubt about what the client is experiencing, ask him or her for direct feedback using neutral (i.e. non-leading) questions* (e.g. "Can you describe what you are aware of right now?").

Eye Closure with Fluttering Eyelids

As the person begins to shift his or her focus and experience hypnosis, his or her eyelids may flutter at a fast rate and usually outside of awareness. Also, rapid eye movements under the eyelid are usually observable throughout much of the hypnosis session, even more so if the process involves a lot of suggestions for visualization.

Change in Breathing Rate

A change, either speeding up or slowing down, of breathing is typical. Observe the client's breathing patterns before and during the process for comparison. When you see changes in the rate and quality of the person's breathing, some internal shift is clearly taking place. Some people's breathing becomes shallower as they get absorbed in the process, some people's becomes deeper. Some breathe from the chest, others breathe from the diaphragm. What's significant is the change in breathing, not necessarily the specifics of the change.

Change in Pulse Rate

A change in the pulse rate of the person, either speeding up but usually slowing down, is also typical of hypnosis. When the client is sitting back, you can usually observe pretty easily the pulsing of the carotid artery in his or her neck. Some clinicians prefer (after asking for the client's permission) to hold the client's wrist "to be supportive" during the session, and use the opportunity to take a reading of his or her radial pulse.

Jaw Relaxes

Often the person's lower jaw drops and seems subjectively to weigh so much that it takes conscious effort to close his or her mouth.

Catalepsy

The term "catalepsy" refers to an inhibition of voluntary movement that is reflective of the absorption of the hypnotic experience. Unlike routine states of consciousness or even a sleep state in which one is in almost constant motion, the client in hypnosis makes very few, if any, movements. It just takes too much effort for the relaxed and focused client. Furthermore, the client in hypnosis typically feels dissociated (i.e. detached) from his or her body anyway, and so tends to simply forget about it.

Every once in a while, and this is especially true of children, you may experience someone who moves around a lot rather than being immobile as you might expect. Even though a client's movement may seem excessive or disruptive, or interpreted as evidence that he or she isn't "getting into it," in fact the client may still be in hypnosis.

Sensory Shifts

The person's body awareness may change in any of a variety of ways: Some people develop feelings of heaviness, as if each limb weighs a ton, while others develop feelings of lightness, as if they're floating weightlessly. Some start to feel physically large, and some start to feel very small. Some people feel more closely associated to their body and become ultrasensitive to physical sensations, and others become quite detached and unaware of their body, even to the point of developing a spontaneous (i.e. one not suggested) analgesia or anesthesia.

Each of these sensory shifts may be used as general indicators of hypnosis, but no one sign alone can tell you what your client is actually experiencing internally. In a sense, the clinician is a visitor to someone else's inner world, and so should be observant, cautious, and, above all, respectful.

Assessing the Phenomenology of Hypnotic Experience

Assessing hypnotic *behavior* is understandably popular as a research method, since behavior can be observed. However, in doing clinical work, as valuable as objective instruments scoring hypnotic behavior might be, what ultimately matters the most is the individual client's actual *experience*, called phenomenology. Thus, some researchers have taken on the task of developing ways to better understanding the phenomenology of the client's hypnotic experience. Psychologists Peter Sheehan and Kevin McConkey developed an instrument called the Experiential Analysis Technique (EAT) for evaluating the hetero-hypnosis experience. More recently, psychologists Ron Pekala and V. K. Kumar developed an

instrument called the Phenomenology of Consciousness Inventory (PCI), also for hetero-hypnosis experiences. These instruments, and others developed by other researchers, represent important steps in the direction of learning more about the range and quality of peoples' hypnotic experiences.

An experience as subjective as hypnosis will inevitably differ in quality from person to person. Therefore, all the general characteristics of hypnotic experience described in this chapter are likely to be present in most clients, but in varying degrees. In some cases, they may even be absent. The single most valuable source of knowledge about your client's experience is your client. If you want to know something about his or her experience, you'll just have to ask. You may not always get as truthful or insightful a response as you'd hoped for, but the person in hypnosis is still the best source of information.

8

CONDITIONS FOR CONDUCTING HYPNOSIS SESSIONS

In previous chapters I have explored some of the personal and interpersonal factors influencing hypnotic responsiveness. In this chapter, I would like to explore some of the other variables that can affect your work. These are discussed in three separate sections: Environmental, Physical, and Legal variables.

Environmental Variables

From my perspective, forming a strong, warm, goal-directed relationship with the client is a necessary precursor to making worthwhile therapeutic interventions. Everything else, including the environment in which you do hypnosis, is secondary. Secondary, yes, but *not* unimportant. There have not been any studies that I am aware of to suggest that one environmental condition (e.g. furniture arrangement, lighting) is more likely to produce hypnotic phenomena than another. In fact, very few writers in the field have even addressed this topic. In the real world, clinicians who use hypnosis do so in all kinds of environments, from sterile laboratories with fluorescent lighting and chairs (apparently chosen by someone who was having a bad day); to hospitals or clinics where monitors are beeping and someone in the next room or even the next bed is moaning in pain; to classrooms or lecture halls where it seems every chair creaks at 90 decibels; to offices that look more like living rooms, with fireplaces, couches, soft lighting, and soft music playing in the background. Not surprisingly, successful hypnosis has been achievable in all of these environments. There are certain environmental conditions that are desirable for doing hypnosis, but they are clearly not essential.

A Quiet Atmosphere

Working in a relatively quiet atmosphere is especially helpful. An atmosphere free of intrusive or, even worse, obnoxious noise, is less bothersome to the client, allowing him or her to focus more on internal experiences rather than external distractions. Realistically, however, phones ring, doors get knocked on, people converse outside your door (if you even *have* a door), traffic zooms by, planes pass overhead, people upstairs drop heavy objects, people sneeze, pets knock over vases, kids argue, and the list of possible distractions goes on and on. No environment is perfectly quiet and free from external noise, nor does it have to be. A key to helping the client focus internally without being unduly distracted by (though not unaware of) external events lies in your ability to tie those events into your process. By commenting on them and framing them as "normal," the client can let the distractions recede into the background.

Near the beginning of the hypnotic process, it may help the client diminish external awareness by offering a general suggestion to the effect that:

> Whatever sounds you may hear in the environment around you . . . as you get more deeply absorbed internally . . . are routine, everyday sounds . . . and you can let them pass through your awareness just as quickly as they enter . . . the sounds of the environment are so routine that you can just let them drift out of your awareness.

By not specifying which sounds you are referring to, you're offering a blanket suggestion to cover all the possibilities. Also, you are avoiding the inappropriate use of negative suggestions such as, "Don't notice the phone ringing," which will, of course, cause the person to notice it.

Perhaps the best thing to do if an intrusion occurs is to use a "chaining" suggestion structure in which you can comment on the current reality of the intrusion, and then chain (i.e. associate) the desired response to the comment. For example, if the phone rings during the hypnosis session, you might comment directly by saying something such as, "Isn't it nice to know the phone can ring and since you don't have to answer it you can just relax even more deeply." Or you can comment on it indirectly by saying something such as, "As you relax, your unconscious mind can *call a message* up to your conscious mind about relaxing even more deeply."

Ignoring the intrusion can inadvertently lead the client to pay even more attention to it. But using the "accept and utilize" structure in which you acknowledge and make use of ongoing events, *whatever* they are,

allows the person to more readily "let it go." Intrusions are integrated as part of the experience, transforming their impact from a negative to a positive one.

Gentle Lighting

The use of soft, soothing lighting may be helpful in doing hypnosis. Lighting helps create atmosphere, and soft lighting can help facilitate comfort. I would not recommend lighting that is too dim, nor would I recommend darkness. Candlelight may be all right for some, but too esoteric for others.

Comfortable Furniture

As the client relaxes, his or her body tends to become heavy and immobile. Neck and backaches can easily result if the client doesn't get adequate physical support. Furniture should be comfortable and, most important, support the client's head and body. Recliner chairs or chairs with footstools are quite good for this reason. Beds or couches to lie prone on may be too suggestive and, furthermore, are likely to put the client to sleep, which you definitely *don't* want to happen during typical hypnosis sessions.

Physical Variables

Physical conditions are also worthy of consideration in doing hypnosis. I refer here not to the client's physical health, but to transient physical experiences that may influence a client's hypnotic responsiveness.

Physical Comfort

It helps if the client is physically comfortable; the body is adequately supported, clothing is not restrictive or binding, the room temperature is comfortable, and the client isn't feeling rushed either by you or life circumstances demanding immediate attention.

It is important that the client have nothing in her or his mouth (e.g. gum, candy) that could choke him or her as she relaxes. Also, many people wear contact lenses, and some contact lenses (e.g. hard lenses) are constructed in such a way that if the client closes his or her eyes even briefly (i.e. a few minutes) the lenses irritate the eyes to the point of becoming uncomfortable or even painful. Ask the client if he or she would like to remove his or her glasses, contact lenses, shoes, or whatever else might inhibit responsiveness.

Alcohol, Drugs, Medications

Alcohol and street drugs do not enhance a person's focus, rather they diminish it, and so are counterproductive to doing effective hypnotic work. Prescribed medications vary in their effects on people. Part of your initial assessment of your client is the quality of the person's focus. If the person has adequate focus, then hypnosis should be helpful. If the person's quality of focus is impaired by the medications they're taking or by their symptoms (e.g. pain, depression, anxiety), hypnosis will be more difficult, but also more important to include in treatment as a means of both reducing symptoms and gradually enhancing focus.

Fatigue and Other Physical Factors

Similar diminished responses can exist for the tired or exhausted client. Given how many people are working too hard and getting too little sleep, this is a commonly encountered impairing factor. Such tired clients may be easy to put to sleep (unintentionally, as they relax and then drift off, if you let them) but are difficult to get to focus internally.

The less you assume about your client, the more objective feedback you will want to seek about his or her condition. You cannot assume the person has normal hearing, normal physiology, no contact lenses, no gum in the mouth, no use of street drugs or alcohol on therapy days, and so forth. It takes only moments to ask, and your sensitivity to such issues can save you a lot of frustration later. The key here, as in the environmental conditions, is to use the spontaneous events that arise. If a client coughs, don't fret. Accept and utilize it by saying something such as, "As you clear your throat, your throat can relax . . . and then *you* can relax even more deeply." Or, you can offer some statement that is less direct, such as, "It's good to *clear the way* . . . in order to be able to swallow new ideas."

When a client coughs or sneezes, the session is far from ruined. You can acknowledge that the client's hypnotic experience has lightened at that particular moment, and then you can use it to help the person go deeper into hypnosis again. Realistically, no one ever nose-dives into deep hypnosis and then stays there anyway. The person's hypnotic experience is generally fluctuating throughout the session, lightening and deepening in intensity from moment to moment. That's normal and to be expected, which you probably know from your own experience by now. (That's why the old incantation of saying "deeper, deeper, deeper" to the client is a poor representation of the experience.)

Legal Variables

The climate for health care providers has been and still is undergoing a remarkable transition in recent years as malpractice suits, highly publicized ethical lapses, and even prosecutions for criminal behavior among clinicians is brought to the attention of the general public.

The legal issues associated with responsible clinical practice in general obviously also apply to the use of hypnosis. However, the use of hypnosis in one's clinical practice adds additional potential legal liabilities of which you must be aware. Since the legal issues (scope of practice, credentialing, insurance, etc.) differ substantially from state to state and country to country, it's a good idea to consult with legal experts about the laws where you live and work.

In this section I will address only one of these issues, but it is enough to highlight to you the vital importance of your checking with your particular state's (or country's, as the case may be) laws about treatment issues with *and* without hypnosis. The issue is informed consent.

Informed Consent

In the medical context, the doctrine of informed consent governs the physical treatment of patients. Patients are not to be touched without it. Informed consent gives patients the power to collaborate in their own treatment as knowledgeable participants. Doctors are required to explain treatment options (e.g. surgery, medications) and provide helpful data about the chances for successful intervention with the various options in order to help guide the patient's choices.

Does the medical model apply to the context of psychotherapy? How much information can a clinician provide without impairing the spontaneity and emotional power of his or her intervention? (Can you imagine a therapist saying to a client, "I'm going to do a paradoxical intervention now in order to indirectly encourage you to take a contrary position to my stated one because that's really the one I want you to take!"?) Despite informed consent obviously not fitting the psychotherapy context as well as a medical one, there is a growing movement in the legal community demanding a new, specialized form of informed consent before any psychotherapy is undertaken.

Hypnosis faces a number of specific vulnerabilities to the need for informed consent. One especially important one, highlighted in this section, concerns what is known in the legal realm as a "per se exclusion rule" regarding hypnotically obtained testimony. Many courts throughout the United States have adopted a per se exclusion rule that excludes the testimony of any witness, other than the accused, who has been hypnotized. Courts have relied heavily on the testimony of hypnosis

experts who have said in no uncertain terms that hypnotically influenced testimony is inherently unreliable and should therefore be precluded from being offered into evidence.

This is an unfortunate and exaggerated response: Hypnotically derived information *can* be unreliable, but is not *inherently* unreliable. More prudent courts think of hypnosis as much the same as any other means of getting information: Maybe it's wholly right, partly right, partly wrong, or wholly wrong, and needs additional validation in order to evaluate it.

Informed consent means patients must be informed about the treatment options available, the scientific merits of the treatments the clinician intend to provide, any untoward potential consequences of the chosen treatment (that builds positive expectations, doesn't it?), and the likely consequences of no treatment. Informing the client about the research evidence for hypnotic procedures is growing in acceptance as simply good practice, even if not (yet) legally required. In the final chapter I will discuss some of the other legal and ethical issues associated with doing clinical hypnosis.

Part 2

PUTTING HYPNOSIS TO WORK

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9

STRUCTURING SUGGESTIONS

The theoretical foundation for your understanding what Ernest Hilgard called "the domain of hypnosis" has, hopefully, now been established. Throughout the remainder of this book, the focus will be entirely practical: I will encourage you to evolve the fundamental skills to do hypnosis effectively with your clients, and to develop an awareness for many of the clinical issues associated with applying hypnosis insightfully. In this chapter, I will begin with the "nuts and bolts" of hypnosis, the way you deliver suggestions to your client.

Suggestions Are Inevitable, but There's No Guarantee They'll Be Accepted

The skill of an effective hypnotist is in his or her ability to formulate suggestions in such a way as to make them relevant, meaningful, acceptable, and *usable*. Merely performing an induction of hypnosis is not sufficient: A deep hypnotic experience on the part of the client is no assurance that he or she will accept offered suggestions, even ones that are clearly in his or her best interest to accept. As you learned in previous chapters, numerous personal, interpersonal, and situational factors ultimately determine the degree of a person's responsiveness to suggestion. The focus in this chapter is on some of the communication variables of hypnotic patterns, specifically the range of communication styles and structures that can be used to form hypnotic suggestions. There are many different ways of communicating an idea to someone, and so the clinician can be deliberate in choosing a means of organizing and delivering a suggestion that carries the greatest chance of being accepted by the client.

Suggestions are dynamic, not static in their structure. They can range along a number of continua, sharing multiple, simultaneous traits. There is no time when all your suggestions must fit into only one category, nor

will there likely be any time you won't want to move up and down on a particular continuum of suggestion as you offer a series of suggestions to someone. What are these continua? On one continuum of suggestion, we have *direct* and *indirect* suggestions occupying the poles. On a second continuum, we have suggestions ranging from *positive* to *negative*. On a third continuum, we have *process* and *content* suggestions. And on the fourth and last continuum we have possibilities ranging from *permissive* to *authoritarian* suggestions. In a related but separate category are *posthypnotic suggestions*, an essential and well-considered part of any clinical intervention. Let's consider each of them in turn.

Direct and Indirect Suggestions

Hypnotic communications can be structured in direct and indirect forms. Not only are they not mutually exclusive in usage, but it is neither possible nor desirable to do an effective hypnotic process exclusively in one form or the other. Which style to use at a given moment depends on the nature of the suggestion (i.e. its complexity, novelty, potential for raising the client's anxiety or defenses, and other such factors) and the degree of responsiveness of the client.

Direct Suggestions

Direct suggestions deal with the problem at hand or the specific response desired overtly and clearly. Direct suggestions provide specific directions as to how to respond. Consequently, they are not known for their subtlety. The generic structure for a direct suggestion is, "You can do X." The form of a direct suggestion can vary within this generic structure, depending on your specific word choice.

To initiate the hypnosis session, the clinician will typically suggest that the client close his or her eyes. If the clinician chooses a direct approach, he or she might offer any of the following direct suggestions:

- Close your eyes.
- Please close your eyes.
- You can close your eyes.
- Let your eyes close.
- I would like you to close your eyes now.

Each of these suggestions *directly* relates to obtaining eye closure from the client as a specific response. There is no mistaking what the clinician wants the client to do. The same direct suggestion structures, by changing their content (i.e. associated details) might be used to obtain virtually any desired response:

- You can go back in your memory and remember when you went to your first school dance. (Age regression)
- I want you to let your arm lift effortlessly and become weightless. (Sensory alteration and arm levitation)
- You will be able to make your hand numb in the next few seconds. (Analgesia)
- Experience each minute as if it were an hour. (Time distortion)

The desired response in each of these examples is apparent because the suggestions directly ask for it. Additional direct suggestions may then be offered in order to provide a concrete means (i.e. a strategy) for accomplishing the suggested response:

- Imagine you are in a time machine that is taking you back to your first school dance.
- You can feel that your arm is tied to a large helium balloon allowing it to float.
- Remember how your hand tingles when you get a shot of novocaine? You can have that same sensation of numbness in your hand now.
- Time passes so slowly when you are waiting for something special, and you can notice now how slowly the hands of time move.

Many clinicians employ a direct suggestion approach to hypnosis almost exclusively. For many, it was simply the way they were trained and so it's what they're comfortable with. Some have difficulty evolving the flexibility it takes to vary their communication style even though they perceive it might be beneficial to do so. Others haven't seen the need to evolve any other style besides a direct one because they haven't seen any evidence for other styles being either as effective or more effective than a straightforward style.

The issue of one style being "better" than another is one of the lingering controversies in the field. *No suggestion is inherently worth much; a suggestion only becomes meaningful when a client accepts, integrates, and responds meaningfully to it.* Thus, generalizations about the superiority of one form of suggestion over another may, at best, be academically interesting, but they have little bearing on what an individual client will respond well to. Thus, if you only know how to be direct, you will be at a distinct disadvantage when you encounter those self-directing or reluctant clients who will respond better to less direct approaches. *The most sensible goal is to be fluent in all suggestive approaches and vary them as circumstances warrant.*

Direct approaches employ suggestions that represent a frontal assault on the presenting problem. For example, if a client presents the complaint of wanting to lose weight, a direct approach might offer suggestions such as:

> You want to lose weight, and you will lose weight. You will lose weight seemingly effortlessly because you will find yourself becoming choosier about what you eat and when you eat. Whenever you reach for either a fattening or unnecessary food you will instantly see the detailed image in your mind of yourself weighing your ideal weight, and it will feel so good and so motivating to you that you will find it much easier to choose not to overeat. You would rather lose weight than eat fattening foods. You will feel so good about yourself in this process that losing weight becomes easier and easier, and you'll find yourself being satisfied with less and less food. You'll feel extra energy as you lose weight and so you will also want to exercise more just to use your extra energy to get leaner and stronger.

This kind of direct approach may work with some people—perhaps some very obedient, highly hypnotizable, and deeply motivated ones! It's not that such suggestions are bad, wrong, or destined to fail. In fact, for people who want to lose weight, they *will* have to do as suggested, that is, eat less and exercise more. But, that's the equivalent of telling a depressed person to "Cheer up!" It's technically correct, but not particularly helpful. For most people, more subtlety and less of an "in-your-face" approach is preferred. Telling others bluntly what to do does not show much clinical skill, nor does it show much respect for their intelligence and creativity. People typically already know what to do, they just don't have access to the resources that would allow them to do it. (Realistically, do you think there's an overweight person out there who *doesn't* already know he or she should eat less and exercise more?) Finally, such approaches don't involve as much of the person in the therapy process as a more collaborative effort would. Thus, direct suggestions can be helpful, but familiarity and skill with both direct and indirect approaches are essential to the development of a broad and flexible practice of clinical hypnosis.

Here is an abbreviated "cost–benefit" analysis of direct suggestions. The advantages of direct suggestions include: (1) their direct relevance to the matters at hand (easing concerns in the client about your ability to deal directly with his or her problems); (2) their ability to keep the client's goal(s) well defined and in sight; (3) their direct involvement of the client in the process in an active way; and (4) their ability to serve as a model for the resolution of this and any future problems that arise through the development of a deliberate problem-solving strategy.

The disadvantages of direct suggestions include: (1) their over-reliance on a conscious willingness to follow suggestions, making less use of unconscious resources; (2) their greater likelihood of engendering resistance in the client by dealing so directly and even bluntly with his or her

problems, potentially a threatening experience; and (3) their defining the client's role primarily as one of mere compliance rather than as an active participant in the therapy.

Appreciating the advantages and disadvantages of the use of direct suggestions is necessary to allow you to make an informed decision as to when their use will most likely result in a successful hypnotic experience.

Indirect Suggestions

Indirect suggestions relate to the problem at hand or the specific desired response in a covert (or, at least, less obvious) and unobtrusive way. They can be quite subtle and usually do not relate directly to the person's conscious experience. Rather, they are indirectly related and thus require the client to interpret them in a proactive and idiosyncratic way in order to make meaning of them. The generic structure of an indirect suggestion is, "I knew someone who experienced doing X." By talking about someone else (or some other situation), the client's response is invited through an indirect means. Use of indirect suggestions can have the client wondering at a conscious level what you are talking about, or perhaps may simply occupy (amuse, entertain, fascinate) the person at a conscious level, while at the same time unconscious associations may be generated that can pave the way for change to take place.

Consider as an easy example a child's fairy tale: When you tell a child the story of *The Three Little Pigs*, the child can easily be entertained and fascinated by the drama of the story and by the playful exchange when you both "huff and puff and blow the house down." But, beneath the content of the story (i.e. the characters and the things they say to each other), there is a deeper message you hope to impart: The importance of planning, discipline, and hard work in order to move through life choosing substance (i.e. houses of brick) over "flash" (i.e. flimsy ones made of wood and straw). People can transmit and receive deeper messages of substance through such indirect paths. We don't have to experience something directly in order to be influenced by it. Clinically speaking, every time someone provides you with a successful case example, you may be interested in and become absorbed in the details of the case, but the inescapable yet indirect message to you is, "When you see this type of client, you can use this kind of an approach."

Indirect suggestions can take numerous forms, including storytelling, analogies, jokes, puns, homework assignments, role modeling, and disguised and embedded suggestions. Any communication device that causes or requires the client to respond without directly telling or asking him or her to do so involves some degree of indirect suggestion.

The use of indirect suggestion is a focal point of study in the "utilization approach" to hypnosis, largely due to the many creative ways they were used by Milton H. Erickson. M.D. Erickson was widely acknowledged for his skill and creativity in formulating successful interventions, often with seemingly "impossible" clients. Thus, an advanced study of clinical hypnosis is literally impossible without studying Erickson's work directly.

To contrast direct and indirect suggestions, you can refer back to the previous section's examples for obtaining eye closure through direct suggestions. If you suspect, on the basis of feedback from your client, that you would be more likely to get eye closure through indirect methods, you might offer any of the following suggestions:

- A responsive client usually begins hypnosis by closing his or her eyes.
- Can you allow your eyes to close?
- Many of my clients like to sit comfortably with their eyes closed.
- Isn't it nice not to have to listen with your eyes open?
- I wonder what you'll think of that will allow you to comfortably *close your eyes*.

Each of these examples seeks eye closure as a specific response, but it has never been asked for directly. The statements are general ones that the client must respond to in some *way since even no response is a response.*

One pattern of indirection may take the form of simply describing others' experiences, allowing the client to choose a similar response or else generate an independent one. Another indirect pattern is to have the client become aware of routine, everyday experiences where the desired response is a natural event. As the client becomes focused on and associated to such a situation, he or she can begin to re-experience it as if in that suggested situation now. The responses associated with the past experience can become a part of the current experience.

As with eye closure, indirect suggestions can be varied in content to obtain virtually any response:

- A close friend of mine has a daughter who went to her first school dance, and I don't know if you can remember yours, but it sure was an exciting time for her. (Age regression)
- When you were in grade school you had to *raise your hand slowly* when you wanted to say something important, and sometimes it would rise as if it were weightless and you didn't even realize it. (Sensory alteration and arm levitation)
- Can you imagine what it's like to have a barehanded snowball fight and have so much fun making and throwing snowballs you forgot to notice you weren't even wearing gloves? (Analgesia)

- Time is so difficult to keep track of, and after all a minute can seem like 5 or 10 minutes sometimes; you've had that experience, where you can get so wrapped up in your thoughts that only a minute can seem so much longer. (Time distortion)

In each of the above examples, the client's immediate experience is seemingly less the focal point than someone else's, or the suggestion seems so general as to be impersonal and therefore not requiring a direct response. It is up to the client to adapt him- or herself in his or her own unique way to the *possibilities* for certain responses raised by the clinician's suggestion. In this way, direct commands for obedience are avoided, and the client's own creative ability to form an individualized response is tapped. How he or she finds a way to accomplish the possible response suggested is as varied and creative as are people.

Here, then, is an abbreviated "cost–benefit" analysis of indirect suggestions. The advantages of the indirect approaches include: (1) their greater utilization of unconscious resources in the client's own behalf; (2) their greater distance between the suggestion and its intended target emotion or behavior, reducing the need for resistant defenses; (3) their permissiveness in encouraging and allowing the client to interpret the suggestions in whatever way might be useful to him or her, demonstrating a greater respect for the client; and (4) their defining the client's role in the treatment process as an active one going beyond mere compliance.

The disadvantages of the indirect style include: (1) the client's possible fear or anxiety that the clinician is either unable or unwilling to deal directly with his or her problem, and "if he or she can't, how can *I*?"; (2) the clinician may be viewed as evasive or incompetent (i.e. seemingly irrelevant in "talking around" issues), and the client may feel manipulated and even cheated; (3) the client's unconscious responses may allow for alleviation of the problem, but may leave him or her consciously wondering how the change occurred, as if therapy was done "to" rather than "with" him or her; and (4) the problem may be solved but may not leave the client with a knowledge of and access to effective and self-managed patterns for solving future problems.

As with direct suggestions, appreciating the advantages and disadvantages of using indirect suggestions gives you an ability to make sensitive choices about their applications. One approach is not better than another. The goal is to use either approach flexibly in order to get the desired therapeutic result.

Authoritarian and Permissive Suggestion Styles

Suggestion style refers to the demeanor or posture of the clinician while offering suggestions. Styles can be described as if on a continuum with "authoritarian" at one pole and "permissive" at the other.

Authoritarian Suggestions

The authoritarian style is a domineering one in which the clinician essentially commands the client to respond in a particular way. The generic structure for an authoritarian style is, "You will do X." Authority and power are the key variables the clinician relies on, and the response from the "good" client is compliance. You can anticipate how easily this confrontational approach might initiate a "power struggle" that is detrimental to the aims of treatment.

Authoritarian approaches involve offering suggestions in the form of commands. The following suggestions are structured in an authoritarian mode:

- Close your eyes when I count to three. (Eye closure)
- When I snap my fingers, you will be six years old. (Age regression)
- When I touch your shoulder, you will go into deep hypnosis. (Deepening)
- You will find it impossible to bend your arm. (Catalepsy)
- You will not remember anything from this experience. (Amnesia)

Directing someone to respond in a specific way that minimizes personal choice does not show much respect for that person's needs or wants. Thus, a strictly authoritarian approach should generally be used sparingly. There are times, though, when such an approach is not only viable, but even desirable: When a vulnerable and confused patient needs a clinician who is clearly in charge and decisive, and when the quality of good rapport between you and the client makes what you have to say far more important than how diplomatically you say it.

Permissive Suggestions

At the other end of the continuum is the "permissive" style, characterized by its emphasis on allowing the client to first become aware of possibilities for meaningful responses then respecting his or her choice as to whether to accept the suggestion, rather than making demands for compliance. The generic structure for the permissive suggestion is, "You can do X." The clinician simply offers suggestions of what the client *may* experience if he or she chooses to. The sensibility of a permissive approach is in knowing you can't make someone respond (e.g. relax or focus). You can simply *suggest possibilities* in such a way that the person, hopefully, chooses to avail him- or herself of those possibilities. Ultimately, the responsibility is on the client to make use of information that has been provided by the clinician in his or her own way. Any response is deemed an adequate or usable one by the clinician, respectful of the person's

choice. In this way, "resistance" is much less debilitating a factor, since whatever response the person generates is deemed acceptable.

Permissive suggestions are intended to raise the possibility of a response, and the following examples may illustrate the point:

- You can allow your eyes to close, if you would like. (Eye closure)
- You may choose to uncross your legs. (Postural shift)
- You might be willing to let yourself relax even more deeply. (Deepening)
- It's possible to experience your body differently. (Perceptual shift)
- Perhaps you can remember a time long ago when you felt comfortable. (Age regression)

In these examples, the client is offered choices and then responds to his or her own choices. The clinician is simply saying, in one form or another, that the client can have an experience if he or she permits it. The client's response in any direction is thus a choice and must be respected as such. Such acceptance by the clinician can add to the rapport by demonstrating a respect for the client as a person capable of making choices for him- or herself. It may be implicit thus far but can now be stated explicitly that when the client's choices are deemed counterproductive to your treatment plan, your strategy needs to be revised. The idea of the permissive approach is to make the suggestions you offered clients acceptable through their personal choice. The skill required in such an approach is probably evident.

In sum, there are those who want to be told what to do and will follow instructions to the letter, and there are those who refuse to follow anyone's lead and will even go out of their way to reject others' input simply because they resist being "controlled." If someone is willing to follow directives obediently, an authoritarian approach may be successfully employed. With most people, however, it will tend to set up "power struggles." The permissive approach is good for creating possibilities in people who like to have a large measure of control in their lives by making their own decisions, but may frustrate the person who wants to be told in explicit terms *exactly* what to do in a step-by-step fashion. Both authoritarian and permissive styles have their place in doing hypnosis, and as with all forms of suggestion, it will enhance your effectiveness when you become comfortable with their usage.

Positive and Negative Suggestions

Positive Suggestions

Positive suggestions are by far the most common, simple, and useful type of suggestion structure. Positive suggestions are supportive and

encouraging, and are phrased in such a way as to give the client the idea that he or she can experience or accomplish something desirable. The generic structure for a positive suggestion is, "You can do X." (You'll recognize this as a permissive suggestion as well.) Since words call to mind the experiences that the words (as symbols of experience) represent, positive suggestions are phrased to create desired responses. The following suggestions are structured in positive and permissive ways:

- You can feel more comfortable with each breath you inhale. (Deepening)
- You can remember a time when you felt very proud of yourself. (Age regression)
- You can discover inner strengths you didn't realize you had. (Resource building)
- You can notice how good it feels to relax deeply. (Deepening)
- You may notice a soothing feeling of warmth in your hands. (Sensory alteration)

These examples are positive suggestions to the client of things he or she *can* experience. These suggestions are meant to be empowering, creating positive possibilities without demanding anything specific to resist. Amplifying what's possible, meaningful, and helpful is the foundation of positive suggestions.

Negative Suggestions

Negative suggestions employ a sort of "reverse psychology" approach when used skillfully. Negative suggestions may be used to obtain a response by suggesting the person *not* respond in the desired way. The generic structure for a negative suggestion is, "You cannot do X." By telling the person what not to do, he or she still has to process and interpret what you say, and the various subjective associations surface as he or she does so. When used deliberately and in a skilled way, negative suggestions can be most useful.

The following are examples of negative suggestions. Notice what your internal experience is as you slowly read each of them.

- Do not think of your favorite color.
- Do not allow yourself to wonder what time it is.
- I would suggest that you not notice that sensation in your leg.
- You shouldn't be thinking about your high school sweetheart right now.
- Please try not to notice which of your friends is the most materialistic.

Did you find yourself doing what was suggested that you not do? If so, why? If you were able to avoid doing what you were instructed to, how did you accomplish this? Did you have to distract yourself with some other thoughts? Would a client be able to prevent herself from following the suggestion if he or she didn't know about negative suggestions?

All too often, negative suggestions are employed naïvely and accidentally, generating an unwanted response that may leave the practitioner wondering what went wrong. If a clinician says (with great sincerity and the positive intention of comforting the client), "Don't worry about it, just put it out of your mind," the client is most likely to still worry and think about "it." Accidental outcomes as a result of non-selective use of negative suggestions can undo in a sentence what might have taken considerably longer to accomplish. Use them carefully!

How might negative suggestions be used deliberately to facilitate the experience of hypnosis? By suggesting to the client that he or she should not do the things you actually want him or her to do (assuming the appropriate client and situational variables), you are paving the way for the client to respond in a way that can only be defined as cooperative. For example, if I say to my client, "Don't let your breathing slow down as you listen to me, or else your muscles might relax," the client can now respond by either letting his or her breathing slow down and muscles relax, positive signs of the beginning of hypnosis, or he or she can continue in the current state, essentially complying with the literal suggestion, a cooperative response. Thus, either response is a cooperative one, directly or indirectly.

Other examples may include negative suggestions such as:

- Don't even consider the possibility that there might be a positive way to solve this problem.
- There's no reason why you should even think about how good it will feel to get this behind you.
- Don't sit in a comfortable position if you can help it. I'd prefer that you don't discover that you can relax here, at least *not yet*.

Negative suggestions are a way of "short-circuiting" resistances, occupying the client with negativity while asking for positive responses indirectly. The typical response of the client is to ignore the negative and respond to the implicit positive suggestion.

Content and Process Suggestions

How much detail in your suggestions should you provide the client? Should you lead the client step by step through some sequence of suggestions designed to culminate in some response? Or, should you keep the suggestions general, and let the client figure out how to make them

meaningful? As you might anticipate, both approaches have merit in different circumstances.

Content Suggestions

Content suggestions contain highly specific details describing feelings, memories, thoughts, or fantasies the client is to experience during hypnosis. The generic content suggestion structure is, "You can experience this (specific sensation, memory, etc.)." Providing details that describe every dimension of the suggested experience can have the desired effect of assisting the client to have the experience more completely and therefore with a greater degree of absorption and clinical usefulness.

Examples of content suggestions may include:

- Think of a red rose with soft, velvet petals you can lightly brush against your nose as you inhale its gentle, sweet fragrance.
- Imagine being at the beach on a bright, clear day, feeling the sun warming your skin, smelling the salt in the ocean breeze, and hearing the lapping of the waves upon the shore.
- Can you remember how pleasing it is to bite into a juicy, wet orange, how your mouth waters, how the juice feels as it runs all over your fingers, and how tart it tastes?

Each of these examples provides specific details about exactly what you are to experience in thinking of a rose, the beach, and an orange. Perhaps those details allowed you to have the suggested experience more fully, in which case the details were helpful to you. When you offer content to someone and the details you suggest actually fit with his or her experience, the details will enhance the experience. However, these examples can also illustrate a potential hazard in using content-filled suggestions, namely that the details I directed you to notice may not be the ones you would have chosen to focus on. Or, at their worst, they may even have been details that negated the experience for you. The potential problem with content suggestions is simply this: The more details you provide, the greater the probability that something you say will contradict your client's experience. The end result is the client will sense that the clinician is not really "with" him or her, and so is less likely to benefit from the experience. A solution is to use process suggestions instead of content suggestions, discussed in the next section.

Process Suggestions

In contrast to the details provided in content suggestions, process suggestions provide minimal details at most, encouraging the client to

provide his or her own. The generic structure for a process suggestion is, "You can have a specific experience." In response to the deliberate ambiguity in the suggestion, the client projects his or her own personal experiences and frame of reference into the suggestion in order to make meaning of it. Consequently, process suggestions are less likely to contradict the experience of the client. For example, if I would like the client to imagine being in a relaxing place, instead of me choosing the beach as a specific place to focus on and then providing lots of details (content suggestions) about what it's like to be at the beach, I can simply suggest to my client that he or she imagine being *somewhere* relaxing. I don't say where that place might be, and so he or she can choose the specific place and which particular details of that place he or she would like to focus on. Process suggestions are so general in nature that the client can project personal meaning into them and then relate to them in his or her own, individual way.

The following are examples of process suggestions:

- You can have a particular memory from childhood, one that you haven't thought about in a long, long time. (Age regression)
- You will notice a certain pleasant sensation in your body as you sit there comfortably. (Kinesthetic awareness)
- You may become aware of a specific sound in the room. (Auditory awareness)
- Can you remember that special time when you felt so good about yourself? (Age regression)

None of these suggestions specifies anything—that is, they do not say which specific memory, sensation, sound, or event the client is supposed to experience. The client chooses that aspect of the experience when he or she projects a response to the suggestion. Notice, though, the use of qualifiers such as "particular," "certain," "specific," and "special" in process suggestions. These can be employed to have the client sift all of his or her experience down to one particular one to focus upon.

Process suggestions are especially valuable in doing group hypnosis processes, in which the opportunity to carefully watch each individual's responses to content suggestions is virtually impossible. Using process suggestions of a general yet specific-sounding nature allows each person in the group to have an entirely different experience in response to a single set of suggestions. Trying to make a group of people share a common, detailed experience is a set-up for failure. Thus, through process suggestions the diversity among people is acknowledged and encouraged.

The content versus process paradigm can be viewed in another way: Dealing with the details contained in the structure of an experience, or

with the structure itself. Content-oriented therapies deal with details of the problem, while process-oriented therapies focus on the problem's structure. For example, someone is married three times, each time to an alcoholic. People have patterns that guide their behavior, and these are generally unconscious. In the current example, the content is each specific person in the succession of alcoholic marriage partners. The names and faces change, but not the structure of how a relationship partner is chosen, that is, the type of person in the pattern. The content approach to therapy might deal with the reason(s) why this particular relationship isn't working out, while a process approach might consider revising the structure of the pattern for how partners are chosen. By altering the structure of the pattern of selection, a change in the details (content) must naturally follow. This is an essential component of brief therapies.

Using process or content suggestions is simply another choice point for the clinician in formulating an intervention. Shifting spontaneously from content to process or vice-versa is an easy thing to do, so the decision about which structure to use is by no means a final one, a "sink-or-swim" proposition. If what you are doing isn't getting the desired response, then flexibly making a midstream shift in your approach is always a good idea.

Posthypnotic Suggestions

Posthypnotic suggestions are those given to the client while he or she is in hypnosis that encourage particular thoughts, behaviors, and feelings he or she can have later in some other context. Posthypnotic suggestions have the generic structure, "Later, when you're in situation A, you'll be able to do (think, feel, experience) X." They are a standard part of nearly every therapy session, since you will almost always want the client to take something away from the session that he or she can use elsewhere in the course of living. Posthypnotic suggestions make it possible for the person to carry over into the desired context whatever new associations he or she has acquired during hypnosis. Without them, the learnings acquired during hypnosis will most probably be limited to the session itself. The reason for this is that hypnotic responses are generally "trance state-specific," meaning they are tied to the immediacy of the hypnotic experience, operating within the boundaries of that experience. If the client can only have the desired experience (e.g. pain relief) during hypnosis, then the value of hypnosis is much too limited.

The following are examples of posthypnotic suggestions:

- When you come out of hypnosis in a few moments, you can enjoy the feeling that you rested to a more satisfying degree than you have in a long, long time.

- When you begin to take your examination next week, you can close your eyes for a moment that can seem much longer and take a deep breath, and you can notice all the anxiety leaving you as you exhale.
- After you go home tonight, you'll have a certain memory that will make you laugh, and it'll feel really good to let off some steam in such an enjoyable way.
- When you find yourself in the next argument with your boss, the feeling of comfort that she can disagree with you but still appreciate you will soothe you enough to handle the discussion calmly in a way you feel proud of.

Each of these examples suggests a behavior or feeling the client is to experience in some future time and place to be based on the suggestions given to him or her during hypnosis. Interestingly, some clients may have no conscious memory for the origin of the suggestion (amnesia), but act on it unconsciously nonetheless. Posthypnotic suggestions are essential to assure that the desired response will likely become integrated into the person's everyday life, replacing dysfunctional or absent responses.

There are other, more specialized suggestion structures that further study of hypnosis can add to your repertoire. The essentials of hypnotic suggestion structures and styles, though, are contained in this chapter, providing you with a strong foundation on which to build your skills.

10

HELPFUL HINTS FOR CONSTRUCTING HYPNOSIS SESSIONS

In the previous chapter, I described the general styles and structures for suggestion formulation. In this chapter, some general guidelines for your choice of particular words and phrases within those styles and structures will be provided. These guidelines are intended to help you form suggestions that are more likely to be accepted by the individual you are working with.

These guidelines are, for the most part, communication skills based on common sense. While these guidelines generally hold true for most hypnotic processes, you should, of course, be aware that each principle has exceptions that may be even more useful to apply with a given client. Therefore, a brief discussion of each principle is provided to encourage you to think critically about it. By thinking of particular cases where the principle might not apply, and thinking of an alternative that might be more effective, you will increase your range of choices in responding skillfully to a particular person.

Keep Your Suggestions Simple and Easy to Follow

Generally, the more complicated a set of suggestions or instructions you provide for someone to follow, the more the person must rely on conscious resources to help understand and respond to them. That's true in *or* out of hypnosis. The more the person must rely on conscious resources, the less the person can respond with unconscious ones, partially defeating one of the primary reasons for even doing hypnosis. Keeping your suggestions relatively simple allows the client to "go with the flow" of the process without having to critically and therefore consciously, analyze, interpret, and judge the merits of your suggestions.

How do you know whether your suggestions are too complex and working against your goals? Observe your client's responses. Every

suggestion that lightens his or her experience of hypnosis, and every undesirable response to your suggestions, indicates that he or she may not be following you (which also means you may not have been following him or her as well as you might have). A more direct means for finding out how your client is doing is to simply ask the client neutrally, directly or indirectly, for specific verbal and nonverbal (such as a finger signal called an "ideomotor signal," for example, "You can raise your index finger when you begin to feel relaxed") feedback about his or her experience during and again after the hypnosis session.

Keeping suggestions easy to follow isn't the same as being predictable and obvious about where you are going with the hypnotic process. If the person is able to guess where you're going and can too easily remain a step ahead of you, there is obviously considerable conscious analysis taking place, increasing (but by no means assuring) the likelihood of reduced responsiveness. If you become aware that you may have lost the client somewhere along the way, you can go back to a point in the process where you sensed he or she was with you (and, if you are observant, you won't have to go back very far) and go on from there, but obviously not in the same way.

Use the Client's Language as Much as Sensibly Possible

One of the lessons from the field of hypnosis that has been especially helpful clinically is the idea of using the language of the client whenever possible. You have learned that words represent experience, and even though we use a common language, our individual experiences are necessarily different. Taking the client's words, then attaching your meaning to them, then translating them into the conceptual language you happen to use, and then, finally, communicating from your linguistic style are all steps that are arbitrary on your part, and thus increase the likelihood of miscommunication. In using the language of the client, you don't assume, even for a moment, that you mean the same thing as he or she does in using it. The main advantage of using the client's language is in your ability to intervene in the client's problem as he or she experiences it, and not as you interpret it. Furthermore, the client can get the sense of being understood to a greater degree, engendering greater trust in the clinician.

Sometimes, using the language of the client is neither appropriate nor desirable. If the person's style of speech is too idiosyncratic, or is related to the client's particular ethnic group or other subculture of which you are not a member, your using the same language to try to make a positive connection may instead be viewed as mockery and insulting. Recovery from such a mistake is difficult.

Have the Client Define Terms Experientially

Since words are simply symbols of the experiences they represent, using the same words as your client doesn't mean you are describing the same experience. Therefore, it is imperative to have the client explain to you the experience he or she is presenting as significant as best he or she can, rather than him or her just using a word or two to represent the experience. Whatever words are used, they will never give you a complete idea of what the person is subjectively experiencing, but the more definition and description of his or her experience you have, the more opportunity you have for meaningful intervention.

Some clinicians are afraid to ask the client for clarification, erroneously believing it will reflect a lack of understanding. Thus, when a client says, "I have this terrible depression, ya know what I mean?" the eager-to-prove-empathy therapist is likely to say, "Yes, I know what you mean." However, what this particular client is actually experiencing is unknown. A more effective response might be, "Can you describe what your experience of being depressed is like for you?" Having the client describe the experience in his or her own way can lead you to a better understanding of how and where to intervene.

In having clients define the meanings of the terms they use, the clinician can often help the person redefine the term and subsequently alter the experience it represents. This is the essence of a common technique called "Reframing," in which an experience can be changed by the use of a different term and a different interpretation of the meaning of the experience to redefine that experience. Reframing as a means of changing the meaning attached to an experience is a core component of therapy interventions of all kinds.

Words are the medium of exchange between the clinician and client, and the more ambiguous the words, the greater the room for miscommunication. This point emphasizes the need to be aware of both the connotative and denotative meanings of your words. If a client takes literally something you intended to be taken figuratively, or vice versa, the result may be undesirable.

Use the Present Tense and a Positive Structure

Generally, suggestions should be phrased in the present tense and in terms of what the person is currently experiencing. Of course, most therapeutic suggestions are intended to influence future behavior in some way, but the hypnotic session is the bridge between what is happening now and what will, hopefully, happen later. The basic structure of hypnotic suggestions is linking what is occurring now to what is desired: "As you experience *this*, you can start to experience *that*." Continuous

feedback about the person's present state is necessary to make the bridge effective.

This point is especially true in the case of working directly with patterns of time, such as in age regression. When you are working with memory, talking to the person in past tense terms of what occurred "then" will produce a different and much less profound response than will talking to the person as if he or she is experiencing that past situation now. Having as much of the client in the "here-and-now" (whether the here-and-now is actually a past or future context) gives the clinician working access to more of the person. Current needs, motivations, feelings, values, and behaviors are available for incorporation into the process. In part, this is where hypnosis as a tool derives its power. Instead of intellectually talking about a situation one is removed from, the clinician recreates the power of that experience now and deals with the resulting issues and feelings as they arise now.

Positive suggestions that assist the client in discovering what he or she can do are a principal goal of treatment. Negative suggestions might tell someone what *not* to do, but don't teach the person what to do instead. Negative suggestions can be effective when carefully used, but the overwhelming majority of suggestions you use will likely be of a positive nature as you use your hypnosis sessions to empower people with new possibilities for improving their lives.

Encourage and Compliment Positive Responses

Support for the client in the form of encouragement and compliments can go a long way in assisting the client to find resources within him- or herself. The process of encouraging a client is typically one of guiding the client into a position where he or she can identify and acknowledge personal strengths and resources previously overlooked in him- or herself. Typically, the person seeking help feels out of control and frustrated. Seemingly empty compliments that contradict the person's low self-esteem are easily disregarded (recall the earlier discussion of cognitive dissonance). Guiding the person into a position of self-acknowledgment by expanding his or her recognition of personal strengths and resources, the heart of employing aspects of the newer positive psychology, can be a powerful intervention. People are much more than their problems.

Determine Ownership of the Problem and Problem-Solving Resources

Different therapeutic approaches have different terminology to express this concept, each one addressing the need to guide the client into accepting a measure of responsibility for what he or she is experiencing.

If the client feels he or she is a "victim," or if he or she is a "blamer" with no awareness of personal responsibility at all for his or her experience, then helping the client to change in some meaningful way is more difficult. If you believe you have no control over your experience, then attempts to demonstrate to you that control is possible will most likely be ignored or dismissed with the ever-familiar, "Yes, but . . ." excuses of why change is impossible. Helping people to discover that they have power to control the events in their lives, at the most, or, at the least, their reactions to the events in their lives, is a necessary component of therapeutic work.

Use Sensory Modalities Selectively

Barring some neurological anomaly, it is important to realize that each person processes experience in all of the senses all of the time. The issue of clinical concern here is which sensory modality is dominant in a given context, particularly the symptom context. The language a person uses spontaneously, particularly the predicates (including verbs, adverbs, and adjectives), may reflect a person's favored information-processing style. Language, because it is structured for the most part at an unconscious level, reflects the unconscious patterns of thinking through the specific words chosen to reflect inner experience. Thus, if in the course of a discussion I make a point that the listener responds to by saying, "I *see* what you mean; that *looks* right to me," I can deduce a visual preference in the listener relative to my point. If the listener responds to my point by saying, "I *hear* what you're saying; that *sounds* right to me," I can deduce an auditory preference. If the listener responds, "I get *a feel* for what you mean; that idea *grabs* me," I can deduce a preference for the kinesthetic modality. In each case, I can use language that will appeal to the preferred style. For example, with a visually oriented person, using visual imagery techniques is likely to be effective, but is likely to be less effective with the person who has a strong kinesthetic orientation.

The use of language patterns that emphasize the sensations of an experience will have a more powerful effect than the use of more distant, intellectual terminology. Consider the effect of the following statement: "Think of how pleasant a walk in the woods can be . . . so enjoyable, enlightening and peaceful. . . ." Contrast that effect with a more sensory rich statement:

> Can you remember taking a great walk in the woods . . . seeing the tall, sturdy trees and bright green leaves contrasting against the sunny blue sky . . . hearing the soothing sounds of the birds chirping and singing and the leaves crackling under your footsteps . . . the gentle feelings of a comfort and peacefulness inside . . .?

The experience of hypnosis is one in which the client's emotions and sensory experiences can be amplified to higher levels, appropriate for making greater use of the person's resources in facilitating change. In this way, a greater rapport may be obtained, and the stage may be set for leading the client into a different sensory awareness. Such a lead may be accomplished by shifting at some point into using language of the sensory system(s) outside of the person's usual awareness. For example, with a person whose favored modality is visual, you can match with visual suggestions and then gradually lead into the kinesthetic area, altering the person's typical pattern of consciousness:

> As you see yourself sitting in that chair, you can see each breath you inhale soothing each muscle of your body . . . visualizing each muscle unwinding, loosening comfortably . . . and as you see each muscle relaxing you can begin to feel the tingle of comfort in the muscles of your arms . . . and feel the comfort growing and flowing to other parts of your body.

Keep the Client as Informed as Desired and as Necessary to Succeed

While it is a high priority to provide relevant information to clients, and the ethical practice of securing an informed consent is highly desirable, it is also clinically necessary not to provide too much information about one's interventions. The spontaneity of the experience of my suggestions is what has an impact on the person, not the explanation of what I am trying to do. If I say to a client, "I'm going to give you a negative suggestion now in a 'reverse psychology' strategy so you'll think you're spontaneously doing what I tell you not to do," what is the likelihood of me getting the response I want? Answer: Zero.

Presenting and withholding information selectively can be an obvious ethical dilemma. How can a client provide informed consent if he or she doesn't know what the clinician is doing and why? Yet, if he or she knows exactly what the clinician is doing, then how can the intervention succeed? This is a matter that must be handled delicately on a case-by-case basis, as the clinician gets a "feel" for how much information the client wants and needs to succeed. Trust, rapport, and respect for the client's integrity are key ingredients in the hypnotic interaction.

Give Your Clients the Time They Need to Respond

Each person does things according to his or her own personal pace. In hypnosis, this characteristic is amplified to the point of being a critical

component of the interaction, one to be noticed and respected by the clinician. To pressure someone to respond to your pace of doing things just won't work in doing hypnosis. Instead, you have to allow the client to form the suggested response, whatever that might be, at the rate he or she chooses.

In the phase of guiding the person out of hypnosis, called "disengagement" or "alerting," this is especially true. I have always disliked using a count-up to guide the person out of hypnosis (e.g. "When I count to three you will awaken, open your eyes, and be alert and refreshed") because it forces the client to adapt to your arbitrary choice of when he or she should come out of hypnosis, instead of letting him or her choose for him- or herself. I prefer a general closure on the order of: "When you have taken the time to complete this experience, you can bring yourself out of hypnosis at a rate that is comfortable for you . . ."

Let the person take the time he or she needs to fully develop the responses you suggest. No need to hurry . . .

Only Use Touch Selectively and *Always* with the Client's Permission

Can you imagine what it's like to be deeply relaxed, feeling good, wonderfully absorbed in some important internal experience . . . and all of a sudden feeling a strange hand on you? I have seen so many sessions that were going well ruined in an instant because the clinician assumed enough rapport was present (if he or she even thought about it, which some "touchy-feely" clinicians never do) to touch the person. The touch was entirely innocent, a well-intended expression of support or empathy, yet was highly disruptive to the client. It is very important to get permission to touch the person for a number of reasons.

First, touch is associated to intimacy—a cross into personal space. Some clients may welcome it, but others hate to be touched and experience it as a violation of personal territory. With such persons, it can hinder or even destroy rapport.

Second, in hypnosis, the person is typically (not always) focused inwardly on some internal experience. To have to notice or respond to a clinician's touch means reorienting one's focus to the external world, which is generally counterproductive to the development and maintenance of a deeper hypnotic experience. If you use touch indiscriminately, you can thus unintentionally work against yourself.

Third, an unexpected touch may simply startle the person, even if he or she doesn't find it offensive. The person may be so lost in thought that he or she may even have forgotten that you are there! To suddenly feel a hand on you can scare anybody, in *or* out of hypnosis.

Fourth, the media have played on the terrible misconception that hypnosis is a means for seducing vulnerable clients. The sexual implication of touching someone unexpectedly even in a decidedly non-sexual way can easily trigger unnecessary problems in this regard.

It is always a good idea to politely ask the client for permission to touch him or her during hypnosis, for it certainly demonstrates a respect for his or her integrity. Whether you ask *before* your hypnosis session begins (e.g. "During this session I will want to touch the back of your hand to gauge your degree of analgesia . . . is that all right with you?") or at some time *during* the hypnotic process is a matter of personal preference (I prefer to do *both*), just so long as you secure permission before touching your client.

Use Anticipation Signals to Announce Your Intentions

It is always a good idea to avoid startling your client out of hypnosis with an unexpected maneuver on your part. The best tool to prevent this problem from arising is called the "anticipation signal." Anticipation signals are verbal announcements about your intentions, effectively letting your client know what action you are about to take so as not to startle him or her. They also serve the deepening function of keeping the client comfortable enough to feel as though he or she doesn't have to be vigilant or guarded about everything you say and do. Such vigilance is generally counterproductive to hypnosis.

Anticipation signals are simple statements you make during hypnosis about what is coming next in the process. The generic structure for an anticipation signal is, "In just a moment, I'm going to (fill-in-the-blank)." For example, I may say, "In just a moment, I am going to touch the back of your hand to highlight your experience of numbness there." Assuming I ask for and receive permission to touch the person (". . . and if that's all right with you, please nod your head"), I am now preparing the person for my touch rather than just touching his or her hand without warning. It is a much gentler and more respectful approach, and clients greatly appreciate that consideration. When you state, "In just a moment I'm going to . . .", and then follow through in a way that is entirely consistent with what you stated your actions would be, a new level of trust can be reached, aiding your future work together.

From the client's perspective, it is very difficult to be relaxed and on guard simultaneously. Anticipation signals are a very quick, simple, and effective way to foster trust in the hypnotic relationship while giving the client a valuable sense of participation in the process.

Use a Voice and Demeanor Consistent with Your Intent

Your tools as a skilled communicator are your voice and body. Beyond your words, your nonverbal communications can serve to reinforce or even negate your suggestions. Paying attention to such factors as eye contact, body posture, gestures, touch, timing, use of space, tone and volume of voice, and facial expressions is necessary in order to maximize the value of the things you say.

It helps immeasurably to have control of your voice and body in communicating, using yourself as the mechanism to drive a suggestion home. To have tension in your voice when you suggest to your client that he or she relax is an avoidable incongruity. To use a normal conversional tone of voice with someone you want to guide into a different internal state of experience is another avoidable incongruity.

It is a good idea to have a well-practiced calm tone of voice and relaxed body posture to model for your client what you want him or her to experience. To gradually shift from your usual tone of voice to one more soothing and hypnotic builds an association (what some call an "auditory anchor") in your client's mind between that tone of your voice and the implied invitation to the client to go into hypnosis. Establishing that association makes it a smoother transition into doing hypnosis in subsequent sessions. Once the client associates going into hypnosis with that tone of your voice, you don't necessarily have to formally announce, "Now let's do hypnosis." Instead, you can gradually lead into using the voice your client associates with entering hypnosis, effectively inducing hypnosis without a formal induction.

Chain Suggestions Structurally

"Chaining suggestions" means linking the desired response to the client's present experience. The idea is to build a link (hence "chain") between what the client is currently doing and what you would like him or her to do. The generic suggestion structure for chaining suggestions is, "As you experience (this), you can start to experience (that)." For example, as you continue to sit there and read these words, you can begin to notice your left foot.

There are three types of links between current and future experiences, varying in the strength of the linkages. With all three links, the first half of the statement matches the person's current experience while the second half suggests a possible, but not current, experience.

The first link is the "simple conjunction." It is the weakest link, and simply suggests an association between what is and what can be. It employs such connecting words as "and" and "but." For example:

- You are looking at me *and* starting to feel comfortable.
- You can see the clock clearly *but* still allow time to slow down.

The second link, a slightly stronger one, is called the "implied causative," employing such connecting words as "as," "while," and "during." For example:

- *As* you notice yourself relaxing, you can let your eyes close.
- You can listen to me *while* your conscious mind drifts off.
- You can feel yourself growing more comfortable *during* your experience of vividly remembering your high school graduation.

The third and strongest link is the "causative predicate." It's the strongest because it claims that not only are the current and desired behaviors connected, but one actually causes the other. For example:

- Breathing deeply will *make* you relax even more.
- Shifting your body's posture will *cause* you to want to close your eyes.

Each of these links forms a bridge to get the client to respond in a particular way on the basis of what he or she is doing currently. A typical hypnotic process, using the "As you X you can Y" chaining formula, may sound something like this:

> As you continue to look at me, you can take in a deep breath . . . and as you take in a deep breath, you can allow your eyes to close . . . and as your eyes close, you can let your mind drift back to a specific memory . . . and as your mind drifts back to a specific memory you can begin to describe the memory out loud . . . and as you begin to describe the memory out loud you can . . .

Suggestions linked in this way are the basis for the hypnotic process being a flowing one rather than a choppy, disconnected one in terms of delivery. Grammatically, of course, hypnotic phrasing is a strict grammarian's nightmare, but to the person in hypnosis, the clinician is smooth and easy to listen to.

Use Process Suggestions to Encourage Individual Tailoring

If you refer back to the last chapter's section on process suggestions, you can recall the general principle that the more general the suggestion, the more personal meaning the client may project into it in order to make

it personally relevant. Thus, process suggestions are an ideal way to help tailor your approaches to the individual. You also learned previously that the more details you provide for someone's hypnotic experience, the more opportunities there are for contradicting it. For example, "Let your right hand feel warmer" as a suggestion for the specific response of hand warmth is easier to resist than is a more general process suggestion: "You may notice a particular change of temperature in one of your hands." In the latter suggestion, which hand was to change was not specified, nor was it specific whether the hand was to grow warmer or cooler. Whatever response the person has can now be defined as a cooperative one.

It is difficult, if not impossible, to avoid the use of detail in suggestions. And, it is not always desirable to do so because often it is the details you provide during the hypnotic process that make suggestions easier to follow. Learning to "be general specifically," that is, sounding specific although being general, can help you avoid some of the unnecessary rejections of your suggestions. Notice as early on as possible whether you are being too specific (or too general) on the basis of the client's responsiveness to you, and, if necessary, shift your style as you go on.

Build Response Sets Gradually

Ideally, the hypnosis session builds momentum as it unfolds. It grows in the client's degree of absorption, level of emotional intensity, and therapeutic value as the session progresses. At the start of the session, the client is starting to focus, but isn't yet fully engaged in the process. His or her mind is wandering, and only gradually getting into the hypnotic experience. That's typical and is the reason for gradually building ever-increasing levels of depth and responsiveness through the building of response sets. The term "response set" refers to a pattern of responding. In hypnosis, the goal is to build a pattern of responding in the client that encourages becoming receptive to suggestions and experiencing their beneficial effects. This is commonly known as the "Yes set" and was first described by Milton Erickson for its relevance to the practice of hypnosis. A "Yes set" on the part of the client is a patterned response of accepting —in essence saying *yes* to—the suggestions you provide. Building an agreeable frame of mind is valuable at any time during the hypnosis session, but is especially important at the outset when you are first establishing the therapeutic alliance and the hypnotic interaction with the client.

The most common means of establishing a "yes set" is with the use of a series of specialized suggestions called truisms. Truisms are statements that seem so obviously true there is no legitimate basis for rejecting them (for example, "Sometimes people surprise themselves by knowing things they didn't know they knew . . ."). As you offer three or four truisms in

a row, the client silently agrees with each one. If you agree with statement number one, then again agree with statements two, three, and four, then what is your most likely response going to be to statement number five? Agreement. In this way, you've built a pattern of agreement, a positive response set.

In general, when doing hypnosis, your session goes from general to specific. Before you ask for *specific* hypnotic responses, such as analgesia, you first have to build a momentum in the client's responsiveness that will facilitate developing such a complex response. So, you might first offer a series of general statements (such as truisms) about ways he or she can begin to think of her physical perceptions as being malleable. For example:

> The human body is so complex in its many organs and organ systems . . . and isn't it interesting how our perceptions of our bodies change from time to time . . . sometimes you feel warm, and sometimes you feel cool . . . and sometimes you feel tuned in to your body, and sometimes you feel distant from it.

Once a *general* sense of variability in physical perception has been established, the clinician can then go from general to specific in suggesting a *particular* change in physical perception, such as analgesia.

The "yes set" is the most commonly used one for what are now obvious reasons, but there are other response sets you can employ as well. There may be times when you want to deliberately encourage rejection of your suggestions (e.g. to foster greater independence) with a "no set." Or, there may be times when you want to encourage skepticism or uncertainty (e.g. with someone very confident about some belief but who is very wrong) with an "I don't know" set.

Most people, as you will discover, don't simply form an immediate response to a suggestion. The skilled clinician recognizes the importance of taking the time to build responsiveness in the client as the session progresses. *In fact, if you were to ask me what single stage of the interaction most influences the overall success of the hypnosis session, I'd say it's the stage of deliberately building a response set. If it isn't managed well, not much of value is likely to follow.*

If Desirable, Substitute Other Terms for Hypnosis

There are those individuals who specifically ask for and want hypnosis as a part of their treatment. They're familiar with hypnosis, receptive to hypnosis, and it's an easy, straightforward interaction. However, there are also people who would greatly benefit from hypnosis who are afraid of hypnosis because of the misconceptions they hold. If you say, "let's

do hypnosis," they shut down. But, if you say, "let's do a focusing exercise" or a "guided meditation," they enthusiastically say, "Sure!" Invariably, people react negatively to the word hypnosis, but positively to the qualities of experience hypnosis engenders.

Since I have no real attachment to the word "hypnosis," if it serves the therapy to use all the same principles and techniques under a different, more acceptable, name, I will do so. If a cancer patient fears hypnosis, yet really wants to experience the anticipated benefits of visualization techniques, why get into a lecture on how visualization is a specific type of hypnotic technique? It may create resistance needlessly. Instead of developing a positive feeling for hypnosis, he or she might develop a negative feeling about visualization.

It isn't terribly important to sell your clients hypnosis; it's only important to help them have positive and therapeutic experiences with it. If the client reacts negatively to your query about any experience he or she might have previously had with hypnosis, you might exercise the option of using another term to label your intervention. Some specific possible alternative labels are:

- progressive muscle relaxation
- controlled relaxation
- guided relaxation
- deep relaxation
- visualization
- visual imagery
- guided imagery
- guided fantasy
- guided meditation
- mental imagery
- systematic attentional training
- focusing exercise.

Do these terms all represent hypnosis? Technically, the answer is no. These approaches are each different in a variety of ways, and so the hypnosis purist will find it incorrect to equate them. And he or she would be correct to object. However, in clinical practice, quibbling about relatively subtle differences wastes time and creates unnecessary conflict when all we want to do is help empower the client to develop important personal resources.

11

STRATEGIES OF HYPNOTIC INDUCTION AND DEEPENING

The phrase "inducing hypnosis" implies the clinician is doing something *to* the client. The language of hypnosis is sometimes limiting and even misleading, for the client is not simply a passive receptacle for the clinician's suggestions. Rather, the client is an active force in shaping the interaction, and the clinician must respond meaningfully to the unique responses of the individual. Guiding the person into hypnosis may be a more accurate representation of the clinician's role. In the capacity of guide, you cannot know the exact experience the client is having or is going to have, and so giving the client room to experience hypnosis in his or her own way is not only desirable but *necessary*. The process of guiding a person into hypnosis is a large responsibility to assume as you make yourself a primary focal point, for the client is now focusing him- or herself on the experiences you stimulate through your communications.

The process of hypnotic induction serves several purposes:

1. It provides a concrete stimulus for the client to focus his or her attention on, serving as a *bridge* between the "usual state" and the experience of hypnosis.
2. It engages and occupies the person's conscious mind, and in so doing effectively dissociates it from other competing awarenesses while simultaneously amplifying the unconscious mind's associational abilities. In fact, this is the chief function of an induction: facilitating the dissociation of conscious and unconscious functions. The degree of dissociation achieved is a relative measure of the depth of the hypnotic experience.
3. It allows for the building of a "response set," discussed earlier.

The induction process as the stimulus for the experience of hypnosis obviously plays an important role in the overall quality of the interaction,

and consequently, deciding which induction to employ is a matter worthy of extra consideration. There are as many induction and deepening methods as there are practitioners of hypnosis, and since it is neither practical nor desirable to list them all I have included only several of the more common and useful ones. I have divided the methods of induction into two general categories: formal, structured inductions; and informal, conversational approaches.

Formal, Structured Hypnotic Inductions and Deepeners

The formal, structured inductions in this section represent the more traditional approaches to doing hypnosis. In using the term "traditional" to describe these inductions, I have two meanings. The first is for the literal meaning of the word "traditional." These techniques have been effectively used for a very long time, handed down from generation to generation of hypnotists. My second meaning of traditional is for the association to a more traditional model of hypnosis in which the process of hypnotic induction is generally more highly directive and ritualized.

Each of the formal, structured inductions, if not scripted word for word has, at the very least, key phrases and concepts that are integral to defining the technique. *Thus, these key phrases and concepts must necessarily be present if that technique is to be employed*. Realistically, a clinician might choose to employ a structured approach, yet still vary at least some of the wording according to the individual needs or characteristics of the client.

These techniques are invaluable in the practice of clinical hypnosis, and should be mastered as basic approaches to hypnosis. Experience will prove to you quite dramatically that you will get a wide range of reactions to the same exact technique, such is the tremendous variation among people. One of the most important skills in doing effective hypnosis is being observant enough to notice and use the responses you get in order to either amplify or shift away from what you are doing. If what you are doing isn't working for some reason, you can have the flexibility to smoothly shift to a different technique and/or style. Stopping midway through a particular technique is a perfectly acceptable and even desirable thing to do when that technique isn't getting the response you want as long as you make some smooth transition statement (such as, "There's something quite soothing about your mind being able to drift in different directions and you can let your mind drift off now to something else it finds even more comforting than the things I've been talking about. . . .").

Each of the techniques presented in the remainder of this section will include a discussion of some of the basic concepts involved in the technique as well as a brief sample of the method. But, first . . .

Beginning the Hypnotic Process

In beginning an induction, there are generally certain minimal responses you will likely want from the client. None of these are essential, since people can even experience hypnosis and generate hypnotic phenomena while active and alert, but they are basic to clinical contexts where putting the client at ease and building receptivity are crucial.

Suggesting, directly or indirectly, that the client assume a comfortable physical position is a good starting point. The general immobility (catalepsy) and extra effort it takes to readjust one's position while in hypnosis make it necessary to be sure the client is in a comfortable position he or she can remain in effortlessly over time.

A second consideration may be to suggest a comfortable rate of breathing; it helps to relax people to encourage a slowed and more rhythmic breathing.

A third consideration is helping the client turn his or her focus increasingly inward, and so suggesting that the client close his or her eyes at the start is generally a good idea. Eye closure blocks out external distractions, encourages internal absorption, and thus facilitates the induction. (An exception to this is the "Eye-Fixation" technique induction, described later in this chapter, which encourages eye closure as the basis for the induction itself rather than as a lead-in to induction.)

With the client comfortable and growing more responsive to the clinician, the hypnotic induction can now get under way. Here, then, are specific structured techniques for eliciting hypnosis.

Progressive Muscle Relaxation Techniques

Relaxation reduces stress, anxiety, fear of change, and defensiveness, and provides a sense of empowerment to the client. Things can simply seem more manageable. Hypnosis is much, much more than just relaxation, but relaxation is commonly used as a therapeutic stepping stone for all of these reasons.

The progressive muscle relaxation technique involves offering suggestions of relaxation of the various muscle groups of the body sequentially. The body is divided into as few or as many specific muscle groups as you wish, depending on how long or short you think the induction process need be. You can start with the client's head and work downward to his or her feet, or vice versa, as a matter of personal preference.

A progressive muscle relaxation technique may sound like this:

> In just a moment I will begin to describe the various muscles of your body . . . and as I describe them relaxing you can notice how easily those muscles begin to relax . . . and how much more

> comfortable you feel as they do . . . and as you continue to breathe comfortably at a slow and easy rate . . . you can notice how the muscles of your feet can relax now . . . you can feel the muscles of your toes, your arches, your ankles all relaxing wonderfully easily, even feeling the tingle of comfort soothing those muscles, relaxing you easily . . . and now you can notice how the muscles of your calves and shins relax, growing more comfortable moment by moment . . . and now the muscles around your knees can relax . . . and now the muscles of your thighs can feel more at ease and comfortable . . . and now the muscles of your hips and buttocks can relax . . . and now you can notice the muscles of your abdomen and lower back growing loose and comfortable . . . and as the muscles of your back and chest relax with each breath, you can feel more and more at ease . . . and then your arms can grow heavier and more comfortable . . . and now your neck muscles can grow loose and limp . . . and finally the muscles of your face and head can relax and leave you feeling so comfortable, more relaxed than you've been in a long, long time.

The above example is an abbreviated version of what can be a lengthier and more drawn-out process. You can be as repetitious and as slow with your suggestions of comfort for each specific muscle group as the client may require. The pace at which you move through the body is an important factor and needs to regulated by the client's response.

After a period of practice, simply going through the naming of the body parts in sequence without providing all the detailed suggestions of relaxation will still elicit the relaxation response from the client as a result of conditioning. This is what makes a lengthy, detailed technique in the beginning have practical value for later sessions; otherwise an inordinate amount of time would be spent on just doing an induction each session. It is invaluable to record your inductions and provide the recording to your clients to speed up the conditioning process and to provide them a means of getting comfortable even in your absence.

A second variation involves using a countdown (i.e. associating a number to each muscle group, e.g. "10 . . . relax your feet . . . 9 . . . relax your calves and shins . . .") as part of the process. Then, in later sessions, you can simply count downward in the established sequence and each number can trigger the associated relaxation response for that particular muscle group.

A third variation, called the "Deep Muscle Relaxation" technique, uses the same sequential progression, but the client is additionally instructed to deliberately tense and then release the muscles of the specific group

under consideration. Have the client hold the tension in the muscles for 10 seconds or so, and then release it. The obvious relaxation of the muscles is both immediate and substantial. This is an especially good technique for very concrete people who need direct and immediate experience of the contrast between tension and relaxation, and also for those who generally have difficulty relaxing.

The variations of the progressive muscle relaxation are among the easiest and most effective inductions to perform. One word of caution, though: People tend to use inductions that they find personally pleasing. I recommend you do inductions with the client's needs in mind, and not according to which work best on *you*. *With each induction you learn, it would be wise to consider for whom the induction would be perfect, and for whom it would be lousy*. For example, progressive muscle relaxation focuses people on their body. Thus, using this body-oriented technique with someone in pain is not generally recommended. Can you see why?

Relaxed Scene Experience

This technique involves offering suggestions to the client to experience him- or herself in some special place where he or she can feel relaxed, secure, and have a general sense of well-being. As you describe details of that special place, the client can experience getting more and more absorbed in the suggested sensations of being there.

To begin, you can directly ask the client if he or she has a special place where he or she likes to go to relax, escape from the daily stresses, or to simply be comfortable. If the client can provide such a place, then feeding back to the client suggestions to experience the soothing characteristics of that place may be used in the induction. A second possibility is for you to choose a place for the client that you're reasonably confident will be a relaxing place for him or her. This is a potentially hazardous choice to make blindly since you cannot know the client's experience of the place you've chosen unless you ask. If you choose the place for the client, it is important to ask, "Have you ever been to (the beach, the mountains, Disneyland . . .)? How would you describe your experience in being there?" Not asking for feedback in this way creates the possibility that you may take the client to a place *you* enjoy but your client does not. Of course, nonverbal feedback from your client is also valuable as you progress with your induction, but that develops after you have already begun rather than employing a preventative approach before you begin. A third possibility is to avoid the mention of a specific place at all in your induction process, using process suggestions to facilitate the experience. I'll say more about this alternative shortly.

In providing the details of the special place to the client, using the sensory-based terms the client uses in describing his or her experience of that place can allow him or her to get more deeply absorbed in the suggested experience since you're using the details the client has already told you are significant. Providing additional suggested experiences in other sensory modalities can round out the induction and allows for a fuller experience of being in that place for the moment. The more involvement the client has in the suggested experience, the more dissociated a state he or she is in, detached from the immediacy of current goings-on elsewhere, allowing for a more meaningful hypnotic experience.

The following is a sample of a content-filled relaxed-scene experience induction. The suggestions all relate to the experience of being at the beach:

> Sometime in your life you have had the experience of being very near to the ocean and seeing it in all of its beauty and vastness . . . and you can begin to see the ocean in your mind's eye now . . . huge and mysterious, and for as far as you can see the ocean covers the earth . . . and way out on the horizon you can see distant ships and boats that sail the waters . . . and you can see the rolling waves in front of you gently and rhythmically lap up on the beach . . . and you can even hear them as they softly roll back into the ocean . . . and the gentle sound of the waves is so soothing a sound . . . and you can feel the cool ocean breeze on your face . . . so refreshing and yet so relaxing . . . soothing and calming you so deeply.

Whatever special place you happen to use, whether a beach, a forest, an art museum, or any place the client finds comfort in, that place is probably full of sensory delights that you can use to ease your client into hypnosis. One word of caution, though: It is also true that the more detail you provide, the more you may unintentionally provide suggestions that *don't* fit.

The solution is to use process (contentless) suggestions for the relaxed scene experience. When you provide few or no details at all, the client must provide his or her own in response to your general suggestions, thus reducing the likelihood of mismatches. A disadvantage to the process form of this induction, however, is its briefer, more repetitious nature. Without the details of the experience, there is considerably less to talk about.

A contentless or process-based version of the relaxed scene induction might sound like this:

> As you continue to sit there comfortably with your eyes closed, you can let your mind drift back to the pleasurable memory of

> some special place, perhaps a special place that you've been to where you felt so good . . . so comfortable and secure and happy . . . or perhaps a place that you'd like to *create* and go to where you can fully sense how very peaceful you can feel inside when there . . . and you can allow yourself to go to that place right now, in your mind . . . you can feel yourself there, feeling the comfortable feelings you'd like to feel there . . . and you can notice the specific sounds of that relaxing place, soothing you . . . and you can see in your mind the images of that place, noticing how pleasing this special place is to you . . . and you can feel so good there.

Going on and on about the sensory details of that place is possible without you having any idea where the special place is your client chose! Anywhere the client can feel comfortable is sufficient in order for this technique to be effective. Notice in the sample the suggestion for "a place you'd like to *create* and go to." In the event the client doesn't have a place in his or her experience where he or she felt good to go to (a common issue in working with people with a history of abuse who often felt unsafe *everywhere*), he or she can then imagine creating such a place. That "safe place" can be a very helpful tool in later sessions beyond hypnotic induction.

Eye-Fixation Techniques

If not the oldest, certainly one of the oldest, techniques for inducing hypnosis is the classic "eye-fixation" method. Popularized in movies, and often employed by classical practitioners, this technique involves having the client fixate his or her gaze on some specific stimulus. The stimulus can be virtually anything: a spot on the ceiling or wall, the clinician's thumb, a dangling watch or crystal ball, a fireplace, a candle, an aquarium, an hourglass, whatever. Anything that holds the client's attention long enough for him or her to respond to the concurrent suggestions for relaxation will suffice in using this technique.

As the client stares at the stimulus, suggestions are offered encouraging him or her to notice every observable detail, and that while fixing his or her gaze he or she can gradually experience his or her eyes growing more relaxed and even tired and eventually wish to close them. One word of caution: Eye closure may take a while to get as a response with some clients, and so can unnecessarily become a battleground in the "test of wills" between client and clinician. (Personally, I find it much easier to just suggest eye closure at the beginning and get on with the rest of the induction process using a different induction.)

An eye-fixation induction method might sound like this one, done permissively and contentlessly:

> As you listen to the sound of my voice, you can let your eyes search the room and find some spot or some thing that is of particular interest to you . . . And when you find that particular object you can let your head begin to gently drop down while you allow your eyes to look upward toward that object . . . That's right . . . And now you can continue to look at it, and you can notice every detail about the way it looks . . . and as you continue to relax and look at it, have you noticed how tired your eyes have become? . . . and as you focus your eyes intently on that object. . . . Your eyes can grow more tired, your eyelids can seem to become heavier and heavier . . . and as soon as you realize that it takes too much effort to keep your eyes open, you can let them drop down . . . and as they drop down you can drop into a very comfortable state of physical and mental relaxation.

Commenting on the client's blinking, pacing your words to the eye blinks, and even modeling eye closure can further enhance your suggestions for eye closure. If after a reasonable period of time (don't hurry!) the client still has not closed his or her eyes, you can either switch techniques or simply suggest he or she close his or her eyes in a relatively direct way, such as: "You can close your eyes . . . *now*." If you still do not get eye closure, you can ask the client about what he or she is experiencing: "You haven't closed your eyes yet, for some reason . . . and as you become aware of the reason . . . if you'd like you can tell me that reason . . . and thereby make it even easier for you to get comfortable. . . ." Or, as another alternative, you can match the client by encouraging him or her "to keep your eyes open . . . as you learn something meaningful. . . . with eyes wide open. . . ."

Even with his or her eyes open, the client can still be in hypnosis, as discussed earlier. Keen observation will tell you this and perhaps save you needless self-doubts or confrontations over whether the client is experiencing hypnosis "properly."

Counting Methods

Counting methods of induction generally involve counting downward (implying "going down" deeper into hypnosis) and in between numbers steadily offering suggestions of relaxation and comfort. At first, the slower and more detailed the process between numbers, the better. As in the progressive relaxation techniques, the client can become conditioned through experience and posthypnotic suggestions to need fewer

and fewer suggestions between numbers until deep hypnosis can be accomplished with just a simple countdown.

This technique is popular because of its simplicity, evidenced in the following sample:

> In just a moment I'm going to begin counting downward from the number 10 to 1 . . . and as I count slowly downward you can relax a little more deeply with each number . . . and when I eventually reach the number 1 . . . you will begin to discover how easily you can experience yourself as very relaxed and comfortable . . . and I'll begin now with the number 10 . . . relaxing comfortably and breathing in . . . and out . . . at a rate that's comfortable for you . . . and 9, relaxing even more comfortably, feeling the relaxation grow a little more with each moment that passes . . . and 8, feeling so much more at ease . . . and 7 times more comfortable than you were just a couple of minutes ago . . . and 6 . . . I can think of half a dozen good reasons to be even more comfortable . . . 5, etc., etc., 4, 3, 2, 1 . . .

A variation involves having the *client* do the counting out loud downward from 100 while the clinician intersperses suggestions of relaxation. Furthermore, the clinician can offer the suggestion that when the client "soon discovers it takes too much effort to first remember and then say the next number," he or she can "stop counting and go even deeper into hypnosis." Rarely have I encountered someone who continued to count below the number 80.

Structured Deepening Techniques

The formal, structured deepening techniques presented in this section have traditionally been used immediately after the formal induction is performed in order to intensify the client's experience of hypnosis. The traditional models of hypnosis, which view the hypnotic capacity of the client as the primary factor in successful hypnosis, have placed a greater emphasis on depth of hypnosis than does the utilization approach. Just how deeply in hypnosis does the client need to be? A deeper hypnotic experience isn't necessarily a clinically more successful one, and so generally *you only need an experience deep enough to be effective*. Simply put, if the client is only lightly engaged yet integrates and applies what you offer, it was deep enough. Achieving deep hypnosis may not always be necessary, but can allow for certain possibilities (e.g. fuller dissociations) that make familiarity with deepening techniques necessary.

The Stairs (or Elevator) Going Down

In this deepening technique, the client is encouraged to imagine (i.e. see, hear, feel) him- or herself at the top of a flight of "special stairs" or on a "special elevator." As he or she imagines going "down the stairs slowly one step at a time, you can go down even more deeply into hypnosis." Or, "as you pass each floor while you gradually descend in the elevator, you can experience yourself going even more deeply into the comfort of hypnosis." Here's a brief sample of how this technique might sound:

> I wonder whether you can imagine yourself standing at the top of a set of very special stairs, the stairs of relaxation . . . and as you see and even feel yourself at the top of the stairs . . . you can be very comfortable . . . and you can take the first step down . . . and as you take a step down the stairs of relaxation, you can step down into an even deeper state of comfort . . . you can relax so very deeply . . . And now you can take another step down, going even deeper into a very comfortable, profoundly absorbed state of mind and body . . . and then you can take another step down going even deeper.

Each step down is emphasized as a "step down deeper" into hypnosis. It is a good idea to make sure beforehand that the client doesn't have any negative associations to going downstairs (e.g. childhood spankings in the basement) or riding in an elevator. If he or she does, then use a different deepener.

Compounding: Verbal and Manual

In the chapter on helpful hints, I discussed "chaining suggestions," also called "verbal compounding." As you may recall, verbal compounding involves the tying of one suggestion to another according to the generic formula, "As you X, you can Y" (e.g. "As you close your eyes, you can take in a deep, relaxing breath"). Besides smoothing the delivery of the process, verbal compounding also serves as a deepener by continually building new responses onto the foundation of past responses, thereby intensifying the hypnotic experience.

"Manual compounding" involves the tying of verbal deepening suggestions to some suggested physical experience. It generally takes the form of offering suggestions for going deeper into hypnosis while experiencing physical sensations that reinforce the suggestions. For example, assuming permission has been obtained to touch the client, you can gently push downward on the client's shoulder(s) while suggesting, "you can feel yourself sinking even more deeply into comfort." Or, you

can raise his or her hand, and suggest: "As I slowly and gently drop your hand back down to your side, you can drop slowly and gently even deeper into hypnosis." The physical sensations of "down" (from the push down on the shoulder or the hand dropping) can amplify the verbal suggestions of "down" and make the experience a more profound one as a result.

The Mind's Eye Closure

This technique involves offering suggestions for imagining the presence of a "mind's eye," defined as the part of the mind remaining active in thinking and imaging even as the body relaxes. By being offered suggestions similar to the "Eye-Fixation" suggestions of the "eyelids getting heavy" for the "mind's eyelid," the client can slowly close out stray thoughts and images as the mind's eyelid closes and thereby have a deeper experience. It might sound something like this:

> Just as you have eyes that can see the world around you, you have an inner eye that you can call the "mind's eye" . . . and it can see images and process thoughts even as you relax deeply . . . and you can think of your mind's eye as having an eyelid . . . and like your physical eyes your mind's eyelid can gradually grow more tired and heavy, and it can begin to drop . . . and as it begins to close it slowly closes out stray thoughts and stray images and can leave your mind perfectly quiet and open and free to experience whatever you'd like . . . and it's closing more and more . . . and your mind grows more quiet, more restful . . . and now your mind's eye can close . . . and close out any stray thoughts or images you don't want to interfere with how relaxed you are.

This technique is an effective way of "turning off" much of the distracting or even unpleasant internal dialogue (ruminating), thereby making deeper hypnosis easier to accomplish.

Silence

Silence can be a useful deepening technique if used skillfully. Following an induction, suggestions can be offered to the effect that the client can now "have some silent time to enjoy the deep relaxation of hypnosis and the wonderful quiet inside; you can even deepen your level of comfort."

You may wish to preface the period of silence with an indicator of how long you will be silent (e.g. "You can take 60 seconds of clock time

to enjoy a silent period during which you can deepen your relaxation even more . . ."), or you may instead suggest that your client signals you when he or she is ready to proceed.

It is almost always a good idea to give some protective suggestion to the client in the form of an "anticipation signal" so when you begin to speak to the client again after a period of silence, your voice will continue to soothe the client and not startle him or her. During the period of silence the client can be so absorbed in his or her internal experience that he or she forgets anyone else is even there!

Here's a helpful hint: The use of silence as a deepener can also provide you with an opportunity to compose yourself and think of what the next step in the treatment plan is. In other words, it is a prime time in the process for the client to go deeper into hypnosis while you figure out what you'd like to do next!

Posthypnotic Suggestion and Re-Induction

This deepening technique, also called "refractionation," is the technique of choice with those clients whose attention spans are diminished by their symptoms. That includes deeply depressed, highly anxious, pain and attention-deficit clients. Refractionation can help build a better attention span.

The technique involves giving the client already in hypnosis from whatever induction you performed a posthypnotic suggestion that "each time you go into hypnosis you can go into hypnosis more quickly and deeply." The person is brought out of hypnosis, then after brief discussion is invited to go right back into hypnosis, ideally going into hypnosis more quickly and deeply as suggested. The clinician thus guides the person in and out of hypnosis *several times in the same session*, each time for just a little longer.

Some clinicians establish what is called a "cue word" or "cue symbol" that the client is to use as a rapid means for entering hypnosis. Building such a cue simply allows for less induction time and more time to use the hypnosis therapeutically. Thus, the use of posthypnotic suggestion and re-induction as a deepening technique is a useful one, with the qualification that if a "cue" is used it be gentle and respectful. The best cues, in my opinion, are the most subtle ones, such as a gradual change in your voice to the voice qualities associated with your "hypnotic voice." The association to entering hypnosis in response to the use of your voice in a particular way allows a gentle transition from one style of interaction to another. Once the client has become experienced with entering hypnosis with you as a guide, such experiences can serve as a foundation for future experiences, which is a conversational approach to induction I'll describe shortly.

Informal, Conversational Strategies of Hypnotic Induction

First . . . an Overview

The formal, structured hypnotic inductions presented above are based on the general assumption that the experience of hypnosis is distinct from other forms of subjective experience and can be induced through some special, if not arbitrary, process such as a countdown. The utilization approach to hypnotic induction rests on different assumptions about the experience of hypnosis, the nature of induction, and the goals in even doing hypnosis, that add a more complex and sophisticated dimension to working with hypnotic communication patterns.

In the utilization approach, which emphasizes an "accept and utilize" strategy (accepting the client's experience as valid for him or her and finding a way to utilize or channel them in helpful directions), hypnosis is viewed as a natural experience occurring routinely in people. In adopting this perspective, one of the tasks of the skilled clinician is to recognize hypnotic responses as they naturally occur in the course of ongoing therapeutic interaction and then build on them meaningfully in a spontaneous and conversational manner. Instead of saying something such as, "I'm going to name body parts while you focus on relaxing" (as in progressive muscle relaxation), which is an example of an *imposing* approach that requires the client to try to adapt him- or herself to the clinician's chosen technique, the utilization approach instead strives to *elicit from within* the client the images, internal dialogue, feelings, and behaviors that are personally meaningful and engaging as the basis for the induction and therapy.

The instructions to the client in the conversational (Ericksonian, naturalistic, utilization) approach to hypnotic induction are typically more individualized, permissive, indirect, and process-oriented than other, more technique-oriented approaches. Furthermore, there is typically not as clear a beginning, middle, or end to the induction compared to the clearer transitions from phase to phase of the hypnosis session found in the more structured, content-oriented approaches of the previous section.

The spontaneity required to "accept and utilize" a client's communications makes it nearly impossible to ritualize (i.e. standardize) the practice of clinical hypnosis in the utilization approach. For some, the lack of a rigid structure to the methods is a turn-off. For others that same trait is a turn-on, for the challenge of how to elicit a meaningful and therapeutically effective hypnotic experience in a particular person in a specific context is a formidable challenge, indeed. Implicit in this approach is the role of clinician as both guide and initiator of what is to happen. The clinician's responsibility to the client is greater in the utilization

approach because the client is assumed to be capable of a meaningful hypnotic experience if a more individualized and flexible approach is employed. This is a marked contrast to the traditional practice of assuming successful hypnosis is more about the client's level of hypnotizability as measured by a standardized test than the quality of the therapeutic alliance or the flexibility of your approach.

The methods for guiding a person into hypnosis described in this chapter are reliable ones. They have a structure, they have a vehicle for delivering the structure, but they are more spontaneous and conversational than more formal approaches. Each involves narrowing the person's field of attention to his or her inner experiences, specifically the associations triggered by your suggestions. Resources long dormant in the client can be reactivated, memories long forgotten can be rediscovered, feelings long buried can be re-experienced, and issues long troublesome can be resolved.

Conversational (Naturalistic) Inductions

Using Past Hypnotic Experiences

The induction method of "Using Past Hypnotic Experiences" involves two general categories of previous hypnotic experiences on which to build: (1) *Informal* experiences with hypnosis, specifically the "everyday hypnosis" experiences people have during the course of normal daily living (such as "highway hypnosis"); and (2) *Formal* experiences with hypnosis, specifically the previous time(s) the client experienced hypnosis positively. Either approach may be offered in either a process-oriented or content-filled structure, described later in this section.

In the first approach of building on previous informal experience with hypnosis, the phase of attentional absorption typically involves some pre-induction discussion about the nature of hypnotic experience while exploring the client's associations to hypnosis. At some point, the clinician can begin to model increased attentiveness, immobility (i.e. catalepsy), slowed breathing, and can begin to hypnotically describe one or more natural situations in which hypnosis occurs. Such situations might include long drives, absorption in a good book or movie, during a massage or jacuzzi, daydreaming, praying, and any other situation in which the person has had the direct experience of being absorbed. The nonverbal shift from a normal pace and conversational tone of voice to one that is slower, quieter, and more meaningfully articulated is fundamental to guiding the person into the suggested memory of that natural hypnotic state he or she has experienced. Through the absorption in that memory, hypnotic responses (i.e. the ideodynamics) naturally begin to occur in the

here-and-now, which the clinician can notice, accept, and utilize according to the "As you experience this, you can experience that" chaining formula. The client need not close his or her eyes in order to experience hypnosis, but the clinician may want to suggest eye closure by offering a direct or indirect suggestion to do so. The following is a sample of how this technique may sound, using a previous informal hypnotic experience of reading with indirect suggestions in the form of embedded commands to obtain specific responses:

> You said earlier you enjoy reading a really good book . . . I really enjoy reading, too, especially when I have some quiet time all to myself . . . a *time for quiet* when I know I won't be interrupted. . . . It's such a luxury to have some time . . . to sit quietly . . . and not have to do anything . . . a time I can let myself *relax so deeply* . . . *sitting* in a way that is *so comfortable* . . . and you know what that's like, too . . . and how easy it is to *sit quietly* . . . just thinking . . . *without moving* for what can seem like a long, long time . . . and I like to read books that encourage you to *experience yourself differently* . . . that *absorb you* in different ways of thinking . . . different ways of feeling . . . books that allow you to expand yourself and *change in beneficial ways* . . . and you probably know quite well what I mean . . . how *your mind can be so active in learning* while *your body gets even more comfortable* with each page you turn . . . and when you get too comfortable to keep on reading, you can *close your eyes and drift off* . . . and I'd like to tell you about a book I read that may have special meaning for you.

The above induction starts out conversationally, then turns to a sharing of personal experience the client can relate to in order to build rapport while simultaneously slowing down and building associations to entering hypnosis. Then the shift takes place from "I" to "you," with an emphasis on the client's experience building into a relaxed and focused state through the tonal emphasis on suggestive phrases. As the client becomes absorbed in the memory of relaxing and learning while reading, his or her responses can start to build in the current context and become the basis for transitioning into whatever hypnosis is to be done.

The above sample is obviously a content-filled one, providing details specific to the experience of reading. A process-oriented approach could also be employed, of which the following is an example:

> Can you think of a time when you were so involved in some deeply absorbing experience that you *detached from* and even

> forgot to notice things going on around you? Every person has had experiences like that where . . . you *find yourself immersed* in some activity . . . and as *you relax* . . . and remember . . . and think about that kind of an experience . . . you can remember a specific experience like that . . . one that was especially pleasant . . . where you were so into it . . . you could *lose track of time* . . . and *forget to notice outside sights and sounds* . . . and only your sensations and thoughts were important . . . and you could *feel so wonderfully relaxed* . . . and isn't it nice to know you can be so wrapped up in your thoughts . . . that people's voices fade away . . . and you're alone with your thoughts . . . and *feelings of comfort* . . . and it's at times like that . . . and like this . . . that *you can learn something important.*

In the above sample, the process of becoming absorbed in sensation and thought is described, but no details of a specific context triggering such experiences are provided. Rather, the client provides those details for him- or herself when the suggestion is offered to choose a specific experience that was pleasant.

In the second approach building on formal experience with hypnosis, the typical pre-induction phase discussion can focus the client's attention on the range of possibilities hypnosis allows, and how previous experience with hypnosis can make future experiences easier, more satisfying, and successful. It seems worthwhile to reiterate a point made in an earlier chapter about exploring the nature and quality of the client's previous hypnotic experience(s). If the client had a positive and meaningful experience with hypnosis, then the clinician has a solid, positive base on which to build. If the client had a negative experience with hypnosis, one that was unsuccessful at least or hurtful at most, then the clinician must exercise caution to refer back to the experience either as little as possible or in a detached way in the course of doing hypnosis. Questioning the client about techniques used and identifying the personal, situational, and interpersonal variables operating negatively at the time can save you from unwittingly duplicating a previously negative experience.

If the client has had a positive experience with hypnosis before, a content-filled approach to the use of the formal hypnotic experience can involve engaging the client in providing an ever-slowing, detailed account of the experience. This approach usually involves a large degree of interaction as the induction progresses, with the clinician simultaneously questioning the client, suggesting possible responses, and building on the client's responses as they occur. The mechanism of induction is structurally the same as in using informal previous hypnotic experiences; as the person becomes absorbed in the memory of hypnosis, the ideodynamic responses associated with that memory evolve in the here-and-now. The

clinician notices, accepts, and utilizes those responses, building hypnotic responsiveness toward the goal of the interaction. The following is an example of this induction approach:

Clinician: You mentioned earlier that you experienced the comfort of hypnosis before, didn't you?
Client: Yes. A couple of years ago I saw a doctor who did hypnosis for another problem I was experiencing.
Clinician: As you begin to think back now, can you recall how soothing and calming an experience hypnosis was?
Client: Yes, I do remember feeling really relaxed. I didn't expect to be able to hear the doctor's voice, but I did. I wasn't sure I was hypnotized, but it felt really good.
Clinician: That's right . . . the experience of hypnosis can be so relaxing . . . so soothing . . . and you can remember how you were sitting then, can't you?
Client: I guess so . . . (Readjusts position).
Clinician: That's right . . . sitting very comfortably now . . . and do you remember how good it felt to breathe deeply and close your eyes?
Client: (Deep breath, eyes flutter closed) Yes.
Clinician: And you can probably recall what you heard then that allowed you to relax so deeply, can't you? And what did you hear that reminds you that you can be comfortable?
Client: Just the doctor's voice . . . telling me to relax deeper and deeper . . . that it was as if I was floating. . . .
Clinician: That's right, and you can remember what it's like to *have that light, comfortable feeling everywhere in your body*. . . .

In a sense, the client is acting as his or her own hypnotist, giving him- or herself the same suggestions from the past in the present, and the clinician's role is a simple one of amplification. The client already knows how to experience hypnosis, has defined it as helpful, and reminds him- or herself in detail of the relaxed, floating nature of the hypnotic experience and, in so doing, unconsciously recreates it. By framing the interaction as a "discussion" about past experience rather than a set of current demands to respond to, the suggestions to enter hypnosis are less direct, more permissive, more natural to the interaction, and the issue of resistance is therefore largely avoided.

To use this kind of an approach in a process-oriented way, the interactional dimension of the induction can, if desired, be eliminated. The following is an example of the use of formal previous hypnotic experiences offered in a contentless way:

> You mentioned earlier that you had an experience with hypnosis before that was a very relaxing and helpful one. If you'd like, you can begin to recall now many of the details of what that experience was like . . . remembering how *your body can be so comfortable* . . . how *your breathing can begin to slow down* . . . and I wonder whether you'll remember how comforting it can be to simply *sit quietly* . . . in a comfortable position . . . while you listen to someone describe some ways that *you can begin to experience yourself differently* . . . and do you recall how good it felt to *close your eyes?* . . . and the memory of relaxing so deeply is still a part of you . . . even if you haven't had time lately to notice it . . . and isn't it nice to *rediscover something familiar and calming* that can help you? . . . and perhaps you can remember the room you were in when you learned how to *feel good in this way* . . . you can see the furniture and you can hear the sounds of that place, and as you remember the details of then . . . *you can feel comfortable* about that experience right now.

The context in which the client had his or her previous formal experience with hypnosis is not known to the clinician, nor does it need to be as long as the clinician is certain the experience was, in fact, a good one for the client by his or her own description.

Making use of the client's previous experience with hypnosis, whether formal or informal, is one of the easiest yet most effective induction and deepening processes. It is a spontaneous, loosely structured approach that generates little resistance because "we're not talking about *now*, we're talking about *then*." The extra psychological distance makes a difference in increased comfort. In sum, the techniques involving use of past hypnotic experiences are reliable and flexible ones and, when well practiced, can be among the best inductions in your repertoire.

Building an Internal Focus

The experience of hypnosis has been described as involving absorption, an intense concentration on some stimulus to the exclusion of others. Usually, but not always, the absorption is internally directed. In doing hypnosis, guiding the client into hypnosis implies having the client selectively attend to the stimulus of the clinician's guidance, specifically becoming absorbed in the subjective associations triggered by the clinician's suggestions. By focusing intently on his or her internal experience, the client can suspend attentiveness to the external world, diminish reality testing, and thereby subjectively experience a wider range of possibilities.

The induction process of building an internal focus involves offering "pacing" statements of what *external* stimuli the client is currently aware of, coupled with "leading" statements describing *internal* responses the client may begin to develop. This can be done in any ratio of pacing to leading statements the clinician judges to be useful. In other words, how many externally oriented suggestions of experience you offer for every internally oriented suggestion of experience is dependent solely on the responsiveness of the client.

Once you've assessed how internally or externally focused the client is at the time you would like to begin your induction, you can make the judgment as to what ratio of external paces to internal leads you think would be effective, modifying it as necessary according to client response. Some clients are already so internally focused at the beginning point that you don't have to have much of an induction beyond, "You can go into hypnosis, now." Others may be so externally focused that they may require five or even ten external pacing statements before a single internal leading suggestion is offered.

As the induction progresses, fewer and fewer externally oriented statements are made while more and more internally oriented suggestions are offered. The following is an example of this induction process with someone deemed moderately externally oriented at the start of the induction. To help you distinguish them, an (e) follows each externally oriented suggestion, and an (i) follows each internally oriented suggestion.

> You're sitting in that chair (e) and you're listening to me describe the experience of going into hypnosis (e) . . . and as you continue to look at me (e) you may notice the feel of the chair underneath you, supporting your body comfortably (e) . . . and as you notice the chair you can hear the phone ringing somewhere (e) . . . and *isn't it soothing* . . . to know you don't have to answer it and *so you can let yourself relax* easily (i) . . . and you can notice the wall behind me with its interesting pictures (e) and you may notice the objects on my desk (e) . . . and as you look around the room you can hear the routine sounds of this environment (e) and you can hear the sound of the world busily going on around you (e) and *you can feel so good* in realizing that your body can grow more at ease (i) . . . and *your mind can begin to drift* back to a pleasant memory (i) . . . and as your mind drifts back you can feel the texture of the chair on your fingertips (e) and as you notice how that texture feels you can also hear the things I have to say (e) . . . and as you listen *you can become aware of a certain memory* (i) . . . one that you feel is important that you'd like to re-experience and learn from (i) . . . a memory that may remind you of something you'd like to know now (i).

In the above example, the induction starts with a series of statements that are pacing what the client is currently aware of, feeding back aspects of what he or she *is* doing, then offering a general statement of what he or she *can* experience. The number of paces to leads shifts as the induction progresses, gradually leading the client into re-experiencing an important memory.

Most hypnotic inductions involve building an internal focus, each according to a different method. This induction provides the barest of frameworks for helping the client experience hypnosis, since all that is provided here is a structured description of the process as shifting the client's focus from external to internal experience. Which externals and which internals you use in what combination in which sensory modality and in which style and structure make for a huge range of possibilities. How successful your induction will be, as always, is determined primarily by how well you have assessed the client's response style and how well you can spontaneously adjust your approach according to the feedback you get.

Metaphorical Inductions with Embedded Suggestions

Rather than use the client's personal past or current experience as the basis for induction, metaphors may describe some other person's (or animal's, or thing's) experience at some other time in some other place. Metaphors in the therapeutic context may include anecdotes, jokes, analogies, or any other form of indirect communication that conveys a meaningful message to the client on conscious and/or unconscious levels. Metaphors provide an opportunity for the client to learn from others' experiences, allowing him or her to identify, to some degree, with the characters, issues, and resolutions of the metaphor.

The popular use of metaphorical approaches in clinical treatment is a relatively recent development, catalyzed primarily by the work of Milton Erickson. His fascinating and often simple teaching stories were able to capture his patients' interest on a conscious level, while his embedded suggestions allowed the patient's unconscious mind to form new associations that could serve him or her in therapeutic ways. More will be said about metaphorical approaches to therapy in Chapter 16; this section focuses on the use of metaphor in the induction phase.

When you formulate a metaphor for the purpose of induction, it helps to know something of the client's personal interests, values, and hobbies. Metaphors built around things that are already a part of the client's lifestyle are more likely to capture and maintain the person's interest. Of course, things of an intrinsically fascinating nature will also serve well.

The broader the base of knowledge and experience you have, the more sophisticated your metaphors can be. The metaphor as an induction method can introduce the client to other clients' experiences, help them build a rapport with the clinician, build an identification with the character(s) of the story, confuse the client as to why the story is being told and thereby stimulate a search for meaning and relevance, all while building the internal focus and receptivity for the subsequent intervention.

Perhaps the easiest metaphors are those that begin with, "I knew someone in a situation similar to yours . . ." When you describe the experience of some previous client, the client can come to identify with that person, and also build confidence in the clinician's experience in dealing successfully with such problems. If, for example, a client presented the complaints of excessive stress and a poor self-esteem, the induction might go something like this:

> You're describing to me how uncomfortably tense you feel much of the time, and I guess it isn't often . . . or often enough . . . that you *take the time to relax* . . . and I'd like to tell you about a client I worked with not long ago . . . a woman who is *not unlike yourself* . . . with many responsibilities . . . and she came to me feeling so tense . . . so unsure of herself . . . uncertain how she could continue to function on too little sleep with too much to do . . . and she didn't know that she didn't have to feel that way . . . and she wanted to *feel good* . . . *feel relaxed* . . . and when she sat in that chair you just happen to be sitting in, too . . . she actually took the time to *notice how comfortable that chair is* . . . and then she let herself *take in some deep breaths* . . . and she seemed to *just let go of the everyday concerns* . . . and she could *listen to me comfortably* . . . while her mind could begin to wander . . . and the memory of the last time she could *relax deeply* helped her realize she knew how to *relax so deeply* . . . and that she could and would take more time for herself . . . simply because she deserved it . . . and she learned how to re-evaluate her priorities . . . and she learned how to *say no more comfortably* to extra tasks she really didn't have time for . . . and she learned.

The above example is simply an induction starting point for leading into more metaphors about possible ways to start to build confidence and better manage stress. As an induction, it begins by matching the client's concerns and then building the identification with another similar client who had a positive experience in some ways that may be of interest.

There is ample room to maintain rapport by incorporating the spontaneous responses of the client into the metaphor.

To illustrate a metaphorical induction tailored to a specific interest of the client's, the following example of a metaphor was developed for a person who likes to watch television:

> You like to watch television when *you can take the time to unwind* . . . and watching television can certainly be an entertaining way to *spend some time relaxing* . . . and I like to watch TV sometimes . . . but not nearly as much as some people . . . there's someone I really think you should know about . . . who, like you, likes to watch television more than almost any other form of entertainment . . . and as a good means of *relaxing you and quieting your mind* . . . and he says he can learn a lot about life and a lot about people by watching television . . . and there was a show on once that he told me about . . . that he watched to be entertained . . . that did much more than that . . . it taught him a lot about himself . . . he didn't know that in that show there was *going to be an opportunity to have a pleasant learning experience* . . . sometimes *you discover important things* in the most unexpected places . . . and he learned something important . . . because in that show he watched, there was a man who . . . not unlike you . . . felt very badly about a problem he just couldn't seem to resolve.

In the above example, television as a learning device and a source of relaxation is used as a vehicle to lead the client into hypnosis. At the point where the example stops, the clinician can go into one or more metaphors about the client's problem and its potential resolution.

Storytelling seems to have become an art on the decline. Television has saturated our society and placed us in the role of passive viewers of experience. Interactions between people become fewer in frequency as more of us learn to "talk" to computers instead. Developing a skill in storytelling is fundamental to developing a balanced approach to the practice of clinical hypnosis. One way to do that is to reread the classic fairy tales, fables, and old mythology, for they are excellent starting points for rediscovering the wisdom of the ages that's been handed down in story form.

The approaches to induction presented in this section are among the most spontaneous and effective means for inducing hypnosis in a naturalistic and collaborative way. Their inability to be scripted in a word-for-word manner is actually their strength. Hypnosis scripts may make clinicians feel a little less insecure about what to say, yet they are a reliable

means for becoming more rigid and less creative in your work. Clinicians who develop skill in the use of these loosely structured and spontaneous approaches will have done so only through multiple sessions of practicing careful observation of client responses while developing the flexibility to turn each obtained response into one that enhances the quality of the interaction.

12

HYPNOTIC PHENOMENA

Eliciting and Utilizing Hypnotic Resources

The various so-called classic hypnotic phenomena defined and described in this chapter are the basic ingredients for the therapeutic applications of hypnosis. Furthermore, they are the basic building blocks of *all* experience, differing from their clinical applications only in degree, not kind. Shades of hypnotic phenomena are found in ongoing daily experience, but they are most dramatic to observe (and experience) when distilled to their essence as in structured hypnotic processes. These hypnotic phenomena can be assembled in ways that may help or hurt, depending on their associated content. More will be said about this idea later, particularly in relation to hypnotic phenomena and symptom formation.

The various hypnotic phenomena represent valuable but typically underdeveloped capacities of human beings. Each person is capable of these hypnotic phenomena to one degree or another in the formal hypnotic interaction because these are, in a sense, clinically structured amplifications of everyday experiences. In fact, these capacities are a *necessary* part of our experience in order for us to function in a normal, healthy way. To claim someone cannot be hypnotized is questionable, for if the person could not focus, remember, imagine, behave in automatic ways, and demonstrate other such hypnotic phenomena, he or she simply could not survive. Of course, people differ in these abilities, so some may have marginal ability at best. But finding someone who can't do any of these at all would be most unlikely.

When I describe the various hypnotic phenomena, I will also describe examples of everyday contexts in which they naturally or spontaneously occur. People generally do not think of these random experiences as related to hypnosis, but they are structurally identical. When they occur, people tend to dismiss them lightly with some variation of, "Gee, that's

kinda strange." No further thought is given them, because they seem to "just happen." The average person senses no participation in or control over the experience. This is a primary reason for acquiring skills with hypnotic patterns: Rather than having such potentially useful experiences remain random and seemingly out of control, clinicians familiar with hypnosis can facilitate these experiences *at will* for meaningful reasons, instilling in clients a greater sense of control in their lives.

Both structured and naturalistic inductions have been presented in the previous chapter, and consistent with my desire to acquaint you with the range of possibilities, both structured and naturalistic approaches to eliciting hypnotic phenomena will be presented in this chapter.

Here, then, are the classical hypnotic phenomena, presented in alphabetical order for easy reference.

Age Regression

Description

Age regression is defined as an intensified absorption in and utilization of memory. Age regression techniques involve either guiding the client back in time to some experience in order to re-experience it (called "revivification") as if it were happening in the here-and-now, or simply having the person remember the experience as vividly as possible (called "hypermnesia"). In revivification, the client is immersed in the experience, reliving it in a close parallel to the way the memory was incorporated at the time it actually happened. In hypermnesia, the person is in the present while simultaneously recalling vividly the details of the memory.

Most people have an intuitive understanding of how profoundly our previous experiences affect our current thoughts, feelings, and behaviors. Certainly, psychology has amassed vast amounts of information to substantiate the point. Consequently, age regression is one of the most widely used hypnotic patterns in therapeutic work. Age regression as a clinical technique provides an opportunity to go back in time, whether it be into the recent or distant past, in order to recall forgotten memories of significant events that can serve to help redefine one's view of oneself, or to "work through" old memories in order to reach new and more adaptive conclusions.

Memory is a process, not an event. *Memory is based on subjective perception, and is therefore malleable and dynamic*. Memories can change in quality over time, as new experiences mingle with and affect older ones. Memories can be influenced intentionally or unintentionally because of their subjective and suggestible nature.

In defining age regression as the intense absorption in and utilization of memory, the everyday aspects of age regression can become apparent,

for people drift into memories routinely. If a song associated with a high school sweetheart comes on the radio, the listener can become absorbed in that person's memory and recall vividly things they did together and events taking place in their lives at that time, even re-experiencing profoundly the feelings from that time in his or her life.

Age regressions can be structured to engage someone deliberately in some memory that seems to have relevance to the symptoms the person is experiencing. People literally define themselves according to their memories, especially those memories that are of highly charged significant emotional events. Many symptoms do, in fact, arise because of how people have interpreted the meaning of past events, and so exploring and addressing memories often becomes a critical part of treatment.

Can People Remember Things that Never Happened?

You probably wouldn't guess it, but speculations about the nature of memory arising in suggestive procedures such as age regression were at the center of a bitterly emotionally charged and divisive issue. It not only created rifts in the field of hypnosis, but it divided the mental health profession as a whole. It has been known as the "repressed memory controversy," the "false memory debate," the "memory wars," and by a variety of far more inflammatory names. Unless you were in blissful oblivion somewhere during the latter half of the 1990s, you were reading almost daily about high-profile trials, reading articles by experts vigorously arguing opposite positions, hearing experts on television vehemently arguing mutually exclusive "realities," all revolving around the issue of whether presumably repressed memories uncovered through therapy in general and hypnosis (through age regression) in particular should be considered true.

There are many therapists who hold the unfortunate belief that virtually all symptoms are necessarily a product of past experiences and even past traumas, almost invariably childhood sexual abuse, that need to be acknowledged and "worked through." Such "one size fits all" beliefs clearly reflect a potentially hazardous lack of critical thinking. Thus, from that vantage point, if someone is unable to recall a memory that would account for the type and severity of someone's symptoms, the assumption is that the memory has been repressed, that is, split off from consciousness as a psychological defense. It is further assumed that excavating the memory is necessary for recovery. In searching for presumably repressed memories, the critically important questions are these: Can traumatic memories be "locked away" and does finding the "key" (with hypnosis or other memory recovery techniques) open them up for *accurate* recall? Or, are the techniques used for locating and retrieving memories

themselves capable of contaminating or distorting memories without either the clinician or client realizing it? To go a step further, can a well-meaning clinician and an unwitting client even *create* complex and emotionally charged memories that seem genuine yet are entirely fabricated (called confabulations)?

The answers to these vitally important questions are now reasonably well established, and the controversy has all but died away for those who are well-trained in the science of memory, especially as it relates to effective psychotherapy. The answer to the first question is yes, there is some evidence that traumatic memories can, in very *rare* circumstances, be locked away only to emerge much later. However, what can only be addressed—but not necessarily answered—is the question of the accuracy of such memories. These so-called recovered memories can be entirely accurate, partly accurate, partly inaccurate, and entirely inaccurate. Without objective evidence to corroborate a memory, there is no known technology for determining its veracity. *Hypnosis does not reveal the truth*. Furthermore, more detail in the narrative or a more emotional telling of the episode does *not* mean it is any more likely to be true. Since a true recovered memory cannot be reliably distinguished from a confabulation without evidence, it becomes even more critical for a clinician to minimize his or her potential contamination of a memory through unwitting suggestion.

The second and third questions above, regarding the memory recovery techniques themselves distorting or even creating memories, can both be answered with a firm yes. Memories have been shown to be highly responsive to a variety of suggestive influences in *and* out of hypnosis. *A therapist who believes in repressed memories and uses hypnosis to find them may very well unintentionally create the very memories he or she is searching for*.

What made this issue so deeply controversial and emotionally charged was a natural and sincere desire to help abused people tell their devastating stories when for so long they had been suffering silently or else were disbelieved and marginalized. The momentum for therapists was in the direction of non-critically believing *all* such stories, regardless of the conditions leading up to their emergence. As cooler-headed researchers and clinicians made their respective points, it became clear that hearing and supporting traumatized people remains a critically important agenda for the mental health profession, but at the same time clinicians would have to take the responsibility to learn and put into practice the lesson that they were catalysts for the quality of the memories that came up in their clients. *Clinicians would have to acknowledge and implement the principle that they are part of the process, not just outside observers of the process*.

Just to clarify and reinforce the key point: This controversy revolved around suggested memories of abuse given to the client by the clinician when the client had symptoms but no recollection of any such trauma. If someone knows now and has always known he or she was abused, then the issue is moot: Such memories can be considered as reliable as any others.

General Strategies to Elicit Age Regression

In using age regression clinically, at least two general strategies can be employed, each giving rise to a variety of specific techniques. The first general strategy concerns the use of age regression to go back to negative, or even traumatic kinds of experiences. The intention is to allow the client to explore the event(s), release pent-up feelings ("catharsis") while simultaneously providing new ways of looking at that situation ("reframing") that may help him or her release or redefine whatever negative influences from that experience may still be affecting his or her life. In this strategy, either revivification or hypermnesia may be employed, depending on the clinician's judgment as to how immersed in or distant from the experience the client can be in order to receive maximum benefit.

The second general strategy of age regression is one of accessing and amplifying client resources, and is compatible with and easily integrated with the first. The strategy involves identifying and making use of specific problem-solving abilities the client has demonstrated in past situations but is not currently using, unfortunately to his or her own detriment. Often, the client has positive abilities he or she doesn't recognize, and because he or she doesn't have awareness for them and a means to access them, they lie dormant. In using age regression, the clinician can help the client rediscover in his or her own past personal experience the very abilities that will allow him or her to manage the current situation in a more adaptive way. For example, if someone were complaining of difficulty in learning something new, the clinician might guide the person back in time to a variety of past experiences of initially feeling frustrated in learning something, and then showing how each frustration eventually led to mastery of that information and greater self-confidence in that area. Learning to get dressed, to read and write, to drive a car, and countless other experiences all started out being intimidating new experiences and later became routine, automatic abilities. Immersing the client in the experience of the satisfaction of mastering learnings that once seemed difficult can help him or her build a more positive attitude (in this case, frustration tolerance) toward the present challenges.

Any pattern of suggestion that helps the client subjectively experience going back in time is an approach to age regression. One general approach

to age regression employs suggestions that involve the use of structured and imaginative imageries as the trigger to recapture past experiences. Other methods involve more naturalistic, everyday approaches to immersion in memory. Either general approach can be a good one, depending on the client's response style.

Special Vehicle Technique

Patterns that make use of the client's imagination include the various "special vehicle" approaches (e.g. train, plane, time machine, space ship, elevator, and the like) that can transport the client back in time to the event under consideration. The special vehicle imagery is an artificial, concrete, and content-oriented means for structuring the experience, and thus requires a considerable amount of detail in order to facilitate the regressive process for the client. The following is an example of an age regression approach (initiated after induction and deepening) using a "special train":

> and now that you can experience yourself as comfortably relaxed . . . you can let yourself have the experience in your mind . . . of going to a special train station . . . a train station unlike any you've ever experienced before . . . where the trains that run are so unusual in their ability to take you back in time . . . and you can go back in time . . . to important experiences you haven't thought about in a long, long time . . . and you can walk over to one and see yourself getting onto the most interesting-looking train . . . and you can easily find your way to a seat that is so comfortable to sit in . . . so soft you can rest there . . . deeply resting . . . and then as you feel the train begin to move in a gentle and pleasant way . . . you can experience the distinct movement of the train's motion . . . going backward in time . . . slowly at first . . . then faster . . . building a powerful momentum . . . and as you look out the window . . . and see the events of your life moving past you like so many telephone poles you pass on the way, the memories of yesterday . . . then the day before . . . and the day before . . . and the day before . . . and all the days before . . . can drift through your mind as you go further and further into the past . . . when way back then becomes now . . . and then the train begins to slow down . . . and then it comes to a stop . . . and now you can step off the train to find yourself in that situation that was so important to you . . . and being in that situation now, you can see the sights, hear the sounds, and feel the feelings of that time and place . . . *this* time and place.

At this point, dialogue between the clinician and client may be initiated, in order to elicit the details of the memory he or she is re-experiencing. Asking the client where in time he or she is, who else is present in the memory, what exactly is occurring, what he or she is thinking, feeling, or doing, as well as any other relevant questions can lead the clinician to better understand how the experience was incorporated by the client as a memory so that a differing perspective, one that may be more adaptive, may be offered as part of the therapy.

If the client knows when a certain significant event occurred, the clinician can regress the client back to that specific time. Often, though, the client has no idea when a certain feeling, thought, or behavior started. In such instances, the clinician can offer some process-oriented suggestions, such as in the special train example above in which no particular age or context for the regression were specified. In that example, it was left entirely to the client to choose an experience to focus on as representative of his or her presenting problem's evolution. The clinician must ask the client to verbalize the details of his or her experience at some point so he or she can assist the client in having access to as much of the memory as possible and in order to determine where and when to intervene.

Whatever approach you choose to employ as the catalyst for the age regression experience, the use of more details to associate to encourages a greater involvement in the experience. To accomplish a more personally distant experience of the past event, suggestions can be provided that the client is present (dissociated) in the secure here-and-now, and it can be "as if you are watching a movie of an experience . . . and as you watch comfortably . . . you can learn something important from watching yourself over there . . ."

Accessing Suggestions Indirectly Suggesting Regression

More naturalistic approaches to age regression involve offering indirect suggestions to become engaged in memory without the formality of saying, "Now you can go back in the past." Patterns include asking accessing questions to orient the person to his or her own past personal history, and conversationally sharing what's important from these experiences. Asking questions to orient the person to his or her own past experiences as an approach involves the client in a search through his or her past in order to recall the appropriate events necessary to respond meaningfully. Such a search can start out as a more distant memory simply being cognitively remembered, but then skillful further questioning can begin to immerse the client in the memory in order to actually re-experience it. The following is an example of such a pattern:

Clinician: Can you remember your fourth-grade teacher? (Orienting the client to age nine or ten)

Client: Sure, it was Miss Smith. As I recall, she was a really nice teacher. (Starting to remember that teacher and some associated childhood experiences)

Clinician: Fourth grade can certainly be an interesting time in one's life . . . many changes can take place in a person's thinking . . . I wonder if you can remember which event of that time in your life was especially important to you? . . .

Client: Well . . . there was a time once when I got into trouble at school and my mother . . . (Relates the story's details)

Clinician: Can you . . . *see yourself clearly in that experience?* . . . as you see yourself in that experience, you can remember how you felt, can't you . . . and those feelings are feelings that are still a part of you . . . even though you haven't thought about them in a long while . . . and you can see the other people and how they look . . . how they are dressed . . . and you can hear what they say that is so important to you . . . and what do they say?

As the clinician asks the client to fill in the details of the memory, the client naturally becomes more and more immersed in it to the point of starting to re-experience it (notice the changing of tenses in the questions from past to present). Such gradual immersion in the memory is a smooth and natural approach for focusing on the past. The involvement becomes greater and greater as the clinician involves more and more of the person in all the sensory components of the memory to as great a degree as possible.

Metaphor as a Regression Tool

In order to make the experience of going back into the past less personally threatening, the clinician can indirectly facilitate regression by describing his or her own relevant past learnings, or the relevant past learnings of others. When the experience of others is described, the client naturally tends to project him- or herself into that situation, imagining how he or she would feel or act in that situation. Talking about the experiences of others as children, for example, can build an identification with them for the client on the basis of his or her own relevant experiences as a child. Thus, the regression occurs indirectly through identification and projection, and the client can go back in time to recall or re-experience the relevant memories. The following is an example of such an approach, offered to a client who felt guilty unnecessarily and unjustly about her parents having divorced when she was only six years old. The regression

involves taking the client back to that time in order to re-experience the irrational feeling that she was somehow responsible for her parents' divorce. This metaphorical example stops before the point of making the hurtful decision, and does not go into the actual re-decision therapy for such a problem.

Clinician: Children are quite remarkable, don't you think?
Client: Yes, I do.
Clinician: Sometimes kids think the whole world revolves around them . . . like life is a universal game of "peek-a-boo" . . . that the whole world stops for a while . . . and goes away to someplace else . . . who knows where . . . maybe someplace really calming and beautiful . . . when the child closes her eyes and the world disappears . . . how well can you remember being a child . . . and closing your eyes . . . and wondering where everyone went? . . .
Client: I used to play hide-and-seek a lot as a child, and I can remember worrying sometimes I'd be all alone, that when I closed my eyes everyone would be gone and I'd never find them again . . . but, of course, that's just a child's silly fears.
Clinician: That's interesting, because a child I'm working with described that same feeling . . . she's almost seven years old now, and she's feeling very proud of being in the first grade . . . excited and thrilled . . . the way almost all kids once were . . . you can remember that, can't you? . . . about being in school and learning to learn about how much there is to learn . . . and that there is a huge and complex world out there . . . a world much bigger than the world of a six year old . . . but the six year old doesn't know that yet . . . she still has to learn to read and write . . . about science and math . . . about adults and other kids . . . about falling in and out of love . . . and the six year old's world is always changing and growing . . . but not so fast as she thinks . . . because part of her still thinks the world revolves around her . . . and that she can cause big things to happen . . . and she won't learn until she's older . . . that the world doesn't revolve around her at all . . . that she's just six . . . and, understandably, afraid of being alone . . .

In the above example, the clinician is matching the part of the client that is feeling overly responsible at age six with the thoughts and feelings of a six year old. When these are described in a way that can allow the client to recapture her similar thoughts and feelings, she can age regress in a more spontaneous and naturalistic way. Furthermore, the seeds for the subsequent therapy are being planted simultaneously when the

therapist points out in a nonthreatening way the distorted perceptions of a six year old. This can pave the way for the client to accept that her thoughts at that time might have been distorted also, and may therefore be more easily transformed.

Other Regression Techniques

Other techniques for age regression include: (1) Affect or somatic bridging, where the client's current feeling or awareness is linked ("bridged") to the first time, or one of the first times, he or she had that same feeling or awareness (". . . and as you continue to be aware of that 'abandoned feeling' you've described, you can drift back in time and recall the first time you ever had that same feeling"); (2) Temporal disorientation, in which confusional suggestions are employed to disorient the client from "now" and reorient the person to "then" ("What happens now and then is that remembering then now reminds you now of then when then is so important and when then becomes now because yesterday led to today and you can remember yesterday as if it were now because now and then remembering then as if it were now can be so important . . ."); and (3) Age progression and regression, in which the client is first guided into the future at which time he or she can remember the things that have happened in his or her past ("Look forward to the times that you can look back . . ."). By orienting to the future first, an even greater emotional distance is created from past experiences, making them easier to recapture and use therapeutically.

Age regression is one of the most widely used and beneficial applications of clinical hypnosis. The clarity of long forgotten memories that can be elicited or the power of constant, intrusive memories that can be restructured are common components of clinical work in general and the use of hypnosis in particular. Knowing the mechanisms of memory, including its strengths and limitations, is vital to sound clinical practice. If you haven't yet made a study of memory, I'd encourage you to do so before your next client walks in and says some variation of, "When I was ten, here's what happened to me . . ."

Age Progression

Description

In contrast to age regression's utilization of memory, age progression involves a utilization of projections of the future. Age progression involves guiding the client subjectively into the future, where he or she may have the opportunity to imagine and experience the consequences of current or new choices, integrate meanings at deeper levels, rehearse new patterns

of thought, feeling or behavior, and, in general, obtain more of an overview of his or her life than a narrower focus on day-to-day living typically affords. You can think of it as encouraging hindsight while it is still foresight.

Foresight is a vital skill to possess, and is quite probably the best tool of *prevention* that therapists could be teaching their clients, if only more of them would be far-sighted enough to do so. People have a part of them that can plan and allow for the possibilities of future experience. It is a resource that, with practice, can become more skilled and efficient. But, even in basic form, people have a sense of how today relates to tomorrow. Common remarks such as, "See you there next week," "I'll read that tomorrow and get it back to you by next week," "I'd like to enroll in that new program next year," and "When I retire I'd like to spend my time traveling," are all statements of intent regarding future experience. In order to make such statements realistically, the person must project some portion of him- or herself into that experience and imagine in some detail what it would or will be like. Any suggestive communication strategy that orients the client experientially to future events is an age progression pattern. Age progression is about becoming *absorbed in the future as if it's now*, giving rise to understandings and emotions not easily accessible in other ways.

Age progression for therapeutic purposes can be structured in many ways. Most clinicians are well aware of the "self-fulfilling prophecy," the unconscious alignment of behavior with an expectation. One way to think about age progression is as the deliberate creation of a therapeutic self-fulfilling prophecy, that is, an expectation of change that can be the foundation for the client adopting new adaptive behaviors. Most important of all in age progression is the ability to experience some of the benefits of implementing the changes encouraged in the client through the therapy. To "jump ahead" and preview and even feel the positive consequences of making important changes helps motivate the client to go ahead and actually do so. It takes the changes out of the realm of theory and gives them some life, some substance in the mind of the client.

Utilizing age progression for the purpose of relapse prevention is another important dimension of therapeutic intervention. Specifically, one can assess whether the intervention's results will likely be lasting ones, and what impact on the client's life the intervention will ultimately have. Even though the change under consideration may seem an obviously beneficial one, there may be less obvious factors (personal, situational, or interpersonal) that can work to keep the client from fully succeeding in his or her endeavors. Age progression allows the client to project into the future how he or she looks and feels after the change, how he or she looks and feels handling old situations in new ways, how others will likely

react to his or her change, what areas might continue to be difficult for him or her, and, in general, which areas of his or her life have been affected positively and which negatively. Such information can be invaluable to the clinician in formulating the intervention while simultaneously addressing the issue of relapse prevention.

Milton Erickson had a little sneakier, albeit sophisticated, use for age progression that he called a "pseudo-orientation in time." By having his patient go forward in time and relate to that time as if the present, Erickson could ask his patient how he or she got over the problem—specifically what Erickson said or did for the patient—or what the patient learned or decided that helped him or her overcome the problem. When the patient gave him the details of the "past" therapy that had helped him or her, Erickson facilitated amnesia for having done so, and thereby obtained his therapeutic strategy directly from the patient!

Posthypnotic suggestion necessarily involves age progression, and sometimes amnesia as well. A suggestion is given for the client to respond in a particular way in some future context, and in order for the client to accept such a suggestion, the client must experience some degree of future orientation. In fact, orienting the client to positive future possibilities is a necessary part of *any* psychotherapy. Even therapeutic approaches emphasizing insights into the past can encourage some future orientation when such insights are expected to generate new possibilities in the client's future.

Approaches to Eliciting Age Progression

Direct Approaches

The direct approaches for facilitating age progression closely parallel the direct approaches described for age regression. These might include a "special vehicle" to take you into the future, a movie screen on which to watch or even step into a movie of the future, a book in which to read about your future and how it *happened*, or the imagery of a photograph collection of future events to view are all structured approaches to facilitate a future orientation or projection. As you can tell, the approaches to hypnosis are as varied as your imagination allows.

A simple, direct, permissive suggestion approach to age progression is exemplified in the following paragraph:

> and now that you've had the opportunity to discover something very important about yourself, I wonder how many ways you'll find to use this new ability of yours creatively on your own behalf . . . and it can be as if a long time has passed since this session . . . a few days . . . and time passes so quickly . . . then a few

> weeks . . . and a few months ago we spent some time together where you learned that you could feel so good . . . and you had a thought at that time that allowed you to look at yourself differently then . . . and feel differently now . . . and as you look back over all the time that has passed since then, how has that thought affected you? . . . How are you different? . . . What can you do now that you couldn't do back then?

In the above example, the client is encouraged to integrate some new thought or learning into his or her life in a way that will prove beneficial. Suggesting directly to the client that it is "as if a long time has passed" orients him or her to the future as if it were now, a time to reflect on the recent change and its consequences. Questions such as those in the above example require increasing involvement in the "then is now" experience, and can provide concrete ideas to the clinician about other factors to include in the overall intervention.

Indirect Approaches

Indirect suggestions for future orientation may include: (1) metaphorical approaches (e.g. "I'd like to tell you about someone I worked with who could clearly imagine herself two months after our session doing exactly what we're talking about now and when she saw herself that way she discovered . . ."); (2) embedded commands (e.g. "I sometimes like to look around and *wonder what will happen in the future* when you can *look back at and feel good about all the changes* you have made . . ."); (3) presuppositions (e.g. "I wonder exactly where you will be and what you'll be doing when you happily realize you haven't smoked in days . . ."); and (4) indirect embedded questions ("You can tell me about how you will *describe the way you solved this problem* to your friends, can't you?"). Each of these approaches and examples demonstrates a capacity for guiding the client into a mental set for developing positive expectations for the future. Positive expectations about improving one's condition are fundamental to success in virtually anything, but are especially important in the healing arts. Why go through treatment if you don't expect some benefit? Age progression patterns are the bridge to get from here to there, from now to later. If the imagination doesn't create new directions, the will doesn't have anyplace to go but around and around.

Hopelessness and helplessness are routinely found in clients in distress. Age progression as a means of building a *realistic* sense of hope, and as a way of empowering the person to take charge of his or her life, is a vital component of good therapy.

Hypnotic Amnesia

Description

Hypnotic amnesia is a suggested loss of memory, and can be most simply described as the structured suggested experience of forgetting something. In both hypnosis research and clinical practice, hypnotic amnesia generally involves the inability to recall items specifically suggested (either directly or indirectly) to be unavailable for recall, and subsequent recall when the amnesia suggestion is reversed (hence called a "reversible amnesia"). The quality of the amnesia may be broad in scope (e.g. childhood memory before age nine) or may be specific to a certain type or category of information (e.g. what happened during the robbery).

Hypnotic amnesia has been the subject of considerable research in the domain of experimental hypnosis. Suggested and reversible amnesias hold the potential to reveal much about the cognitive basis for memory and other unconscious processes. There have been many different viewpoints developed over the years, ranging from the view of hypnotic amnesia as a socially prescribed role enactment, an "unmotivated" but prescribed forgetting, and a prescribed breakdown of specific memory mechanisms.

In everyday living, examples of forgetting that parallel hypnotic amnesia are abundant. Lost keys, forgotten phone numbers, missed appointments, forgotten names of people you know you know, missed assignments, showing up on the wrong day for a meeting or date, forgetting details of significant experiences, and forgetting where you hid something important are common examples. There are countless opportunities in daily life to observe people forgetting things that may, on the surface, seem unforgettable. There are conditions that serve to enhance memory, and there are conditions that serve to interfere with memory. Some of these are biological in nature, as psychologist Ernest Rossi described in his considerations of state-dependent learning, and some are social and situational. Structuring someone's experience hypnotically to create the conditions in which information can be "split off" in order to deliberately create amnesia may occasionally be a goal in the course of treatment. Why might a clinician want to foster amnesia in a client?

There is often a detectable motivation for the act of forgetting, a reason why, even though the reason may objectively seem a poor one. Classic psychoanalysis is a long-term process of recovering hidden or latent memories, particularly those of childhood, and bringing them into conscious awareness as "insights." Having insight into one's motivations and associated intrapsychic dynamics is thought to be the primary vehicle of change by a number of different schools of psychodynamic psychotherapy, primarily those in which the conscious mind's role is considered

to be the most significant in the process of change. Herein lies a fundamental difference between the utilization approach to hypnosis and other therapeutic approaches that emphasize developing greater conscious awareness. The utilization approach emphasizes the greater positive potentials of unconscious processes, and thus makes considerable use of amnesia whenever possible. It is tempting to think of an unconscious that can be trusted to generate positive responses to life stressors through hypnosis, but clearly such a one-dimensional view of the unconscious isn't entirely realistic. However, there are responses formed at unconscious levels that are, in fact, helpful to the individual. Thus, the use of amnesia to split off conscious awareness to focus on the unconscious *may* have therapeutic utility.

Milton Erickson was a firm believer in and strong advocate for the notion that the unconscious can be more powerful in generating changes than any other part of the person. Erickson was convinced that if the appropriate information is provided to the client's unconscious from within his or her frame of reference, ideally with minimal interference from the conscious mind, the unconscious could effect rapid and lasting change. Consequently, Erickson developed a variety of ways to deliberately facilitate amnesia in order to promote change at an unconscious level. By inducing the client to consciously forget the various suggestions and experiences provided, one can enable the client's unconscious to form its own unique response, free to use the hypnotic suggestions and experience as creatively and idiosyncratically as it desires. As often as not, the client's solution catalyzed by the clinician's suggestions is more creative than the clinician's.

Amnesia is a common characteristic of deeper hypnotic experiences. When the client emerges from hypnosis, he or she may have little or no recollection of what the hypnotic experience involved, even if no direct suggestion for amnesia was offered. Such amnesia is referred to as "spontaneous amnesia" for obvious reasons. If amnesia is a specific response the clinician wants the client to develop, gambling on spontaneous amnesia is not a certain bet; rather, playing a more active role in facilitating amnesia increases the likelihood of obtaining the amnesia response in the client.

Amnesia is not automatic with hypnosis, as many erroneously believe. In fact, for those who rely on an intellectual means of maintaining self-control, paying careful attention and remembering everything that happens during the hypnosis session may serve to reduce their anxiety. Inducing amnesia in such persons, as might be expected, may be more difficult. That might work against having a deeper dissociative experience of hypnosis, but it doesn't necessarily work against still having a therapeutically productive experience of hypnosis. If a client is motivated to remember suggestions and experiences, he or she will. When spontaneous

amnesia occurs, it is, in part, a reflection of the client's trust in the clinician's skills. It indicates the client didn't feel the need to carefully scrutinize everything the clinician said.

Strategies to Elicit Amnesia

Indirect Approaches are More Likely to Succeed

Amnesia, more than any of the other hypnotic phenomena, is less likely to be obtained the more directly the clinician suggests it. Suggesting to someone that he or she "forget everything that took place during this time" can be very threatening, even to a responsive and even compliant client. In facilitating amnesia in clients, indirect approaches are much more palatable to people, in my experience.

If a direct approach to amnesia is employed, it is probably more likely to be accepted if offered in a more permissive manner, as in this example: "You can choose to forget about that experience now, because it no longer has a place in your life . . ."

Indirect approaches may take a variety of forms, including indirect suggestions, attentional shifts, and confusional suggestions. Indirect suggestions for amnesia create the possibility of amnesia occurring without your overtly asking for it as a specific response. The following is an example of an indirect and distracting approach to amnesia:

> and as you continue to relax, each breath soothing you . . . I wonder how much attention you have paid to the different thoughts floating through your mind . . . your mind can be so active while it relaxes . . . and then you can realize how difficult it is to remember what I was talking about exactly seven minutes ago . . . and you could try to remember what I was saying nine minutes ago, or what you were thinking four minutes ago, but doesn't it seem like much too much work to try and remember? . . . it takes more effort than it's worth . . . and so why not let yourself relax comfortably . . . knowing you don't have to remember when it's too much work to do so.

The above example is indirect because it doesn't specifically suggest to the client he or she forget, it only describes the difficulties of remembering. Another indirect suggestion for amnesia is: "You can remember from this experience what you choose to remember . . ." This suggestion carries the unspoken implication that, "You can forget what you choose to forget." I view this suggestion as a respectful way of offering amnesia as a choice for the client to make without demanding it.

Another indirect approach to facilitating amnesia is the "attentional shift." The mechanism for this approach is easy to understand when you consider a routine interaction: You say to your friend, "I have something I have to tell you." Your friend says, "Well, I have something to tell you, too, and it's really important so let me tell you first." You agree, and so you listen and then respond to your friend's concern. Finally, when he or she is through, he or she says, "OK, now what were you going to tell me?" and you say, "Uh, well, gee, I uh . . . forgot." The irritating but predictable response from the other person then is, "Well, it must not have been very important!" What actually took place? Your attention was on a particular "track," a particular line of thought. But when you leave that track in order to attend to your friend's input, the flow of thought was interrupted and was difficult to retrieve, thus creating a temporary amnesia. The reverse phenomenon happens as well: You have information "on the tip of your tongue," but the harder you try to remember it the more elusive it is. Only when you divert your attention away from deliberate effort to recall it does it eventually float back into awareness.

Shifts in attention obviously have an impact on how information goes back and forth between conscious and unconscious levels of experience. Deliberately shifting the client's attention away from his or her hypnotic experience is one way to get him or her to "jump tracks" and thereby develop amnesia for the hypnosis. To do this, when the client is disengaging from hypnosis, the clinician can gracefully and congruently distract him or her by having him or her respond to something totally irrelevant to the content of the hypnosis session. For example, the clinician can look bothered and say something like, "Oh, I just remembered. I needed to ask you which tests you had done at your last physical examination. Do you recall?" By encouraging the client to abruptly shift into thinking about his or her last physical examination (or whatever), you give the client no opportunity to consciously analyze the hypnotic experience he or she just had, and it can therefore integrate at an unconscious level. (You won't know whether the person's unconscious has integrated *anything*, however, until subsequent meetings when you have the opportunity to find out whether anything has changed, and what degree of conscious awareness the person has for *how* things changed.) Discouraging conscious analysis inhibits opportunities for the client to pick apart or reject dimensions of the hypnotic experience that such conscious analysis might deem irrational. (Hypnosis sessions often involve suggesting experiences, such as "floating peacefully through space and time," that may be emotionally powerful but are logically impossible.)

Other approaches to facilitating amnesia include: (1) Metaphors, in which stories are told with embedded suggestions for forgetting (". . . and when she opened her eyes it was as if from a deep sleep, barely able

to remember anything but the good feelings of a restful night . . ."); (2) Seeding, in which advance hints are provided of the amnesia suggestions to come later ("Some people experience such deep or meaningful hypnosis that when they reorient later it's surprising how little there is to remember . . . and it's so interesting how they change for the better even though they don't necessarily remember how . . ."); and (3) Dissociation, in which suggestions can be offered about remembering and forgetting as separate mechanisms that can function independently ("Your ability to remember is complemented by your ability to forget . . . and when your thoughts remember that situation, your feelings can forget to be there because they are remembering someplace else to be of greater importance and comfort . . .").

Observation of your self and others in various situations where memory is on display can teach you a lot about the routine nature of remembering and forgetting. Further study of the nature of human memory is also recommended to guide one's developing skills in the use of both age regression and amnesia.

Analgesia and Anesthesia

Description

Hypnotically induced analgesia and anesthesia exist on a continuum of diminishing bodily sensation. Hypnotic analgesia generally refers to a reduction in the sensation of pain, allowing other sensations (e.g. pressure, temperature, position) that orient the client to his or her body to remain. Hypnotic anesthesia generally refers to a complete or near complete elimination of sensation in all or part of the body. Applications and approaches for analgesia and anesthesia overlap to a great extent, and so for the sake of simplicity only the term "analgesia" will be used in this discussion of these hypnotic phenomena.

Hypnotically induced analgesia is truly one of the most remarkable capacities human beings have. The potential to reduce pain to a manageable level or even eliminate it altogether is one of the most meaningful applications of clinical hypnosis. Given the large number of people suffering with chronic and debilitating pain, and the potential for any of us to suffer pain from injuries and medical conditions, the value of any tool for managing pain effectively is obvious. Consequently, pain relief through hypnosis may well be the most intensively studied of all the hypnotic phenomena, and may also be the most empirically well-supported application of hypnosis.

In studies evaluating the merits of hypnotically induced analgesia, hypnosis provided significant pain relief for about 75 percent of the population across different types of clinical populations and painful

conditions. Further analysis indicates that hypnosis appears to be at least as effective as other nonphysical approaches, such as cognitive-behavioral pain management approaches. And, there is evidence that when hypnosis is added to standard patient-controlled sedation, hypnosis affords significantly greater pain relief than does conscious sedation alone. Hypnosis is not addictive; it is empowering to the patient, and it encourages a healthy proactive role in managing pain.

Given the merits of hypnosis in pain management and related issues in behavioral medicine, I have devoted an entire chapter to this topic, Chapter 16. There you will find a discussion of methods and applications.

Catalepsy

Description

Catalepsy is defined as the inhibition of voluntary movement associated with intense focusing on a specific stimulus. The degree to which the client is focused on the subjective associations triggered by the clinician's suggestions is the degree to which the client can demonstrate cataleptic responses. Such responses may include a fixed gaze, general immobility, the "waxy flexibility" usually associated with the catatonic patient who maintains his or her limbs in whatever position the clinician places them, muscular rigidity, unconscious movements, and the slowing of basic physical processes such as breathing, blinking, and swallowing. Signs of catalepsy can be relied on to a large extent as indirect indicators of hypnosis (both formally induced and spontaneous), or they may be directly suggested for specific therapeutic reasons to be described shortly.

The so-called "everyday trance"—spontaneous experiences of hypnosis arising in the course of daily living—is a period of catalepsy where the person may be daydreaming, self-absorbed, enthralled, captivated, but somehow preoccupied to the point of temporary immobilization by the intensity of the focus. Routinely over dinner, for example, people stop mid-reach for the pepper (or whatever) when the conversation turns intense and absorbing for the moment. Similarly, people will stand rigidly fixed in one spot, in one position, when more and more of their mind is called on to make sense out of a situation that seems to require a meaningful response.

Suggestions to the client for a part of the body to be stiff and rigid, such as an arm (e.g. "Your arm is so stiff and rigid that you will find yourself unable to bend it"), is a demonstration of "arm catalepsy" or "large muscle catalepsy" if those suggestions are accepted. Suggestions to the client that "the eyelids or eye muscles of your closed eyes are so rigid or relaxed as to prevent your eyes from opening" may be accepted by the client, resulting in "eye catalepsy" or "small muscle catalepsy."

Some clinicians use such suggestions as behavioral tests to gauge the client's responsiveness. (Personally, I prefer not to offer such challenging suggestions that unnecessarily create the possibility of failure.)

There are numerous therapeutic purposes for eliciting catalepsy, but they can be described in two general ways. Catalepsy can either serve to facilitate further hypnotic involvement through the client's recognition of his or her ability to respond in automatic, non-volitional ways, or it can be a target response in itself. Catalepsy as a target response may be used, for example, to assist any client whose physical movements need to be minimized in order to recover more quickly and comfortably (such as back injuries or burns). As a catalyst of further hypnotic experience, catalepsy can be a basis for securing and maintaining attention (thus serving as an inducer "as you discover yourself getting more mentally focused and your body becomes too heavy to move"), facilitating greater independent activity of the unconscious and increasing the degree of involvement or focus of the client (thus serving as a deepener).

Strategies to Elicit Catalepsy

Direct and Indirect Approaches

Anything that captures the intense interest of the client can facilitate cataleptic responses, including interesting stories, surprises or shocks, and confusion. *Thus, catalepsy can and typically does arise as a spontaneous hypnotic phenomenon even if you don't suggest it.* Eliciting catalepsy as a response from the client can be accomplished directly or indirectly, verbally and nonverbally, as desired. Direct suggestions for arm catalepsy are evident in the following suggestions in conjunction with arm levitation:

> as you continue to breathe in . . . and out . . . at a rate that's comfortable for you, . . . you can start to notice which of your arms is beginning to feel lighter than the other . . . light, almost weightless . . . and your hand can begin to float easily and effortlessly . . . rising . . . that's right . . . lifting without any effort on your part . . . and as it rises it becomes stiff and rigid . . . like a steel beam . . . so stiff and rigid you can't bend it . . . the harder you try to bend it the more stiff and rigid it becomes.

An indirect way to encourage catalepsy is to offer general suggestions for relaxation and immobility, such as in the following:

> it can feel so good to you to know your body knows how to take care of itself . . . it knows how to *breathe comfortably* . . .

> in, and slowly out . . . effortlessly . . . and it knows how to *relax deeply* . . . and you will keep on breathing effortlessly . . . as your mind drifts off to some special memory . . . a memory you haven't thought about in a long, long time . . . and it also knows how to *sit quietly still* while you *get absorbed in enjoying that memory* . . . and isn't it comforting . . . and soothing . . . to *know your arms can rest heavily on the chair* with no need to move them? . . . and it takes more effort than it's worth to move when you are so comfortable.

Both of the above examples are obviously examples of verbal approaches for eliciting catalepsy. The use of gestures and touch can facilitate catalepsy on a nonverbal level. You can model catalepsy as you begin your induction, showing a fixed gaze and a reduction in movement as you proceed.

While general immobility is the typical application or sign of catalepsy, remember that catalepsy has been defined as the inhibition of voluntary movement, which leaves ample room for involuntary or unconscious movement. The client in hypnosis may move in unconscious ways that are considered cataleptic, discussed later in the section on ideodynamic responses.

Dissociation

Description

Dissociation is defined as the ability to break a global experience into its component parts, amplifying awareness for one part while diminishing awareness for the others.

Most clinicians learn about dissociation in the course of their clinical training, but almost invariably in the context of psychopathology, as in the dissociative disorders (such as Dissociative Identity Disorder, psychogenic amnesia, fugue states, and the like). Dissociation is considered to be a basic response of people in trauma (e.g. an assault victim reporting he was floating above his body during the attack, an experiential detachment), and dissociation is thought to be so extreme in some instances that a person can dissociate and develop amnesia for intense and prolonged trauma. However, dissociation, like the other hypnotic phenomena, is neutral, capable of being applied for positive or negative purposes. Dissociation to repress trauma that deteriorates into a dissociative identity disorder is clearly an unhealthy adaptation. In contrast, dissociation as a pain management strategy when someone learns to detach from his or her body, is a potentially helpful application of the same principles.

It's important to appreciate that what defines the positive or negative value of some process is the outcome it generates, and not the process itself.

In the domain of clinical hypnosis, dissociation relates to the more autonomous functioning of conscious and unconscious processes in contrast to their normal, more integrated functioning. Dissociation as a hypnotic phenomenon allows for the many intriguing possibilities hypnosis as a tool affords.

Dissociation is a natural experience, for all persons are capable of processing and responding to information in ways they are not even aware of. On a daily basis, people talk to disembodied voices through an instrument called the "telephone." Physical processes go on routinely (e.g. blinking, swallowing, adjusting the body, breathing, etc.) without any conscious involvement whatsoever. Each person has had the experience of feeling divided within him- or herself, as if simultaneously both participant and observer in some experience. Even common sayings reflect dissociated states: "I'm beside myself with joy," "Part of me wants to go, but another part of me doesn't," "I'm out of my head to do this."

Through dissociation, people do not have to be attached to their immediate experience, involved, and "present." They can "go through the motions," but not really be "there." The conscious mind can drift off somewhere, preoccupied with whatever else has its attention, and therefore the person's unconscious is freer to respond in whatever way it chooses. The deeper the hypnotic experience, the greater the degree of dissociation and the greater the opportunity for non-conscious responses. Hypnosis is by its very nature a dissociative experience. And, dissociation is a defining characteristic of hypnosis: You can be in hypnosis without being relaxed, but you can't be in hypnosis without *some* degree of dissociation being involved.

Dissociation allows for the automatic, or spontaneous, responses of the client to occur; the forgotten memory can be remembered, the hand can lift with no conscious effort, the body can forget to move or notice sensation, and so forth. Facilitating the expression of a specific part of a person can have profound therapeutic impact. Finding and treating the part of the client that has felt weak and powerless, for example, when other parts of the person feel strong and able enough to take meaningful risks can give the clinician an opportunity to help the client resolve a troublesome problem that has existed "for no apparent reason."

Countless other examples of dissociation can be found in the literature on hypnosis, but the best examples are those of daily living. In what situations do you observe people responding in an automatic, detached way? When are people least integrated in terms of mind and body? Intellect and emotion? Past and present? Optimism and pessimism?

Masculine and feminine? The more polarities or "parts" you generate on a variety of levels (i.e. physical, mental, emotional, behavioral and spiritual) to describe the range of experiences people are capable of, the more you can appreciate how many different interrelated parts there are of human beings; each is capable of being dissociated and amplified for clinical use. It is a common theme of therapy to help people better recognize and utilize different parts of themselves.

Too often, people have personal resources they could be using to help themselves, but these resources are either hidden from them or they simply don't know how to access them. In that sense, the parts of the person that may have appropriate skills for problem resolution are already present but dissociated. The clinician's role is to build new associations (i.e. cues, triggers, bridges) that will give the client access to more of his or her own abilities in the desired context. Dissociation is thus a valuable stepping stone in the process of recovery.

Strategies to Elicit Dissociation

Suggestions that facilitate divisions of experience are suggestions for dissociation. Dissociation can be facilitated through a variety of approaches, including direct suggestions for dividing experience into parts, Erickson's "middle of nowhere" technique, and indirect suggestions of subjective divisions.

Direct and Indirect Approaches

Suggesting analgesia by "feeling your body resting comfortably here while you see that small part of your body that was uncomfortable way over there" is a direct suggestion for division. Suggesting age regression by saying, "Your feelings can go back to age six while the rest of you remains an adult with me in the here-and-now," is yet another example of direct suggestion of dissociation. Anything you say that fits the pattern of the general dissociative suggestion statement that "part of you is experiencing *this* while another part of you is experiencing *that*" is a direct suggestion for dissociation. Further examples are evident in a variety of models of psychotherapy that make abundant use of dissociation without ever really identifying it as such, including Gestalt (which emphasizes the integration of disconnected parts), Ego State Therapy (which refers to each part as an ego state that must be recognized and coached in appropriate expression and integration with other ego states), and Transactional Analysis (which dissociates each person into "Parent–Adult–Child" states).

A technique of dissociation that Milton Erickson often used is called the "middle of nowhere." Since one is guided to someplace called

"nowhere," the paradox has the effect of dividing the person between the experience of being someplace but also being no place. An example of this approach might sound like this:

> and when you sit that way it can become so easy to recognize that *a part of you is here* . . . but when *the rest of you drifts away* . . . and it *can* drift away . . . and you really don't know where it goes, do you? . . . to the middle of nowhere . . . where there is no time . . . and there is no place . . . in the middle of nowhere . . . there can just be my voice . . . and your thoughts . . . and nowhere is such a fine place to be . . . because nowhere else can one be so free to be nowhere . . . after all, you always have to be somewhere, sometime . . . but not now . . . nowhere is fine . . . and the middle of nowhere is a very pleasant place to be, isn't it?

In this example, the client is encouraged to let him- or herself go to nowhere in particular, with no need to have any ties to anyone, any place, or any thing. As the client experiences him- or herself splitting her awareness between "here" and "there," the dissociation is intensifying.

Dissociation is indirectly suggested whenever suggestions for a particular hypnotic phenomenon are offered. Use of metaphors and other forms of indirect suggestion all may facilitate dissociation. Metaphors are essentially stories that encourage you to leave here-and-now and go into the context of the story. Indirect suggestions for dissociation are contained in the following metaphorical example:

> and I thought it might interest you to learn that I had a similar experience to the one you described . . . an experience that taught me a lot about myself and others . . . that I'd like to tell you about . . . and isn't it amazing how you can learn important things from other people's experiences that . . . on the surface . . . seem so routine? . . . sometimes you can listen so intently . . . it's as if a *part of you is experiencing it, and another part of you is watching yourself go through the experience* . . . wondering what will happen . . . and how you'll feel when it's over . . . and then the things that were so confusing at one level are made clear by the parts of us that understand . . . at a much deeper level . . . how to think creatively . . . and there's a creative part in everyone, I'm sure you'd agree . . . and in the experience I had, I found myself in a situation . . .

In this example, dissociation is suggested on a number of different occasions. A part is created that "experiences," another part that

"observes," another part that will "wonder," another that can "feel," another that can "clarify," and still another that can be "creative." Each of these parts can now be isolated, addressed, and utilized to accomplish some therapeutic goal. Each of these parts can be identified and acknowledged by the client as present in him- or herself, even though the suggestions are offered indirectly as comments by the clinician about him- or herself or as comments about people in general.

In facilitating dissociation, the final consideration for the clinician is related to the process of reintegration. Should the dissociated part(s) be reintegrated fully? Partially? Or not at all? Certainly an area of pain is best left dissociated, at least in part. Positive parts, such as the creative or adaptive parts, would probably need to be fully reintegrated. The task here for the clinician is to have some insight into the needs and motivations of the client in order to know what beneficial or harmful consequences might be associated with dissociating or reintegrating parts of the person.

Given the numerous daily experiences each of us has with hypnosis and dissociation, it should be apparent that all clinical applications of hypnosis involve making use of the processes that people use routinely to create their subjective ideas of reality. Developing insight into the multifaceted nature of dissociation can have an enormous impact on the future of your clinical interventions, for in every psychological disorder known to me, an element of dissociation is present. Clinical artistry often involves redirecting dissociative processes in more adaptive directions.

Hallucinations and Sensory Alterations

Description

Generally, people find it a bit unnerving in daily life to encounter someone who is experiencing things that no one else is. Comedian Lily Tomlin asked the question, "Why is it that when I talk to God I'm praying, but when God talks to me I'm schizophrenic?" Hallucinations that are involuntary are generally maladaptive.

Hallucinations created hypnotically are suggested experiences the client can have that are also removed from current, more objective realities, but they are structured to be adaptive and the client can, of course, accept or reject suggestions for experiencing them. Hypnotic hallucinations allow one to step outside conventional reality in order to have some beneficial experience that could not otherwise occur. For example, one therapeutic application might be to have a client go back in time (age regression) and have a meaningful conversation with a parent now deceased in order to settle some lingering personal issues.

A hallucination is, by definition, a sensory experience that does not arise from an external source. Simplistically, there are at least five senses in the normal human being; hallucinations may therefore exist in any or all of the sensory systems. For the sake of simplicity, the kinesthetic sense in this discussion will include separate but related sensory systems capable of detecting pressure, temperature, muscle feedback, that orient one to one's body and position in space, and to changes in motion. It is possible to hypnotically facilitate visual, auditory, kinesthetic (tactile), gustatory, and olfactory hallucinations. Hallucinations can be further characterized as being either "positive" or "negative." These terms do not refer to the emotional impact of the hallucinations on the person experiencing it. Rather, these terms refer to the structure of the hallucinations.

A positive hallucination is defined as having the (visual, auditory, kinesthetic, olfactory, gustatory) experience of something that is not objectively present. For example, you can take in a slow, relaxing breath, and as you inhale you can smell the fragrance of baby powder . . . and as you smell the fragrance of baby powder, you can realize that you have just had a positive olfactory hallucination.

A negative hallucination is not experiencing something sensorily that is objectively present (thus the flip-side of the positive hallucination). As you read this sentence, your awareness can drift to a sound in your environment that you didn't notice until just now . . . and as you become aware of that sound, and perhaps the feeling of surprise that you didn't notice it earlier, you might realize that you have had a negative auditory hallucination.

Positive and negative hallucinations occur routinely in the course of everyday living. Everyday examples of positive hallucinations include having a taste for food you crave, feeling itchy all over when you find an insect on or near your body, thinking you see someone you're trying to avoid wherever you turn, hearing someone call your name when no one is around, and thinking you smell something burning when nothing is. Everyday examples of negative hallucinations include not hearing the doorbell ring because you're engrossed in something, not noticing something (such as a building) on your way to work and then suddenly seeing it one day and exclaiming, "Wow! Where did that come from?" and not noticing that the milk you're drinking has gone sour until someone else tastes it and says, "Yecch!"

Sensory alterations and hallucinations are distinct but closely related terms. *Sensory alterations are defined as changes in sensory awareness, either magnified or diminished in some way*. The overlap between them exists because in order to facilitate hallucinations, the clinician must alter the client's sensory awareness, and in altering the client's sensory awareness, sensory hallucinations will be created. The client will have

one or more of his or her senses made more or less sensitive, and more or less active, depending on the desired outcome.

Strategies to Elicit Hallucinations and Sensory Alterations

Direct Approaches

To deliberately facilitate the experience of hallucinations, both direct and indirect approaches can work well. A direct suggestion to experience something (e.g. "You can open your eyes and see yourself over there having that special experience") is usually sufficient; generally by the time a clinician attempts facilitating hallucinations, they have already attained sufficient rapport with and responsiveness in the client.

Suggestions for hallucinations, whether positive or negative, should generally be offered in a positive suggestion structure so the client knows what he or she is striving to experience. As an example, you can refer back to the earlier part of this section in which I offered you a direct suggestion for the positive olfactory hallucination of smelling baby powder. I let you know in a very direct and specific way what kind of experience you could have. In working hypnotically with a client, the more details the clinician provides, the more sensory experiences the client can have. Thus, extending an earlier example, if you want the client to see his or her deceased mother in the chair opposite him or her in order to have the meaningful conversation that never took place, the positive hallucination will be enhanced by having the client see his or her mother's clothing, smelling her perfume, touching her shoulder, seeing her physical position, and hearing her voice, all in as much detail as possible. All of these suggestions can be directly offered, immersing the client in the experience more and more intensely with each suggestion. In general, positive hallucinations are fairly easily accomplished through direct suggestions, of which the following are some examples:

- You can look over there and see someone you've wanted to see whom you haven't seen in a long, long time . . . and how does she look?
- You can hear a voice telling you something you really shouldn't not know . . . and whose voice is it? . . . and what does it say?
- You can smell the aroma of the coffee perking . . . and that smell brings you back to a situation you haven't remembered in a long, long time . . . and where are you?

In the above examples, while the sensory modality in which the positive hallucination is to occur is specified (i.e. see, hear, smell), the content of the hallucination is not. The person, the voice, and the situation to be experienced by the client in the above suggestions are left to the client's

projections. You can now recognize these as process suggestions for hallucinations. If the clinician wanted to, it would be just as easy to suggest that the client see a specified person, hear a specified voice, or experience a particular situation, providing all the appropriate sensory details.

Indirect Approaches

Indirect suggestions may also be used to facilitate hallucinations. Suggesting that the client be aware of his or her arm is an indirect suggestion to not notice her leg. Referring back to the earlier discussion on negative suggestions, it should be apparent why the negative suggestion, "Don't notice the pain in your neck" as a suggestion for a negative kinesthetic hallucination won't likely work. Thus, indirect suggestions for hallucinations usually take the form of positive suggestions for experiences that would preclude the unwanted experience. For example, rather than directly suggest, "You won't know anyone else is present," in order for the client to negatively hallucinate other people in the vicinity, such a negative hallucination is indirectly accomplished by directly suggesting, "You can be alone" or by the indirect suggestion embedded in the question, "Where did everyone else go?"

The following suggestions exemplify indirect suggestions for hallucinations:

- . . . and how does it feel to see yourself standing over there as a child?
- . . . and whose voice is that that you're hearing?
- . . . and why didn't you notice earlier that your hands were floating effortlessly?
- . . . and when I went to the woods to hear the silence and smell the fragrance of pine needles, and I'm sure you know those sensations, too.

In the above examples, suggestions in the form of presuppositions are used to facilitate seeing one's self, hearing a voice, and feeling floating hands. By asking the client how it feels to see the child, whose voice it is he or she hears, or when he or she noticed his or her hands floating, the clinician presupposes the client is having these experiences, an indirect suggestion to do so. The last example is a metaphor with embedded commands to indirectly suggest certain sensory experiences. "Hearing the silence" is also an indirect suggestion to negatively hallucinate ongoing auditory stimuli.

Since the client tends to suspend reality testing during hypnosis, he or she can more readily get absorbed in suggested realities. As you've learned, the person generally retains some sense of objective reality (recall

Hilgard's "hidden observer"), but only if the person is aware of a more objective reality. Thus, a clinician would have to be quite astute in making sure that sessions structured to provide hallucinatory experience are not going to inadvertently amplify or promote delusions, magical thinking, or psychosis.

As for sensory alterations, simply consider under what conditions you might want to enhance or diminish someone's sensory capacities. Suggesting less auditory sensitivity to tinnitus (a condition featuring a ringing in the ears), or greater auditory sensitivity to hearing the stress in a spouse's voice in order to encourage more empathy, are examples of appropriate suggestions for auditory sensory alterations.

Ideodynamic Responses

Description

The powerful effects of conditioning can be observed in a lot of different ways in daily life since so much of our daily functioning is done on an automatic, unconscious level. If you had to pay attention to every single thing you did each day, by the time you got showered and dressed and ready for work it would be time to call it a day! Our automatic functioning frees the conscious mind to involve itself in higher-order activity. The automatic functions that humans are capable of exist on at least four different levels: cognitive, motoric, sensory, and affective. Collectively, these are the "ideodynamic responses"; individually, the responses are the "ideocognitive response," the "ideomotor response," the "ideosensory response," and the "ideoaffective response." *Each is an automatic response generated at an unconscious level in response to some stimulus, either external or internal.*

The ideocognitive response is what cognitive theorists might call an "automatic thought." These are the unconscious cognitive associations triggered in the client's thought processes in response to the clinician's suggestions. Hypnotic processes employ all kinds of procedures to encourage so-called cognitive distortions, irrational beliefs, and unrealistic expectations as self-limiting ideocognitions to come to the surface for identification and correction. This is especially the case when hypnosis is used in conjunction with cognitive-behavioral therapy approaches.

The ideomotor response is the physical manifestation of mental experience, or, in other words, the body's unconscious physical reactions to one's thoughts. Being a passenger in a car and reflexively moving to hit the brake is also an example. So-called body language is an entire category filled with thousands of examples (the body moves unconsciously as an analogue to what is thought or verbalized) of ideomotor responses.

Ideomotor responses may be facilitated for diagnostic and/or therapeutic purposes. Diagnostically, the clinician may suggest to the client an automatic physical response to questions. For example, one might suggest that if the response to the question is "Yes," the client's head will slowly nod automatically and effortlessly, and if the answer is "No," the client's head can shake involuntarily from side to side. It is not uncommon for a client to verbalize the "Yes" response while simultaneously indicating the "No" response with his or her head. Which would you believe? While the ideomotor response is certainly not a lie-detector, it can provide evidence of the existence of multiple cognitive controls and conflicting feelings within the client.

In fact, there are clinicians who regularly build their therapies around such "ideomotor signaling." They suggest an unconscious means of communication through finger signals, first setting up an "unconscious signal system" such as a "yes" finger, a "no finger," an "I don't know finger," and a "I don't want to say" finger. Then they proceed with questioning the client regarding the onset and function of the symptom: Did this symptom develop before the age of ten? Before the age of five? Does it have anything to do with your family? Your friends? Is your unconscious mind willing to let go of the symptom? The questions a clinician might ask can obviously go in many different directions. Can the unconscious really be accessed in this direct way and reveal "the truth" the conscious mind suppresses? This is controversial in some quarters, but it seems evident that if someone is prone to believing this is feasible, just as if they believe in regressing to past lives, they will be more likely to respond positively to such interventions.

Ideosensory responses are automatic experiences of sensation associated with the processing of suggestions. Having the normal range of sensation and a kinesthetic memory for what the experience of the sensation was provide the basis for the ideosensory response. When someone suggests that you recall the experience of having peanut butter stuck to the roof of your mouth, the sensation can come back to you quite automatically as you make sense of what was asked of you. The taste and feel of peanut butter in your mouth is immediately available to you only because of your past experience with it. The suggestion would have no effect if you had never tasted peanut butter (or if you do not have a mouth). Describing in elaborate detail the various sensory components associated with an experience allows the client to re-experience those sensations to a degree determined by the amount and type of past personal experience with it, and the degree of kinesthetic awareness the person generally has.

Ideoaffective responses are the automatic emotional responses attached to the various experiences each person has. People have a diverse range of emotional responses to life's events, each differing in the types as well

as degrees of intensity of response. It is difficult, if not impossible, to feel entirely neutral about something. Therefore, as the client experiences the suggestions of the clinician, different feelings associated with the ideas contained in the suggestions come to the surface. Buried negative feelings of hurt and despair can arise in a flash, as can positive feelings of joy and pleasure. The emotional intensity of people's responses to suggestion during hypnosis sessions often catch both the client and the clinician off guard. Emotionally intense responses will inevitably arise, even though you can't know for certain just when. Be ready! This sensitive topic will be discussed further in the final chapter.

Ideodynamics are simply structural components of a total experience. Every experience you have occurs on a variety of levels, each adding to the overall experience in a different and complementary way. In doing hypnosis, the ideodynamics are important variables for two important reasons. First, they reflect the inner experience of the client at the unconscious levels where change is sought. Second, they are a part of the current therapeutic experience, and will be the thought, action, feeling, and sensory-based components of the therapy that the person will recall and rely on as the basis for change in the future.

Strategies to Elicit Ideodynamic Responses

Direct Approaches

Unlike many of the other hypnotic phenomena, ideodynamics will occur no matter what you do. There is virtually no way the client can prevent unconscious body movements or thoughts, or keep from re-experiencing feelings and sensations as they get absorbed in the hypnotic experience. In facilitating ideodynamic responses hypnotically, the issue becomes one of whether the client responds well to suggestions for specific automatic responses or not. The thoughts, feelings, sensations, and movements that the clinician suggests will be responded to more easily the greater the degree of dissociation present, since ideodynamics are defined as unconscious responses. Therefore, facilitating dissociation is a necessary first step before attempting procedures such as automatic writing or finger signaling.

Direct suggestions offered permissively are useful for facilitating ideodynamic responses. The following suggestions are examples of this type:

- . . . as you listen to me describe that experience, I wonder what thoughts will pass through your awareness that might surprise even you. (Ideocognitive response)

- . . . as you let your body relax . . . your head begins to slowly drop downward . . . and let it do as it wishes. (Ideomotor response)
- . . . and as your muscles continue to relax . . . you can feel the tingle in that spot. (Ideosensory response)
- . . . while you remember that picture of yourself as a child . . . you can notice the feeling that the picture recreates within you. (Ideoaffective response)

Each of the above suggestions directly suggests an automatic experience not consciously created. They "just happen" as the client follows the suggestion, and the client doesn't have to will them to happen at all.

Indirect Approaches

Indirect suggestions for ideodynamic responses are also very useful, as long as the clinician chooses words carefully since the words used will engender the specific response obtained. Examples of indirect suggestions for ideodynamics include:

- . . . as a reflex you can think you're to blame for that event happening, but a new thought will occur to you to make you seriously doubt it. (Ideocognitive response)
- . . . I don't think your conscious mind will know your unconscious knows about that event until your finger has lifted. (Ideomotor response)
- . . . I wonder whether you can recall how good it feels to cool off by jumping into a cool swimming pool after feeling hot and dried out from the heat of the sun. (Ideosensory response)
- . . . It can be a great relief to find out that what you thought would be a major car repair is only a minor one. (Ideoaffective response)

Preoccupying the client with the content of the suggestion facilitates the ideodynamic response, for while the client projects him- or herself into the described situation and attempts to make meaning of it, his or her unconscious is already responding.

Time Distortion

Description

The experience of time is a purely subjective one, meaning you experience the passing of time in your own way at any given moment. Everyone has had the experience of doing something pleasurable and fun, and discovering that what seemed like a short period of time was actually a

relatively long one: "Time flies when you're having fun." Likewise, you have no doubt had the experience of being in situations that were difficult or boring, and after checking your watch and waiting . . . for what seemed like three days . . . you then checked your watch again and found, much to your distress, that only 5 minutes had gone by. *The subjective passing of time can seem much longer or much shorter than is objectively true, depending on your focus of attention*. Such distortions of time take place in all people's experience, and like all other subjective experiences, the experience of time can be significantly altered in deliberate ways hypnotically with appropriate suggestions.

Facilitating the distortion of time in a client's perception can make for a very useful therapeutic experience. Think of situations where it would be helpful to lengthen or shorten one's sense of time: When a client is in pain, for example, condensing a long period of painful existence into what seems like a very short period of time can be a most compassionate intervention. Expanding the perception of time of comfort in between the contractions of a woman in labor can make the birthing experience a much more comfortable one. Having a long workday subjectively seem shorter can make a difficult job a little easier to take. Having only a short period of clock time in which to take an examination and yet subjectively experiencing plenty of time to think responses through can allow for better performance. These are but a few potential examples of useful applications of the hypnotic phenomenon of time distortion.

Strategies to Elicit Time Distortion

Direct Approaches

Approaches for facilitating time distortion can range from your "simply getting out of the way" and letting time distortion arise spontaneously to the offering of direct and indirect suggestions for its deliberate elicitation. Time distortion tends to arise with no suggestions for it at all, for once someone closes his or her eyes and becomes absorbed in internal experience, the passage of time is generally unimportant. For the client in hypnosis who is relaxed, absorbed in meaningful and helpful experience, and enjoying the experience, the tendency is to underestimate the passage of time. The client typically thinks that a 20- or 30-minute session was only 5 or 10 minutes long. It's often a convincer to people that they were, in fact, hypnotized when they discover the big difference between what the clock on the wall says and what their "inner clock" told them.

Direct suggestions for time distortion, especially when offered permissively, can facilitate the experience well. The following are examples of direct suggestions for time distortion:

- . . . and it can seem to you as if a long period of time has gone by . . . and that you have had many hours of high-quality rest. (Time expansion)
- . . . an hour can seem like a minute . . . and time can pass so quickly . . . when each thought passes through your mind at a rate so fast that it's easier to just let your thoughts pass quickly by than try to catch one. (Time condensation)
- . . . your mind and body have been so busy here . . . and it takes so much time to do everything you've done . . . hours might seem to have passed by while you have been so preoccupied. (Time expansion)

Indirect Approaches

Indirect suggestions for time distortion gently plant the notion that the experience of time can be altered. Indirect suggestions (e.g. "I wonder how few minutes have gone by during this time . . ."), stories containing examples of experiences where time was distorted (e.g. "I was so busy I didn't even notice how much time had elapsed"), questions with presuppositions (e.g. "Are you surprised at how much you've accomplished in just a few minutes?"), and double-binds (e.g. "Did it seem like a very long time or just sort of a really long time to you?") are all capable of facilitating time distortion. The following suggestions provide another example of each:

- . . . keeping track of time is so difficult sometimes . . . and right now it's hard to know whether 5 minutes or 6 minutes have gone by . . . and how can anyone really know whether only 5¼, minutes have gone by or 5½ . . . or 5⅝ or 5⅞ minutes have gone by . . . (indirect suggestion for an expanded experience of time)
- . . . I worked with someone not long ago who felt so uncomfortable when she first came in . . . her problem bothered her a lot . . . but when she closed her eyes and let herself listen to me . . . deeply . . . she forgot to notice how much time went by . . . and she let herself relax so deeply . . . it seemed like hours of comfort . . . soothed her mind and body . . . and she felt so good . . . for a long time afterward . . . (metaphor regarding an experience of time distortion)
- . . . and you've been so comfortable sitting and listening to me, haven't you? . . . That's right . . . and it isn't easy to know how long . . . very long . . . a period of time has passed, is it? . . . (conversational postulate)
- . . . and now I wonder whether you realize how fast and short this period of time has gone by . . . and you can guess if you'd like . . . would you say it's been only 5 minutes or would you say it's been as much as 7? . . . (forced choice orienting the person to a specific time span)

In the first example above, by getting so specific about how much time has elapsed and framing all the choices within a short period of time, one can help the client become oriented to that time frame and thus feel as if a lengthy process actually took only 5 to 6 minutes. If the clinician wants to expand time, the frame used can be an exaggerated one (e.g. for a 10-minute hypnosis session, the clinician can suggest how difficult it is to know if 20 or 20½ minutes went by . . .). In the second example, a metaphor is offered that lets the client know he or she can be comfortable for what feels like a long time by being in hypnosis through the building of an identification between him or her and the person in the story. In the third example, the conversational postulate is employed; by asking the client to realize how difficult it is to assess the length of elapsed time, the presupposition is that a long time has passed. In the last example, the client is forced to choose between two times that are both much shorter than the actual time elapsed. Perceptions of time can be expanded by making the forced (double-bind) choices you provide much longer than the actual time elapsed.

When clients disengage from hypnosis and discover how distorted their perception of time has been, they know they have experienced something out of the ordinary. The result can be a new respect for the complexity and sophistication of their own inner world. A boost in self-esteem accomplished so easily is one of the most positive dimensions of doing hypnosis.

Disengagement—Ending the Hypnosis Session

Description

As good as it feels to be in hypnosis, eventually you have to disengage from the hypnotic experience and move on with your day. Disengagement is the final stage of hypnotic interaction. The client may indicate a readiness to disengage through a diminished focus of his or her attention and by beginning to move and stretch. The clinician has to make a decision at the moment of observing such signs as to whether the work is done for that session or whether the client's initiation of disengagement is some form of avoidance that can be addressed therapeutically.

The clinician is directing the therapy session, and should generally be the one to decide when initiating disengagement is appropriate, just as he or she decides when the induction of hypnosis is appropriate. In deciding when disengagement is appropriate, the clinician can also decide on what the manner of disengagement will be.

Direct Approaches

When and how to disengage is a matter of individual clinical judgment, based on the overall treatment plan and the accomplishments of that specific session. The clinician has, by this time, employed a suggestion style and structure in his or her approach to the client, and the disengagement can be consistent with these. If the clinician has been relatively direct throughout, he or she can offer such suggestions as the following for disengagement:

- . . . You can bring yourself out of hypnosis at a rate that is comfortable for you . . . taking as much time as you'd like to in order to comfortably complete this experience for yourself.
- . . . When you're ready, you can open your eyes and reorient yourself to the here-and-now, feeling relaxed and refreshed.
- . . . When you open your eyes in about 1 minute and rediscover the outside world . . . you'll be able to notice how good it feels to have been in hypnosis.

Most direct approaches to disengagement (traditionally called "awakening" or "alerting") have employed an authoritarian counting method, e.g. "I'm going to count to three and snap my fingers and you will then be wide awake . . ." Such an approach is not particularly respectful of the client's need to disengage from the hypnotic experience at his or her own rate. Expecting a client to respond to an arbitrary count and come out of hypnosis simply because you want him or her to does not allow the client whatever time he or she may want to complete the experience for him or herself. Furthermore, expecting *any* human being to respond to a finger snap is simply degrading and undesirable.

Indirect Approaches

If the hypnosis session has been an informal, spontaneous one, the clinician can choose to be consistent in his or her approach by offering indirect suggestions for disengagement. The following suggestions are exemplary of such an approach:

- . . . and I wonder whether you've realized how comfortable it has been to let your mind consider that possibility . . . and that can certainly be an *eye-opening* experience.
- . . . and after a nice rest such as the one you've just had you can certainly *alert yourself* to the joys of living.
- . . . did I tell you how I learned about that? . . . I was so preoccupied with myself that I didn't notice things around me much . . . but one

> can *become less self-absorbed* and *move around* in the world and *notice things outside yourself . . . opening your eyes* to new possibilities.

In deciding on the when and how of disengagement, the clinician can consider such factors as whether amnesia is desirable to suggest and what type(s), if any, of posthypnotic suggestions might be offered. How the hypnotic experience is concluded will have a significant impact on the client, since human memory is generally stronger for the most recent events (called the "recency effect"). In other words, the feeling the client has as he or she disengages from hypnosis are the feelings he or she is most likely to associate with the whole hypnotic experience. This is another reason why it is usually the best option to allow him or her the time he or she wants or needs to complete his or her processing of the events of the hypnosis session. Letting the client disengage at his or her own chosen rate allows him or her the opportunity to feel relaxed and unhurried under your care.

13

DESIGNING AND DELIVERING GOAL-ORIENTED HYPNOTIC INTERVENTIONS

Knowing the basic forms of suggestion structure, the fundamentals of hypnotic induction, and the potential shifts in experience associated with various hypnotic phenomena, we can now focus more specifically on developing hypnotic and strategic approaches to treatment. In this chapter, I will consider some of the practical foundational principles for introducing and integrating hypnosis into the therapeutic context. How will you decide what exactly to say to a client who is suffering when you know that each word, each phrase, you employ has the potential to make a positive difference?

The key word in the previous sentence is "potential." There should be no illusion on your part that if you say everything just "right," *as if you could even if you wanted to*, you will be successful. As you have learned in previous chapters, there are many factors influencing the outcome of an intervention, hypnotic or otherwise. Some of these factors are in your control (such as your choice of wording and your sense of timing) and some of these factors are *not* in your control (such as your client's idiosyncratic interpretation of your meaning, medication side effects, and the residuals of your client's treatment history). This chapter is meant to provide some guidance in helping you do the things you can do in order to increase your potential effectiveness in applying hypnosis in treatment. Clinical skill counts for a lot (even though it doesn't account for everything), and many of the considerations in this chapter are meant to enhance your clinical skills in applying hypnosis.

Doing Hypnosis versus *Being* Hypnotic

There are many practitioners of hypnosis who know how to perform hypnotic techniques. However, I believe there is an important distinction to make between *doing* hypnosis and *being* hypnotic. Someone reading

an impersonal script to a client may be doing hypnosis, but I don't believe he or she can necessarily be considered hypnotic. Someone who is detached from the client and the process, who has the idea that what he or she says is less important than the person's susceptibility measure, is not likely to be very hypnotic. Being hypnotic means being able to fully engage the person, being so attuned and connected to the client that you are difficult to ignore or take lightly because what you're doing and what you're offering is so relevant and absorbing.

Think about those people that grab and hold your attention—the people that you don't want to take your eyes off. What about them grabs you and holds your attention? Whatever that quality is, *that's* hypnotic, even though the person isn't necessarily doing hypnosis. When are *you* hypnotic? Are you aware of those special times in therapy when your clients seem riveted to your every word?

Being hypnotic means engaging purposefully with people, accepting the responsibility for being an agent of influence and change, and striving to use your capacity for influence intelligently and sensitively. Being hypnotic also means knowing that the capacity for being absorbing, engaging, and influential doesn't only happen when formal induction takes place. Being hypnotic simply means incorporating hypnotic principles of focusing people and introducing positive possibilities to them into your very way of being, and is thus revealed through each interaction to one degree or another.

The Skills of a Clinician

The skills needed to be an effective clinician, in contrast to those needed to merely perform an induction, are substantial. These include a broad knowledge of current clinical literature, an ability to relate to the client and form a therapeutic alliance, and an ability to organize and direct a well-structured intervention. These are all complex skills that require significant investments of time and effort to develop. You won't learn them in a weekend workshop.

Who we are as people is the foundation onto which the veneer of our clinical training is later glued. Consider for a moment why you structure your clinical practice the way you do. What does it say about you as a person that you maintain your individual philosophy of treatment, are attracted to and strive to practice well a particular style of therapy, and practice in such a way as to even try to lead your clients to believe as you do, however directly or indirectly you may do that?

This is hardly a new concept. We've known for a very long time that we get attracted to and practice therapy, including our hypnotic interventions, on the basis of what we subjectively find appealing. Someone goes to a hypnosis workshop and learns about and experiences

an "inner sage" induction technique, for example, discovering some previously untapped inner wisdom, and thought it was an inspiring experience. So, he or she goes back to work with a new enthusiasm and starts doing "inner sage" techniques with almost every client. Someone else is a believer in "past life regressions" and so conducts such sessions with their clients from that framework. It is an ongoing challenge to minimize the intrusions of our personal biases into clinical treatment, where these can too easily lead us away from a more scientifically informed treatment.

Ideally, our personal backgrounds and interests should not be the primary basis for designing and delivering our interventions, hypnotic or otherwise. In the "real world," however, all of our clinical training prepares us to focus in on "this" but not "that" when we interview our clients, so we may understand what's going on "this" way and then treat it "that" way. Having a philosophy or belief system to provide you a foundation is both necessary and desirable. Perhaps where clinicians sometimes err, though, is when they only see things one way and don't stretch themselves to consider how other perspectives might help in understanding and addressing the problem. Almost any problem can credibly be understood and treated from many different viewpoints. It seems important, to me at least, to distinguish between the facts of a case and the interpretations or inferences you might make when designing your intervention so your inferences don't become rigid dogma.

The Preliminaries to Hypnotic Intervention

As I have stated previously, the value of a specific therapeutic technique or a generic tool such as hypnosis is largely determined by the context in which it is applied. *Any approach has the potential not only to fail, but even be damaging to the client if the therapeutic context doesn't support its use*. It goes well beyond the scope of this book to try to address all the salient clinical skills needed to establish a therapeutic context, but I can at least draw your attention in a general way to a few of them.

Some of the preliminary considerations include:

- your defined professional domain (which encompasses your academic credentials and appropriate licensure to legally and ethically do whatever you do);
- how you obtain referrals, how you represent the nature of the work you do to potential clients and to referral sources;
- your agreed-upon fee for service;
- the length of your sessions;
- the frequency of your sessions;

- the type and amount of intake information you want (including any formal testing, whether for hypnotizability, mood, or some other dimension of the client's experience);
- the nature of your proposed interventions and the underlying rationale for wanting to employ them;
- the building of a therapeutic alliance with the client;
- the means for assessing progress;
- other avenues of treatment that may be desirable or necessary during or after your treatment;
- the criteria for termination;
- the schedule for follow-up.

The rest of this chapter proceeds with the necessary assumption that you have created a therapeutic context in which your client is amenable to participating in therapy in general and hypnosis in particular. Now we can focus more directly on how to design and deliver effective hypnosis sessions.

Strategically Designing Hypnosis Sessions

With simplicity in mind, there are four basic questions I pose to myself when I am working with a client that help me develop a clearer focus on what I want to address in treatment and how I want to address it. Here are the four questions I find helpful in organizing my therapies:

1. What are the client's goals? And, as a corollary, what is an appropriate order (i.e. sensible and with a likelihood of success) for addressing them?
2. What are the resources (such as information or skills) the client will need in order to be able to accomplish the goal(s)?
3. Does the client already have the necessary resources in his or her repertoire or in his or her history and primarily needs help mobilizing these? Or, does the client not have those resources and needs assistance in first identifying and then building them?
4. How will contextualization be accomplished, i.e. how will the resource(s) be made available in the appropriate context(s)?

The first question is about goals. Hypnosis is a directive approach, and its use presupposes a purpose, a goal to strive for. Goal setting is the first step in the treatment process and creates the framework for all else that follows, for better or worse.

The second question is about resources. Addressing this second question skillfully presupposes that you know what skills would be necessary in order to accomplish some goal. Unfortunately, the language

of therapy is often so abstract that clinicians sometimes lose track of precise meanings and the concrete actions necessary to produce a desired effect. We speak the "psychobabble" that employs phrases such as "building self-esteem," "increasing ego strength," "building permeable boundaries," and then act as if these phrases actually mean something. They represent experiences, and it is essential to know what experiences they represent. The task for me in answering this second question is having a concrete definition of what exactly the person needs to be able to say or do (within themselves and/or out in the world) that would make achieving the goal possible. *If there aren't specific steps to follow, then it isn't a goal.* It's merely a wish.

The third question is about where the necessary resources will come from once they've been identified as necessary. Can anyone do anything if they just have the proper motivation, that is, "where there's a will, there's a way?" I think that is a potentially destructive notion because it defines all problems in terms of motivation alone. It would be more accurate to say, "Where there's a will, *maybe* there's a way." Motivation without the necessary abilities frustrates people. *Both motivation and ability matter in treatment, and neither alone will get the job done.* Thus, I first want to assess what abilities the client might have that he or she isn't using to his or her detriment, and then I want to create a bridge to them that makes them accessible. Such "bridge-building" is a prime use of hypnosis. If the client doesn't have the necessary abilities to accomplish what they want or need to accomplish, then it becomes my task in treatment to provide a structured means for teaching those skills and making them learnable. Teaching skills is another prime use of hypnosis.

The fourth question is about contextualization. Having resources is one thing; using them in an effective way at the appropriate time is another. As you learned when studying posthypnotic suggestions, the chief function of the posthypnotic suggestion is to establish an association, a link, between the desired response and the context for that response. Of course, there are also other ways of building this association besides the posthypnotic suggestion. You can employ role-playing strategies, cognitive rehearsals (e.g. success imageries), and homework assignments for the same purpose. The goal at this stage is simply to take what is being learned in hypnosis and therapy and be able to apply it in the course of living.

Hypnosis and the Targets of Treatment

Clients routinely present statements to clinicians such as, "I just want to feel better," or "I just want to have a good relationship." Statements such as these are so global as to be nothing more than mere wishes. They are not well-defined targets for clinical intervention. If a clinician is

unclear as to what he or she specifically needs to address, the intervention will likely go nowhere. In my opinion, the times hypnosis in particular and therapy in general work best are when there is a clear target to be hit and a well-defined means for doing so within the context of a good therapeutic relationship.

Designing Interventions: Where to Focus First

Clients typically have multiple problems, even multiple diagnoses. Clinical judgment requires making a decision about where to begin. Not all problems are equal. Some symptoms are generalized throughout the client's life, and some are specific to particular situations. Some are merely annoying, but some are clearly dangerous. Some are relatively easy to resolve, and some are refractory.

The first priority, of course, is what's urgent, and urgency is governed by hazard potential. Suicidal ideation, drug abuse, and reckless behavior that endangers one's self or others, are just a few examples of when clinicians must establish an order of priority for intervening that one might not otherwise choose if the symptoms or problem behaviors posed no immediate danger.

Where to begin, though, if no symptoms or behaviors are in urgent need of immediate attention? Generally, it is best to begin where you can generate some rapid symptom relief and thereby start to build a positive momentum in treatment. One of the most underemployed but useful constructs in applying hypnosis is called the "response set," discussed previously in terms of building greater responsiveness to suggestions as the session progresses. As a parallel, by focusing on what the client can achieve relatively quickly, a momentum for greater responsiveness to the therapy gets established.

Response sets can only be effectively designed and delivered when the session's goal is relatively clear. If you can't clearly state the hypnosis session's goal or your primary therapeutic message in 25 words or less, then it may be best not to do the session (unless the goal is to simply "go fishing," which may occasionally be a reasonable choice). An unfocused session that yields too little benefit can too easily demotivate the client from participating in further hypnosis sessions. Likewise, a therapy that goes on and on but doesn't produce results that help build motivation to continue likely leads to dropping out.

Delivering Interventions: What About Using Hypnosis in the First Session?

Having interviewed the client and obtained a symptom description and history and medical history, and having assessed the psychosocial factors

operating in this person's life, the clinician might well have enough information to formulate a meaningful hypnotic intervention, even in the very first therapy session. Some clinicians claim one should have a strong rapport and therapeutic alliance built over many sessions *before* doing hypnosis out of the fear that hypnosis might be introduced too early in the treatment process and somehow harm the alliance. I believe that position is too limited. I would suggest instead that one can often use the hypnosis itself as a means to build the necessary rapport with a client.

The ability of hypnosis to provide anxiety reduction, lowered agitation, and reduced ruminations are some of the best reasons to use hypnosis early on in treatment as a means for demonstrating to the client that his or her symptoms are malleable, effectively building positive expectations for therapy. The clinician's responsibility, even in the very first session, is to facilitate hope and meet the need for at least some relief as quickly as possible. Hypnosis can help you do both.

Delivering Interventions: Introducing Hypnosis to the Client

Making the transition from clinical interviewing and establishing rapport with the client to beginning an actual hypnotic intervention is easier than many people seem to think. One can interview a client, and then 20 or 30 minutes into the session, assuming you want to do hypnosis with the client, say something such as the following as a lead-in to the hypnosis:

> I've been *listening intently* to you now for the last half hour or so, describing your symptoms and problems, and how *absorbed* you have been in just trying to manage. I've been impressed by your suffering and despair, and it's obvious to me that *you want things to change*. Having been *so focused on and absorbed in* all the most hurtful thoughts and feelings, it seems obvious to me how valuable it would be for you to *start to consider and then get absorbed* in *different thoughts and feelings* that can help you feel better. You came here knowing it would be important *to get absorbed in a different way of looking at things*, and to help you *start to get absorbed* in a different way of thinking and feeling you can just let your eyes close and focus yourself on some of the possibilities I want to describe to you.

And thus the hypnosis session begins. I cannot think of a single instance in all my years of practice in which a client refused to participate or was even reluctant to join the process when I introduced the purpose of focusing to them in this way. Clients are typically looking for direction and feedback, knowing *something* has to change, but they are typically unclear as to what.

There is another style for introducing hypnosis to the client, of course, a much more conventional and structured one in which the clinician asks the client whether he or she has worked with hypnosis before and how he or she would feel about working hypnotically in the therapy. The clinician draws out existing attitudes about hypnosis, identifies and corrects any misconceptions, establishes both cooperation and expectancy by describing what hypnosis is, how it feels to be hypnotized, what the potential benefits of hypnosis are in his or her particular case, and so on. Some clinicians even go so far as to have the client sign a release form authorizing hypnotic treatment as tangible evidence of informed consent.

Designing Interventions: A Generic Structure for a Hypnosis Session

The structure of hypnosis sessions varies far less than their content. If we consider the structural elements necessary for *a formal* hypnosis session to take place, we can create a "generic structure" of primary components. The generic structure provides a skeleton framework for your session, and your decisions as to session content (e.g. which induction to employ in what style of suggestion, or what problem to address with which kinds of suggestions) produce the variations in one client's treatment compared to another. So, even though you may be treating five different people for depression, what you actually say to each will vary dramatically depending on what their individual needs and patterns of self-organization are. Let's go through the generic structure, component by component, so you may be clear about what's happening at each stage of the process.

Orient the Client to Hypnosis

If you intend to do hypnosis with your client, at some point in the interaction you will want to shift the person's attention away from wherever it has been focused, and redirect it towards creating a state of readiness to begin the process of hypnosis. A statement as clear and direct as, "Now that you've had some time to talk about this problem, it seems like a good time for you to start to focus on getting comfortable so we can do some hypnosis" is usually a good way to start the process.

Perform an Induction Procedure

Encouraging the client to position him- or herself comfortably, breathe comfortably, let his or her eyes close, focus and listen, and simply relax are all the stepping stones to beginning the induction. Which induction you use is, of course, a matter of judgment based on all the considerations detailed in previous chapters.

Build a Response Set

Most people simply can't produce hypnotic phenomena (such as analgesia or regression) instantly on demand. But, given time and an atmosphere that encourages safe and purposeful exploration, people can usually develop hypnotic responses sufficient for therapeutic purposes. Paying attention to the deliberate building of response sets is simply a way of increasing the likelihood of catalyzing a positive response to the hypnotic experience.

The general pattern for building a response set is this: Before asking your client for a specific response, you present ideas in a general and irrefutable way that indicates such a response is humanly and even personally possible. Thus, before attempting to generate an analgesia in a specific part of the person's body later in the hypnosis session, for example, it is helpful to first get the person comfortable with and attuned to the notion that noticing or even creating variations in your perception about your body is possible, suggesting for example that, "Sometimes your body feels tired, and sometimes it feels well rested . . ." In this example, the client is oriented in a general way to the irrefutable recognition that one's experience of one's body varies. Establishing that point serves as a stepping stone to the larger goal of the session, namely, creating a specific variability in sensation with suggestions for analgesia (described in Chapter 16). In essence, you're saying, "your experience of your body varies, and since it does it can vary like *this*." The response set moves the client in the direction of the larger therapeutic goal without yet demanding a specific response from him or her.

The importance of building a momentum of responsiveness in the client cannot be overstated. In fact, I have already indicated that I consider this the most important step of the entire therapeutic process because if the client isn't encouraged to be responsive, then not much else is likely to happen when you offer subsequent suggestions.

Introduce Therapeutic Theme #1

The advice I gave earlier was to distill your message to the client down to 25 words or less when you're planning your session so *you* can be clear about the session's purpose. What do you want to say to this person that is meant to be helpful? What is the client's misperception or self-limiting belief you want to address? What empowering resource(s) do you want to associate the client to? When you are clear about what the message you want to convey is, then you have established the topic of your therapeutic theme. For example, a client complains life is unfair and acts like a victim when there are things he or she could do to help him or herself. The message you want to get across in 25 words or less is "Quit acting like you're a victim and take charge of your life!" But to

help soften that abrupt and emotionally threatening message, I need to say it in a way that's more comfortable and easier for the client in a victim mindset to absorb. So, I might introduce that theme more gently by saying something such as:

> As I continue to talk to you about different ideas and different possibilities you might well become aware of how different people experience life in very different ways . . . Some people think life is just whatever happens to them, while others think they can create whatever kind of life they want . . . Isn't it interesting how some people think they have control over the quality of life and others feel they don't . . . Sometimes people overestimate how much control they have and try to control things they really cannot . . . While others sometimes underestimate how much control they have and don't try to control things and make good choices they really could . . . It can be very confusing to know what's in your control and what isn't, don't you think?

I have now introduced the theme and focused the person's attention on the therapeutic issue of controllability. A more direct approach at this stage would be to say something such as:

> You see yourself as a victim in the circumstances of your life, as if you have no control over what goes on in your life. You have more control than you realize, you are not merely a victim, and I want to talk to you about ways you can begin to take charge of your life.

The next step in the process then builds on whatever therapeutic theme you have introduced to your client at this stage in the process.

Provide Suggestions Addressing the Theme

The next step is to address the theme by offering suggestions that can help resolve the problem and/or accomplish the therapeutic goal. This is the stage at which your therapeutic strategy is implemented. Are you going to try to teach the client a specific skill that can empower him or her? Challenge a self-limiting belief or misconception he or she holds as true? Share a meaningful observation or philosophy about life you believe he or she can benefit from? Try to alter a perceptual process he or she engages in? Whatever your intended use of hypnosis, hopefully you have some strategy in mind for how to achieve the goal of your session.

Whatever strategy you decide on determines the kinds of suggestions you will use to address the therapeutic theme. Direct suggestions to "stop doing that and start doing this" (such as telling a smoker, "whenever you feel the urge to smoke you can go outside and slowly and deliberately take in some deep breaths of cool, clean air and you can enjoy knowing you're gradually making yourself healthier than you have been in a very long time") are probably the most commonly used approaches. Indirect suggestions, most commonly through the use of storytelling, are also used quite commonly to suggest new ways of thinking about and responding to old problems (such as "when the townspeople started suffering strange symptoms, they finally realized the damage the smokestacks of the factory were doing to them and their families . . . and even though it was hard for them because the factory employed so many of them . . . they realized they had to shut the factory down so they could start breathing in clean air again . . . and get their health back . . . because what good is a job if you're sick or the people you care about are sick?").

The suggestions you employ in addressing the therapeutic theme are meant to associate some new response(s) to the problem context.

Interaction Regarding Derived Meanings

This is the "check-in with your client to find out what's going on" phase of the hypnosis session. Whatever the intention of your message, what your client actually receives may be quite different. As you've already learned, meaning is not in the words you use, rather *meaning is in the person* who relates to your words in idiosyncratic ways. Thus, you can give someone a direct suggestion to go take a walk outside when they feel themselves getting stressed, and all the person heard was "take a hike!" Or you can tell someone a story about another client with a similar problem and all he or she hears is that you talk about other clients in your examples. Then he or she gets wrapped up in anxiously wondering whether you'll be using him or her as an example, and thus never hears whatever the point of your story is!

Instead of talking *at* the client and hoping he or she absorbs some intended message, at this stage of the session you have offered suggestions of one type or another to help the client and now you need some feedback as to what, if anything, he or she received from your input. The easiest way to do this is to simply say to the client, "In just a moment I'm going to ask you to describe what you're aware of right now in terms of what's different in your [understanding, body, perception, feelings], and you can describe to me quite easily what you're aware of." (Did you notice the therapeutic presupposition in that suggestion?) The client can then verbalize what, if anything, is different, and you now have the opportunity

to reinforce it if it's useful or contradict it if it isn't. *But, only by checking in with the client during the session can you have any sense as to whether he or she is deriving anything useful from your session and thereby have the chance to make midstream corrections to your approach if necessary.*

Introduce Therapeutic Themes #2, 3, and so on

How many topics or themes can you address in a single hypnosis session? It depends on the client. Specifically, how much does it take for this person to feel appropriately stimulated (i.e. challenged, supported, enlightened), and how much does it take for the person to feel overloaded? You have to assess this person's focus, stimulus need, level of distress, openness to the process, and other such variables that help you decide just how much to pack into a single session. However many themes you choose to address, you will obviously be *providing suggestions* and hopefully *checking in with your client* each step of the way.

Provide Posthypnotic Suggestions (Contextualization)

By this late stage in the session you have already introduced the ideas, perspectives, and methods that are meant to help your client, and you've "checked in" and received some indication he or she developed some new possibilities. The challenge now is how to help the client integrate these new possibilities you've suggested into his or her life. You may want to *summarize key concepts, insights, or suggestions from other parts of the session* at this point in the process as a precursor to linking them to ongoing life experience. Then, using the generic structure for posthypnotic suggestions you learned previously ("Later, when you're in situation X, you can do Y and Z"), you can offer fairly direct suggestions that build those links to the person's everyday life, such as:

> The next time . . . and each time . . . you feel someone is trying to take advantage of you by imposing their wishes upon you . . . you can remind yourself that while other people may want what they want . . . which is quite natural . . . you now have a new choice . . . instead of just giving in to them . . . you can say yes or no to their demands depending on what you decide is best for you and best for the circumstances . . . and enjoy feeling stronger as a result.

Provide Integration and Closure

The session is now complete, and the process of generating closure begins. It is important to give the client some time to process and integrate

what has happened during the session (such as, "You can review and absorb whatever important new possibilities you wish to as you prepare to bring this session to an end") before suggesting actual closure.

Suggest Gradual Disengagement and Full Re-Alerting

The final step in the process, the client is encouraged to gradually reorient and open his or her eyes ("And when you're ready to, you can fully reorient yourself, and let your eyes open whenever you'd like, fully reoriented, becoming fully alert"). The first moments after the person has opened his or her eyes are particularly sensitive ones as the person thinks about the session while "reconnecting" with you. Waiting silently until the person feels like speaking is generally a good idea, although you can also quietly offer further suggestions consistent with your goals at this time, since the client is still usually partially in hypnosis. Reorienting is a process, not an event.

Delivering Interventions: Following up the Session

When the hypnosis session has ended, the opportunity exists to do some debriefing with the client about the session. As with every other aspect of the treatment process, this requires some thoughtful planning. On one hand, detailed debriefing about the session (e.g. "How was that for you? What was your experience like?") can provide you with valuable feedback about how the client responded (i.e. thought, felt) that can be important in shaping future sessions and even the overall direction of the treatment. On the other hand, some of the things that happen during hypnosis sessions, such as fantasy imagery that has no logical basis (such as visualizing being a carefree child again) can create powerful emotional responses that are very helpful to the person to have, yet they would fall apart under conscious scrutiny. *So, you have to give thought as to how much of the session you want to analyze without such an analysis being detrimental to the session's results.*

The next opportunity for follow-up is in the next session. This is when the clinician has the chance to find out what, if anything, is now different in the client's experience. Has anything changed? If so, what? Does the client seem to have absorbed and made use of suggestions given during the hypnosis session? If so, is the client aware of having done so, or does whatever is different seem outside of his or her awareness? The times hypnosis is most mysterious and compelling are when the person has made changes in obvious response to the suggestions you have offered, yet the person seems to have no awareness for the connection between what you suggested and what he or she is doing differently. It gives hypnosis that "magical" quality, which is fascinating, but which may

also be clinically undesirable. *If we want to empower people, having them make changes without any sense of personal connection to those changes simply reinforces a disempowering belief that these things happen to them instead of being caused by them*. I'm a strong fan of taking the magic out of the process and replacing it with a sense of deliberateness on the part of the client, emphasizing that he or she did actively participate in some way to make changes possible. You can do that by linking new behaviors with improved conditions, asking about and reinforcing "what's different and better."

What if the person comes back for the next session and nothing is different, or, worse still, if things have actually gotten *worse*? There are many different possibilities as to why an intervention of *any* type, including hypnosis, can fall flat. Debriefing the client under these circumstances becomes even more important for the clinician. I want to know what I can do differently in subsequent sessions to be more helpful.

In this chapter, many of the nuts and bolts of clinical intervention involving hypnosis have been assembled into a general framework for evolving the art of doing clinical hypnosis. No book, no person, no scientific study can tell you exactly what to say, or when and how to say it best to a particular client. The single person that can give you the most feedback about "what works" is your client. And, as you probably already know, what works for one may be quite different from what works for another. Perhaps ironically, hypnosis, a highly directive approach, is simultaneously among the most respectful and client-centered of approaches.

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HYPNOTIC PATTERNS COMMONLY EMPLOYED IN TREATING COMMON PROBLEMS

Hypnosis is unambiguously and unapologetically goal-oriented in nature, for each time one does hypnosis there is a specific outcome the clinician has in mind. The goals, of course, are established by the client, and the clinician strives to create a context through hypnosis that makes it possible for the person to develop the necessary skills to reach those goals. It bears repeating that hypnosis in and of itself cures *nothing*; rather, it's what happens *during* hypnosis that has great potential to be therapeutic.

Applications of hypnosis are as diverse and creative as the number of clinicians who work with it. There is no human problem that can be solved in all people through a "one size fits all" formula. Giving simple and direct suggestions to your hypnotized client for a problem's resolution is one possible form of intervention since such an approach can actually work with some people. But, the patterns described in this chapter are based on the recognition that most people need something a little more multidimensional than simple direct suggestions of symptom reduction regardless of how amenable to hypnosis they might be.

Individualizing treatment is always a necessity, in my opinion, and that means tailoring general patterns of intervention to the specific needs of the client. Patterns range from relatively simple and obvious to very complex and subtle. The following are some of the more basic and common hypnotic patterns for intervening in client problems. More complex and specialized approaches are readily available in the clinical literature I encourage you to explore. The patterns described here are listed in alphabetical order for easier reference.

Patterns of Hypnotic Intervention

Accessing and Contextualizing Resources

Among my favorite strategies because it is so positive and empowering, the process of hypnotically accessing and contextualizing resources brings to life the belief that people have more strengths and resources than they realize. This is particularly valuable when they are preoccupied with feeling symptomatic and powerless, the antithesis of feeling resourceful. It is positive psychology in action.

The essence of the strategy is to delve into the person's history, find examples of having used resources well that are the very resources that would be helpful to counter the problem situation (the phase of accessing resources), then crystallize those resources and extend them into the problem situation as better ways of managing it (the phase of contextualizing resources). Age regression is used to recall or revivify some meaningful episode from the past, resources are identified and named, such as courage, creativity, or perseverance, and then age progression is utilized to integrate those resources into some trouble spot in such a way that those resources would lead to new helpful perspectives, reactions, and behaviors. When people reconnect with their own resources, inarguably present in their history, it is often a moving and transformative experience for them.

Changing Personal History

The pattern called "Changing Personal History" has been used routinely in clinical intervention in a variety of forms and with a variety of names. As you can gather from its name, the purpose of the hypnotic intervention is to help people redefine their view of their own personal history. So often in treatment, people have come to see themselves as victims of the past, permanently damaged and unchangeable. This strategy is appropriate to use with such clients, particularly when a client is presenting a problem that has its origins in a hurtful episode where the person made some negative life decision that perpetuates his or her distress. For example, if a client had the experience of being physically abused as a child and made the decision (i.e. formed the generalization) that the world is an abusive place and people are never to be trusted, the clinician might age regress the client to his or her earliest memories and suggest the hurtful decision be "re-decided" in order to facilitate the (imaginary) experience for him or her of feeling loved, cared for, and protected by others. The resources of affection and caring can be provided through imagined but realistic suggested interactions, such as his or her mother expressing love and approval when he or she brings home a good report card or

just offers spontaneous hugs and affection. The client is then guided forward through time while having a subjective sense of love and caring present across all his or her life experiences. In doing so, his or her feelings about him- or herself and others can change in a healthier direction.

Here's a case example illustrating the pattern: In the case of a man I worked with whose mother had died when he was a boy of seven, he had "decided" (not consciously) that "women were not to be trusted and gotten close to because they leave you." Through age regression to the time of his mother's death, he remembered feeling abandoned, angry, and hurt and he decided then that the best way to prevent such emotional pain was to never get close to anyone, especially women. His life, as you can imagine, was lonely and painful.

The strategy of changing personal history was used with him. When he was age regressed to his fondest memories of his mother, times when he felt her closeness and love, it was possible to make those good feelings of having her around more readily available to him for recall when he wanted them. This was done through the building of an "anchor," or association, to those good feelings; specifically, he could vividly "see" her and "hear" her voice respond to him in his thoughts whenever I touched his arm. The next step was to suggest a temporary amnesia during the session for the reality of his mother's death. Once this was established, we could examine his life experiences, both good and bad, and have him "recall" sharing them with his mother as if she had really been there. In hypnosis, she could grow older with him and be there for him in the way he had needed her. The experience of having his mother "with him" in a variety of very specific life situations through the years, such as preparing for his first job, getting his driver's license and pleading to use the family car, graduating from high school, allowed him to redefine his view of her and his relationship with her. Suddenly, his mother hadn't abandoned him and women weren't so unreliable. It served to alter his feelings and behavior toward women, especially when he had the insight that "dying obviously wasn't her idea, anyway."

In helping "change" his (perceptions of) personal history through hypnosis, I simply provided a means to experience many of his important life experiences with the "missing piece," namely, his mother. This felt sense of having her there instead of a gaping hole where she should have been allowed him to gradually feel, hear, and see life from a different, healthier, and happier perspective. Did he know the life experiences generated in hypnosis with his mother were imaginary? Yes, of course he did. Were they emotionally powerful anyway? Yes, they were. It is the power of hypnosis to help people get absorbed in experiences that are not objectively "real" that makes therapeutic interventions with hypnosis potentially so therapeutic. Recall the earlier discussions of trance logic and "believed-in imagination."

Critical (Traumatic) Incident Process

One can't go through life without experiencing trauma of one sort or another. Cars crash, people die, wars are fought, crimes are committed, and people seem to have countless ways of hurting each other. In addition to these harsh realities, "everyday" traumas can often have a serious impact: The mean kid in class who made fun of your freckles, the practical joke at your expense that left you standing there wanting to die of embarrassment, and the thoughtless and cruel comment by a loved one that should never have been said are all examples of the "everyday trauma" (i.e. non-life threatening) that can have a profound impact on one's life. Years later such traumas may even seem silly and irrational on a logical level, yet they can still carry a big emotional wallop. In persons who have suffered a trauma of some sort (as defined by them), the traumatic event may well have been a turning point in the person's life. If it were a turning point for the worse, which not all traumas are, then the critical incident process may be an appropriate treatment strategy.

This is an emotionally powerful hypnotic process, intending at its initial stages to release pent-up emotions associated with a traumatic event ("catharsis"). *If the client has conscious memory for the content of the critical incident, you may simply proceed in a relatively straightforward way. However, if the traumatic incident seems to have been dissociated and forgotten in whole or in part, the process can be hazardous*. I suggest you exercise extreme caution in dealing with trauma, and study considerably more in-depth material than that provided here before embarking on trauma treatment. You can still do a critical incident process, but you must be careful to let the client work at his or her own rate and not push the client to deal with something directly he or she feels unable to. Ideomotor questioning (finger signals to provide responses) may help assess whether the client is ready, willing, and able to deal with the traumatic experience and/or the consequences in their life.

The critical incident process as a treatment strategy involves an age regression (either hypermnesia or revivification, depending on the appropriate level of emotional intensity needed to rework the situation) back to the time of the traumatic experience. Generally, it is a good idea to first do a regression to a positive experience, demonstrating to the client that he or she can trust the clinician's guidance, find comfort (or *something* positive) within him- or herself, and control the flow of information and emotions during the hypnosis experience.

Once the client has become immersed in the experience, and describes it aloud so the clinician can know what's happening and how the person is interpreting the meaning of what's happening, the clinician's primary role is to offer him or her support for exploring the episode.

Simultaneously, the therapist identifies and amplifies a part of the experience the client had previously not attended to, such as how insecure (angry, sick, hurt . . .) the other person involved might have been, or how well he or she coped in the face of adversity, or some such thing that can be used as a pivot point to start to redefine the way the traumatic episode is stored and remembered. One might strive to change the history of the situation by adding something new to the interaction to make it easier to bear (e.g. successfully fighting off the attacker). By supporting the client's expression of emotional pain while introducing alternate and empowering focal points, the clinician can usually guide him or her to a point where he or she can start to feel differently about the situation. Frequently, just having the chance to tell the story that has never been told and release some pent-up emotion in a supportive atmosphere has ample therapeutic value. But, the strongest part of this process is in guiding the client into a new awareness or new understanding of the meaning of the experience, redefining its place in his or her life in an empowering way. To complete the process, the client can be age progressed, integrating into the future the changes in thoughts and feelings associated with the release of the hurt, bringing with him or her new conclusions about both the critical incident and him- or herself.

One can also use the critical incident process to revivify an experience that was critical in the client's life in a *positive* way. With the growing emphasis on a "positive psychology" in the field, this choice can be an especially powerful means of helping people get and stay connected to the best parts of themselves. The reality is that if you look for people's pain, you will always find it because everyone suffers at times. However, that isn't necessarily therapeutic and may actually be *anti-therapeutic*. Caution is advised.

Seeding Homework Assignments

In a recent review of the literature on homework and psychotherapy, researchers concluded that *across treatment modalities*, those therapists who assign their clients homework, and who facilitate client cooperation with actually doing the homework, are likely to observe better treatment outcomes. Prescribed properly, a good homework assignment will usually address unconscious dynamics of the presenting problem(s). When the client actively engages in an activity that will cause him or her to experience him- or herself differently while confronting self-limiting thoughts, feelings, and behaviors, new associations are formed and the desired change may be accomplished.

Most clinicians claim to regularly make use of "homework," educational tasks the client is given to carry out in between therapy sessions. These are intended to encourage new behaviors, the development

of new skills, test out the accuracy of one's perceptions, and amplify particular thoughts, feelings, and behaviors that the clinician judges important to the therapy. Homework assignments operate on the level of actual direct experience, a more powerful level than the merely intellectual. Homework helps people integrate new learnings on multiple levels. And, by assigning homework, the client has to expend effort, increasing the likelihood that they will value the therapy more.

The homework assignment isn't necessarily hypnosis, but it is certainly hypnotic in its potential to absorb people in new frames of mind and develop deeper understandings of themselves and their life circumstances. Homework can be done in hypnosis, however, when carried out in the "waking" state as in an "active-alert" hypnosis framework. Homework can also be thought of as an *experiential metaphor* in the treatment process, a parallel to the client's problem that is embedded in an activity rather than a story.

Preparing the client to do the assigned homework is an effective use of hypnosis. This is a process called "seeding," described by strategic therapy pioneer Jay Haley as establishing certain ideas and later building upon them. Psychologist and Milton H. Erickson Foundation Director, Jeffrey Zeig, Ph.D., defined seeding as "activating an intended target by presenting an earlier hint." During the course of the hypnosis session, addressing therapeutic themes and presenting suggestions for experiential possibilities, the clinician can allude to places one might go to observe or learn something valuable, and then, after the hypnosis session is completed, present an assignment to actually do and experience what was alluded to during hypnosis.

In one case example involving assigned homework while working with a depressed client, at one point in the therapy I wanted to target this woman's depressing patterns of making negative comparisons between herself and others. She assumed and really *believed*, "Everyone else is happy, I'm not," "Everyone else has fun, I don't," "Everyone else's life is easy, mine's hard," and on and on. She virtually never strayed outside her immediate comfort zone to go anywhere interesting or try anything new, and it's fair to say she was exceptionally dull. Simply telling her, "You know, you assume way too much about things at the expense of actually checking out whether things are as you think they are," is an intervention that would likely have fallen flat. She believes herself too easily. So, to make the point more experientially, I instructed her to go to a nearby state park and hike a trail there called the Azalea Glen Springs Trail. Sounds beautiful, doesn't it? Can you picture the fields of beautiful azaleas? Can you imagine the clear mountain springs spilling over the rocky terrain? Well, don't. There are probably four azaleas you see on the hike, and the "spring" is little more than a metal pipe dripping water out of the side of a hill! This particular client, as part of her depressed

mental set, built things up way beyond what they really are in a way that always put her at the bottom. In instructing her to hike the trail, I knew she'd imagine flower fields and the springs as abundant, beautiful, and flowing with water. I also knew she'd be in for a big surprise when she got there after several miles of moderately difficult hiking and found such an unexpected and underwhelming sight. And, I knew that for someone who hardly ever leaves her living room, the experience would be dramatic. It was.

When I saw her the day after her hike, she was by far the most animated she'd been since I'd met her. At the start of the hike, she was annoyed with me for telling her to go, and she was annoyed with herself for agreeing to go. She couldn't understand what she could learn on a trail that she couldn't learn more directly and easily in my office. But, she stuck with it, to her credit. When she finally arrived at the Azalea Glen Springs, filled with expectations, and found only a small pipe dripping water out of a mound of dirt labeled the springs, at first she was confused. But then she found it very, very funny that after all her hiking and high level of expectation all she found was a dripping pipe coming out of the ground! During her return hike she thought very hard about why I would ask her to hike such a disappointing trail. After a while she had the realization that *she had set herself up for disappointment* by building the springs up into something special in her mind when, in reality, the springs weren't at all the way she had imagined them. She broadened her thinking, and had the "big *aha*!"—that she is almost always building things up to be better than they really are, and *making herself worse* than she really is. On the spot, she decided to make greater effort to find out the true value of things from her own direct experience, rather than from assumptions rooted in her insecurity.

This homework assignment provided her a much more intense experience of herself than would my saying to her in or out of hypnosis, "You build things up in your mind to be better than they really are and you make yourself out to be worse than you really are so stop doing that!" The hike served a number of therapeutic purposes: It symbolically matched her "going uphill against the world" feelings, it got her physically active, a great tool in dissipating depression, it caused her to confront her unconscious pattern of maximizing everything and everyone else while minimizing herself, and it boosted her self-esteem by giving her a greater feeling of being in control of herself, for she had accomplished something meaningful all by herself.

Assigning homework or task assignments that will address the client's concerns can take a variety of forms. In addition to the symbolic task described above, another type of assignment can involve "making the symptom inconvenient" for the person. Typically, a symptom is coddled and catered to, for the client adapts his or her life to its presence. Having

the client do something that will make the symptom exceptionally inconvenient can effect a surprisingly rapid and lasting change. It can mobilize resistance against the symptoms themselves.

Homework assignments involve more dimensions of the person in the therapy than does verbal dialogue alone. It also allows the interventions to generalize to times and places outside the clinician's office, allowing changes to be more easily integrated into the client's life. Homework assignments can make a point on a variety of levels simultaneously, both directly and indirectly, and when used skillfully they are an art form in their own right.

Reframing

The meaning of an event or a communication is determined to a large extent by the context in which it appears. For example, a single word such as "no" can actually mean a wide variety of things ranging from a firm, clear "no" to a wishy-washy "I don't know" to an affirmative, "I guess so," depending on one's tone of voice, body posture dynamics, and the social context.

The various euphemisms that abound in the English language are all simple and effective "reframings." Reframing means changing the meaning of some event by changing the context that defines the way the event is perceived. *Psychotherapy in whatever form it happens to take at a given moment necessarily involves reframing*. Liabilities are turned into assets, traumatic events are converted into learning experiences, weaknesses are turned into strengths, and so forth. Reframing can be accomplished with a single remark, or can involve a lengthier, more experientially absorbing hypnotic experience. Any approach that encourages the client to have a different perspective on the problem involves a reframe. As soon as you say, "Look at it this way . . .," you're attempting a reframe.

Humor involves reframing as the vehicle for the joke. Humor softens hard times, gives us emotional distance from despair, and provides us with a means to make something big much smaller and easier to handle. For example, after the national trauma of 9/11, how healing it was to have our comedians make us smile again. Reframing through humor made life bearable again.

The clinical skill involved in reframing is to suspend the client's self-limiting belief system long enough for him or her to consider an alternate viewpoint. Turning the "half empty" glass into a "half full" one is an obvious example of how a negative viewpoint can be transformed into a positive one. Reframing can work in the other direction, too. An action a client engaged in that he or she felt fine about until the clinician said, "How could you let yourself do that?" could rapidly turn his or her

comfort into pain, sometimes necessary when someone doesn't take seriously what might be serious, indeed. Most interventions, though, are intended to transform pain into comfort. The underlying assumption in doing reframing as an intervention strategy is that *every experience (i.e. thought, feeling, behavior) has some positive value somewhere*. By taking an experience that the client views as a negative one and commenting on how and why that same experience might actually be an asset to him or her somewhere, one can change the client's attitude about that experience, allowing the negativity to be discharged.

As an example, a woman complained that her husband's habit of snoring was disturbing her sleep. She was told an emotionally charged story by a widowed friend she happened to complain to. The widow described her loneliness since her husband died, how much she felt the weight of her husband's death on her every experience, and how much she longed to hear her deceased husband's snoring, something she said she'd hated about him when he was alive. The impact on the woman complaining about her husband's snoring was to instantly develop an appreciation for her husband's snoring, because it was clear evidence he was still alive and well. It actually became comforting to her. Her husband's snoring behavior was the same, only her attitude about it was changed. That's a successful reframe.

Symptom Prescription

Symptom prescription is a paradoxical therapeutic strategy that involves the direct or indirect encouragement of the client's symptom(s). When the client is encouraged to continue to do what he or she is already doing, but in a way that is slightly different through some adjustment requested by the clinician, the habitual symptom generating sequence is interrupted. The symptom is no longer a puzzling thing that "just happens." It happens in response to the clinician's direction, only now it happens differently, in a way easier to see as both arbitrary and unnecessary rather than as important and inevitable. Consequently, symptoms lose their original meanings and associations.

Symptom prescription, in a sense, is a sort of "reverse psychology" approach. Encouraging people to do what they are already doing robs their action of spontaneity and personal ownership (i.e. it's not "theirs" anymore). When the pattern loses spontaneity and personal ownership, it provides no gratification for continuing to engage in that behavior. For example, encouraging a "resistant" person to "be resistant" redefines that resistance as cooperation. Encouraging a client to have a prescribed relapse redefines a relapse (unless the client resists and refuses to have one, which is better yet) as an acceptable and required part of the treatment process. Encouraging clients to do what they are already doing

can give what seems like an uncontrolled symptom some concrete defining limits that make it a little easier for them to be dealt with effectively.

Therapeutic Metaphors

Stories as teaching tools have been the principal means of educating and socializing people throughout human history. Metaphor, in the world of hypnosis, has come to mean the use of stories in the treatment process. The use of metaphor is a core component of most hypnotic processes. The building and telling of engaging stories as a vehicle for imparting therapeutic messages is a powerful therapeutic skill to develop.

The best metaphors are usually those found in the client's own personal experience. Naturally, these are more personal, more immediate, and easier for the client to relate to in a meaningful way. If you take the time to review incidents in the client's life that had special significance for him or her, usually because they taught him or her something valuable about life, you can have immediate access to a wealth of potentially meaningful metaphors. Likewise, your own background and personal history reflect important learning experiences, and these may be used as the basis for therapeutic metaphors as well. *The more you participate in life, the more experiences you have to draw upon when constructing therapeutic metaphors*. Cases you have worked on or read about that illustrate worthwhile points are also a good source of metaphors. Other sources include storybooks, movies, jokes, anecdotes that illustrate important points about human nature, newspaper stories, television programs, and virtually any other milieu from which you have the opportunity to learn important lessons about living life well from considering other people's experience.

Learning to tell stories in a hypnotic manner (i.e. meaningfully, in a way that focuses and absorbs the person's attention, accepting and utilizing the client's responses, embedding suggestions, with an expectancy of the person learning something important, etc.) is a skill for doing hypnosis that is vital to develop. The necessity of formally inducing hypnosis diminishes as the client becomes absorbed in the telling of a story. The natural ability of the client to drift in and out of hypnosis as he or she listens to the clinician can be tapped and amplified by the clinician wanting to use a metaphorical approach.

Metaphor is obviously an indirect way of suggesting possibilities to the client. Instead of saying, "Do this," you say, with exaggerated simplicity, "Once I had a client who faced a problem similar to yours and one day he tried this and it helped." The client can be encouraged to learn from others' experiences, whether to apply a specific suggested solution or, more generally, to simply be willing to experiment with new possibilities. The use of metaphor isn't a heavy-handed approach. It is a

respectful way of suggesting possibilities without demanding much from the client. A common consequence of this approach is that change can sometimes seem relatively effortless, as if it "just happened," a possibility that the clinician can allow for. Other times, the person works hard to improve, but the story is memorably embedded in their positive efforts.

There are numerous components of each of the therapy patterns described above, and each must be considered and properly integrated in order for the pattern to be effective. For a more complete understanding of the concepts and techniques of these and the countless ways to structure hypnosis sessions, studying other writings in these areas is invaluable. Reading those listed in the Appendix provides a good beginning.

Addressing Common Clinical Concerns Hypnotically

In the course of clinical practice, clinicians encounter a wide range of presenting concerns. Some problem presentations are rare, others quite common. This section contains a brief and superficial consideration of five of the most common clinical concerns and some quick ideas for how hypnosis might be used directly or indirectly in their treatment.

Anxiety, Stress

Some have called this the "Age of Anxiety," and there is considerable justification for doing so. The pressures each of us face are more numerous and more complex than at any other time in the past. Personal safety, a core issue in anxiety, is uncertain when acts of terrorism can occur at any time, in any place, and threats to our self-image and self-esteem are frequent. Just as soon as we get used to one technological advance, it becomes obsolete, requiring us to readjust. Traditional values holding society together have been and are continuing to deteriorate, emphasizing individualism and personal gain over social responsibility, and making even the most important relationships seem only transient. Gender roles are much less specific, and committed marital and family relationships are often taking second place to making strategic career moves, confounding many people trying to figure out how to make their relationships work. Finding work and staying employed is a more demanding and complex task than ever before as people matter less to companies than does the company's "bottom line," threatening people's economic security. The number of potential sources of stress in our lives keeps growing, and most people will struggle with these issues to one degree or another at some point in their lives.

Some stress can be prevented with some insight and foresight, but some stress can only be managed well, simply because life inevitably throws all kinds of things to cope with at each of us we can't avoid. But, as

often as not, stress isn't just generated by external circumstances, it's also internally generated by unrealistic expectations (such as perfectionism), a rigid need for things to be orderly and predictable when too little of life is that way, or any of a variety of ways people torment themselves with their own internal issues. Hypnosis can be used to address any and all of these sorts of issues, teaching more realistic thinking, greater flexibility, and better problem-solving skills.

There is one particular aspect of anxiety that bears special consideration, if only briefly. It has to do with the foundation of anxiety. There are two separate but related structural components of most people's anxiety: The tendency to *overestimate the risks* one faces, and the tendency to *underestimate one's resources* or abilities to manage those risks successfully. Thus, teaching people how to more realistically assess the risks they face and how to cope with them skillfully can go a long way in reducing people's anxiety. The reality is, no place is truly safe, and many life experiences are inherently ambiguous, requiring us to manage them skillfully as they arise. Trusting yourself to do exactly that, rather than getting overwhelmed and fearful, is critical to keeping anxiety within normal limits. Using hypnosis to teach such critically important skills such as risk assessment, frustration tolerance, impulse control, information gathering and decision making, critical thinking, self-reliance, and personal resourcefulness are all vitally important ways to use hypnosis that can keep anxiety in check.

Hypnosis in its most superficial yet still helpful application in managing anxiety can help the anxious client build relaxation skills and an increased sense of self-control. Teaching clients the skill of self-hypnosis (hypnotic inductions and utilizations they can perform on themselves whenever they'd like to) is a necessary part of using hypnosis in clinical contexts. Simply knowing you have the ability to relax deeply and reorganize your thoughts, feelings, and behaviors can have a powerful effect in helping you better manage stress and anxiety. Managing anxiety effectively allows for better concentration, clearer thinking and problem solving, better self-esteem, better time management, better job performance, greater receptivity to new ideas, and better just about everything.

Depression

Depression has been a major focus of my professional life, having been my area of specialization in clinical practice, and the subject of many of my books, book chapters, articles, and clinical trainings. Depression is a complex, multidimensional problem that can be the product of many different contributing factors. And, just as there are many pathways into depression, there are many potential pathways out of depression. There is no one cause nor is there only one type of effective treatment.

Studies of therapeutic efficacy make it clear that active psychotherapy approaches that teach specific skills, especially in clear thinking, effective behavior, and building positive relationships, match and, in some ways, outperform medications in terms of both symptom management and relapse rates. Psychotherapy for depression should be considered an essential aspect of treatment, since no amount of medication can teach coping skills, problem-solving skills, social skills, build a support network, or do all the other things that are known to not only reduce depression but minimize the potential for relapses. Antidepressant medications can be valuable, but should not generally be considered a sole form of intervention.

Hypnosis can be used in many different ways in treating depressed individuals. Many of the possibilities are addressed in considerable detail in my books *Hypnosis and the Treatment of Depressions* and *Treating Depression with Hypnosis*. There you will find detailed descriptions of specific hypnotic strategies, case transcripts with commentary and analysis, and in-depth discussions of key aspects of treating depression effectively. Possible targets for intervention might include the depressed person's negative and demotivating expectations (i.e. hopelessness), the perception that no amount of effort will yield success (i.e. helplessness), cognitive distortions, faulty attributions, ineffective behavior, poor social skills, low frustration tolerance, poor coping skills, and any of the other many subjective patterns of thinking, feeling, and behaving that can help form and exacerbate depression. Empowerment is a basic theme in treating depression, and, in that respect, hypnosis can be an invaluable part of the treatment process.

Relationship Problems

Considering the fact that the majority of marriages in this country end in divorce, as well as the fact that more people today live unhappily alone than ever before, the indication is quite clear that people are having a harder time building and maintaining healthy relationships with others than ever before. Why? There are many reasons: The still-changing roles of men and women, the self-absorption of people who crave endless attention and often strive to get it through questionable means, the increasing technological advances that keep diminishing our need for contact with others (i.e. more time on the computer and smartphone than with actual people) and prevent the development of good social skills, the ease of divorce, the lack of good role models teaching the skills good relationships require (consider the role models on trashy television) and the still-casual attitudes about sex despite the spread of sexually transmitted diseases and low self-regard it engenders are just some of the factors affecting each person's ability to relate to another in a positive and balanced way.

Good relationships don't just happen. There is much, much more to them than just "good chemistry." They require nurturing, and a considerable range of skills including empathy, compassion, tolerance, impulse control, problem solving, negotiation, communication, self-sacrifice, and an attitude of protectiveness to name just a few.

In intervening in relationship problems, factors to consider include the quality of each person's expectations (a primary determinant of one's level of satisfaction such that when the other person does as you think he or she should you're happier with him or her), the quality of their communication skills, and their subjective views on issues such as "power" and "intimacy." Often, the partners in a relationship have inadequate communication skills, poorly defined or even inappropriate expectations, more interest in being "right" than effective, more investment in advancing themselves than the relationship, and other such barriers to building an effective relationship.

When working with couples and families, you are less likely to employ formal hypnosis, although hypnotizing one member in front of the others or hypnotizing the whole group can easily be done if you think it an appropriate intervention. Much more likely, however, is the use of informal hypnosis, using hypnotic strategies (e.g. metaphor, imagery, symptom prescription, or role playing) to focus and absorb family members on ideas and perspectives you present to them that are meant to empower them to be more effective in their relating to one another. Many clinicians will see couples or families as a unit and then see the members individually. Hypnotic strategies may then be employed to clarify expectations, increase the level of motivation to resolve differences respectfully and skillfully within the relationship, enhance communication skills, and address self-limiting patterns that interfere with the growth of the relationship (i.e. increasing empathy, frustration tolerance, impulse control, etc.).

Self-Esteem Problems

Your self-esteem is your subjective assessment of your value as a human being. It is formed in part by the feedback we get from others, but it is formed to an even larger extent by our beliefs and how they serve as filters for the feedback we get. You may recall the earlier discussion of cognitive dissonance and its implication for the experiences a person will and will not permit him- or herself. If you think you're no good, then other people telling you that you *are* good will not likely change your view of yourself. Cognitive dissonance leads you to filter out feedback that contradicts your belief about yourself, serving as the perceptual mechanism for maintaining an unfortunate status quo.

Self-esteem has been the target of many therapists' interventions. They have believed that most problems stem from poor self-esteem, and thus made raising a client's self-esteem a primary therapeutic goal. Self-esteem in this regard has been vastly overrated. Self-esteem is a statement as to how you feel about yourself. Good self-esteem doesn't mean you're more socially aware or skilled, or a better or more compassionate person, or more skilled in any way. It just means you feel good about yourself. Some of the most seriously disturbed or malicious people (such as full-blown sociopaths) on this planet have quite good self-esteem. They are dysfunctional or destructive people who just happen to feel good about themselves.

Helping people become more skilled is a more expedient path to raising self-esteem, though, than is simply telling people how "special" they are. I want my clients to be able to move through their day being effective in what they do, allowing them to say to themselves many times during the day, "I like what I did there. I like the way I handled that." *Self-esteem rises as people develop and use well their skills in living.*

When you work with self-esteem issues hypnotically, the client can be encouraged to take control of situations by planning and implementing a deliberate and effective course of action. The person can learn that their problems are not caused by fatal flaws, but by a lack of salient skills, ones that can be learned. Absorbing the person in learning alternative ways of addressing the issues in his or her life, and solving problems while also teaching broader skills in problem solving, are fundamental components of good therapy. Hypnosis enhances skill acquisition, encourages a willingness to try new behaviors, and empowers people to feel better about themselves as they come to better "own" the changes they make. Hypnosis can also help the client learn to generalize skills to other areas of his or her life.

Sleep Disturbances/Insomnia

Insomnia is the most common symptom complaint associated with both anxiety and depression, the two most common disorders clinicians are asked to treat. An individual may complain of having difficulty initially falling asleep or staying asleep, the latter condition manifesting as either middle of the night or early morning awakenings.

The negative consequences of chronic insomnia are substantial. Occupationally, these include a higher rate of absenteeism from work, greater use of health services, a higher number of accidents, and decreased productivity. On a personal level, chronic insomnia sufferers report a decreased quality of life, loss of memory functions, feeling fatigued, unable to concentrate well, and diminished interest in socializing or engaging in pleasurable activities, further increasing depressive symptoms.

A sleep disturbance can increase the risk for alcohol-related problems. Survey respondents who reported sleep disturbances, more than 12 years later, had twice as high a rate of alcohol-related problems.

The use of self-help techniques, such as self-hypnosis, for enhancing sleep offers several key advantages: Self-help will not lead to either addiction or dependence, it can be applied under all conditions, and it will not lead to potentially harmful interactions with other interventions.

The use of hypnosis in treating insomnia and sleep disturbances has been described in numerous clinical reports. There are specific skills that someone suffering insomnia can learn that will make a positive difference. These skills include: relaxation, good sleep hygiene, and decreasing rumination (repetitive thinking). Rumination generates both somatic and cognitive arousal, both of which can increase insomnia, but the evidence suggests cognitive arousal is the greater problem. Minimal cognitive processing and a relaxed focus on sleep are key treatment goals.

Hypnosis can teach the ability to direct one's own thoughts rather than merely react to them. Reducing the stressful wanderings of an agitated mind and also relaxing the body while simultaneously helping people create and follow a line of pleasant thoughts and images that can soothe and calm the person are valuable goals in the service of enhancing sleep. To achieve these aims, there are a number of important components to include in one's treatment plan. These include: (1) Teaching the client how to efficiently distinguish between useful analysis and useless ruminations. The single most important distinguishing characteristic is the conversion from analysis to action; (2) Enhancing skills in "time-organization" (compartmentalization) in order to better separate bed time from problem-solving time with the well-defined goal in place of keeping them separate; (3) Establishing better coping skills that involve more direct and effective problem-solving strategies; (4) Addressing issues of sleep hygiene and attitudes toward sleep in order to make sure the person's behavior and attitudes are consistent with good sleep; and (5) Teaching "mind-clearing" or "mind-focusing" strategies, especially self-hypnosis strategies of one type or another, that help the person direct their thinking in utterly harmless directions.

Learning how, when, and where to apply the many different potentially therapeutic experiences available through hypnosis requires many years of practice and study. The deeper your understanding of the numerous components that are a part of each and every symptom, the greater the respect you can have for the overall integrity of the finely balanced system called "the client." The deeper your understanding of how to define problems as solvable and then treat them effectively, the greater will be your sense of skill and satisfaction with your chosen work.

15

SAMPLE HYPNOSIS SESSION TRANSCRIPTS FOR COMMON PROBLEMS

The effective use of clinical hypnosis involves tailoring your approach to the unique characteristics of each client. However, I also recognize the value of modeling as a teaching tool. So, this chapter contains three samples of hypnosis sessions that may serve to help you more easily integrate all the information about hypnosis contained in this book. In the next chapter on the use of hypnosis in managing pain, there is another full transcript of a session for your review and analysis. These four session transcripts are derived from hypnosis sessions done with actual clients seeking help for a variety of problems. I hope you will study them with a deep consideration of the personal, interpersonal, and contextual variables that led to the creation of the therapeutic suggestions made. You will be given some background on each of the clients, an explanation as to the goal(s) for that particular hypnosis session, and how the session relates to the larger goal(s) for the client's therapy.

As a final point regarding these sample transcripts, I have presented in this chapter only those things that I said to the client in order to illustrate the various forms hypnotic suggestions may take. Thus, I have edited out client interaction. (For DVDs of full clinical demonstration sessions with a wide variety of clients, visit www. yapko. com.) In reading the following transcripts, your learning of hypnotic patterns can be enhanced by actively considering the suggestions offered and reasoning out the rationale for their inclusion.

Case 1: Self-Definition and Taking Care of Self

The client is a woman in her early sixties who initially sought treatment for nightmares, recurring traumatic images associated with childhood episodes of molestation, poor self-esteem, and an inability to effectively set limits in her relationships with others. Supporting her working through

the feelings associated with her traumas was one obvious and necessary part of her treatment plan. Another part of her therapy focused on her lack of a sense of Self—what many clinicians call a lack of good "personal boundaries." Assertiveness and limit-setting capabilities are possible to achieve later in a therapy sequence, after a sense of Self is first defined. Without a sense of Self, there's little to defend. This woman was so global in her self-understanding and so adaptive to whomever was around her that she knew very little about her own thoughts and feelings. The following transcript represents part of one hypnosis session conducted quite early in her therapy addressing the theme of building boundaries and evolving a clearer definition of Self.

> All right, Molly, you can begin by taking in a few deep . . . relaxing breaths . . . getting yourself comfortable . . . getting yourself oriented now . . . to enter into internal experience for a while . . . so that you can really enjoy the balance between conscious awareness and unconscious awareness . . . let each breath relax you . . . let your thoughts run loose for a while . . . until they tire themselves out . . . and then little by little, they can slow. . . becoming very slow . . . so that more and more of your mental energy can be spent on learning . . . at the deepest levels within yourself . . . of the experience of comfort . . . about the experience of being so distant . . . from all the usual focal points of your awareness . . . so that you really can know deeply . . . that all the inner terrain . . . your inner landscape . . . can be traveled comfortably . . . looking at this natural formation . . . and that natural formation . . . the feelings and thoughts . . . the historical markers . . . your curiosity . . . and a very deep recognition . . . of inner capabilities . . . and it's interesting to observe the evolution . . . what the experience of development is like . . . to see a newly born baby . . . and no one really knows *whether* the baby thinks or *what* the baby thinks . . . and to watch an infant discover its own fingers, its own toes . . . to see the amused look on an infant's face . . . when it discovers that it can make a finger wiggle . . . at will . . . and little by little . . . that infant learns . . . this is *my* body . . . and it is separate and distinct from any other part of the world . . . from all other people and places and things . . . and each square inch of your skin . . . is a boundary . . . between your inner world . . . and the outer world . . . and it really isn't possible for you to jump out of your skin . . . you are *self-contained* . . . and it's interesting . . . that there are some people who don't have a home in which to live . . . who believe that the sky is their roof . . . that the earth is

their home . . . and then there are others who mark off huge territories, acres of land . . . they clearly mark that it is theirs . . . and each wall . . . keeps something in and keeps something out . . . and there are walls of stone . . . walls of wood . . . steel-reinforced walls . . . and there are the walls . . . that you can build for yourself . . . deliberately and happily . . . that are permeable walls . . . the kind that can selectively let things in and let things out . . . and it's that kind of a wall . . . that allows just enough distance from discomfort . . . to be able to drive down a freeway . . . comfortably . . . it is the kind of permeable wall . . . that when someone makes a comment during a conversation . . . that perhaps you can relate to . . . that permits a comfortable distance . . . a protective . . . distance from which to consider each bit of input . . . and you can feel secure that each person's feedback to you will have to check in at your front gate . . . before you decide to let it in or not . . . before you decide *whether* to react or not . . . and *if* you react . . . to decide *how* you'll react . . . based on what works . . . and feels good at the deepest levels within yourself . . . so, why not have a construction party? . . . and build a pretty wall . . . and a creative wall . . . and I wonder what colors you'll use . . . what materials you'll use . . . and what does the check-in gate look like? . . . and how very much room is there . . . for lots and lots of growth . . . and the walls . . . can always be moved when you so desire . . . they can be built up or built down . . . you can put in peep holes and panoramic windows . . . after all, the walls are yours . . . and all I know is that the ability . . . to walk into an open space . . . has at one level . . . unlimited freedom . . . but at another level . . . where's the structure to guide experience meaningfully? . . . and when I moved into this particular office that I'm in now . . . it was a huge space . . . I had to draft a plan . . . detailing how many walls I wanted . . . and where I wanted them . . . how many outlets . . . and how many doors . . . and did I want the doors opening in or opening out . . . how many "on" switches and how many "off" switches . . . and there's a part of you that knows very well . . . that designing uses for space . . . is a real art . . . and you discovered over time . . . that each part of you . . . all the parts of you . . . have some space . . . and how you want to use that space . . . is certainly a matter of individual design . . . and the aesthetics . . . of a high wall here, or a low wall there . . . more space for this part and less space for that part . . . and you can really enjoy . . . the incredible clarity . . . that comes along . . . with increasingly sophisticated designs . . . movable and

> removable walls . . . and what a relief to know . . . that nothing that you experience need necessarily flow right through all of you . . . that you have lots of *inner protection* . . . walls of *inner strength* . . . and you've seen pictures of the Great Wall of China . . . and you've heard of the Wailing Wall . . . and you've read about the Berlin Wall . . . and you know about Wall Street . . . and maybe you've even heard about Wall Drug, South Dakota . . . and the natural wall of the Rocky Mountains . . . the sheer cliff walls on the beaches of La Jolla . . . and with all the different possibilities . . . your unconscious mind can . . . without any real effort on your part . . . it can plan . . . and build . . . and if you were to work for your own Border Patrol . . . you'd really know about the importance of enforcing and protecting the walls that separate inner from outer . . . twenty-four hours a day. . . seven days a week . . . one really must protect one's borders . . . and there are a lot of deeper meanings . . . that I really know . . . you can absorb and use . . . a day at a time . . . and so take your time . . . to process . . . to architect . . . and then . . . when you feel like you want to . . . and when you're ready to . . . that's when you can reorient . . . and open your eyes when you are ready.

Multiple sessions were successfully conducted with Molly emphasizing inner awareness, the recognition and acceptance of her own uniqueness, the ability to make positive choices on her own behalf, and the ability to deal with past traumas so as to permit future growth.

Case 2: Getting "Unstuck": Developing a Goal (Future) Orientation

The client is a man in his late fifties who presented the problems of "being stuck" in an unstable "on-again, off-again" relationship that he finds distressing, having high blood pressure, and procrastinating around issues of his career. He presented as "wanting to achieve enough personal growth to be able to move forward with my life." He did not have any specific goals in mind as to what would represent "moving forward." If the client's goal isn't well defined, and if there aren't specific steps to follow to achieve it, then it isn't a goal. It's only a wish. Thus, one goal in this client's treatment was to help him evolve a clear sense of direction in his life. During the course of treatment, hypnosis was utilized to encourage the development of a clear and specific sense of the future, enough to compel him to take some decisive courses of action in the present. The client is an educator who claimed to be well acquainted with clinical hypnosis in general and the work of Milton Erickson in particular. This transcript is from the third of a dozen sessions.

Okay, Jay, you can begin by taking in a few deep, relaxing breaths . . . and little by little . . . you can let the various recollections . . . drift through your awareness . . . of what it's like to be deeply internally absorbed . . . in a way that's pleasing and comfortable . . . and it's been quite a while . . . since you last experienced . . . a formal hypnotic process . . . with me as guide . . . but there was a time . . . not all that long ago . . . when you first became accustomed . . . to hearing my voice . . . get quieter . . . to hearing me . . . speak in a very slow . . . deliberate way . . . and it was during that initial experience . . . when you were first beginning to learn something about hypnosis . . . and were open to much deeper possibilities . . . that you allowed yourself to experience . . . some of the most interesting dimensions . . . of becoming so focused in this way . . . and since quite some time from our first hypnosis session has elapsed . . . and since you've grown in so many ways since . . . it can certainly be much easier . . . to *drift into a deeper experience* . . . and a much more comfortable state of mind and body . . . moment by moment . . . and this is one . . . very worthwhile opportunity . . . to rediscover . . . your ability . . . to drift . . . in a way that's useful . . . in a way that's meaningful . . . and I know . . . that the various possibilities . . . as you explore your experiences . . . can certainly be most intriguing . . . as the various possibilities . . . allow you to rediscover . . . old awarenesses . . . that pave the way for new awarenesses . . . and as the new awarenesses drift . . . into your consciousness . . . that's when it's so easy . . . to discover how little attention . . . is necessary . . . to allow all kinds of comfort . . . that we can build upon . . . in a future experience . . . of each day . . . and I'm aware that your mind is drifting . . . to nowhere in particular . . . that the things that you think about at this moment . . . are tied . . . to past experiences . . . and future expectations . . . and you know and I know . . . that so often . . . if the seed . . . can get planted today . . . it generates the greatest amount . . . of worthwhile . . . future possibilities . . . and as Erickson correctly pointed out . . . you can't change the patient's past . . . you can only change his perspective of it . . . and how much the past relates to your future . . . you'll presently come to know . . . because it's the present that is connected to your past . . . and leads to your future possibilities . . . that you're willing to explore . . . and your presence here . . . confirms that . . . as you make yourself the present . . . of a positive future . . . that wisely incorporates learnings of the past . . . of things that you experience presently . . . and all that talk about past and present and future . . . isn't

really meant to disorient you in any way . . . that might be worthwhile . . . but it certainly can help you . . . in seeing the perspective . . . that the impulses of the moment . . . can be looked at differently . . . as you discover . . . that the most worthwhile things to be made . . . you can make on the inside . . . from within . . . in your deep self . . . your deep self . . . and if you think back . . . through the worthwhile things that you've already experienced . . . few of them came easily . . . for the simple reason . . . that whatever you've obtained . . . you've worked for . . . and there were so many times . . . on your way to becoming a teacher . . . that it would have been so much easier . . . to skip class . . . and go play . . . to go to the beach . . . or to go for a run . . . and you certainly would have been justified in doing so . . . but you felt deeply . . . there was something more important to be gained . . . in the name of sacrifice . . . and every self-sacrifice for self-improvement really isn't much of a self-sacrifice . . . because when you think about the relationship between sacrifices and improvements . . . and you improve the sacrifice . . . and you sacrifice more than you improve . . . you really haven't sacrificed . . . you've just improved . . . and gone a step further . . . and the questions from within . . . that generate the momentum to grow . . . and experience . . . is a dwindling internal pressure . . . that each experience can comfort . . . each new opportunity . . . for growth . . . can be recognized for what is . . . and there's been so much that you've learned over time . . . so many ways that you've changed . . . and as each change equalizes the pressures outside . . . by responding deeply to the appropriate demands from inside . . . you've become so skilled . . . and the results have shown . . . and you can have a very powerful impact . . . when you allow yourself . . . to release . . . maybe to teach . . . in a sharing way . . . what you already know . . . and going to school is only one way . . . to evolve . . . and change . . . in a self-sacrificing way . . . that leads to a greater sense of self . . . than anything you've experienced before . . . and all through your past . . . there was self-sacrificing . . . that had an aura . . . of taking care of yourself . . . beneath them . . . and when one becomes a parent . . . it's apparent . . . that the selflessness of parenthood . . . is the shiny surface . . . of a selfish decision . . . to have children . . . that one hopes will reflect one's self . . . with pride . . . and accomplishment . . . and the debate about the selfish nature of the selfish decision to have children . . . continues . . . and the sacrifice . . . of a loving relationship . . . that gives you what you want . . . and you know what it means to give . . . in order to

get . . . and whatever you may have to openly give . . . grows . . . easily . . . and as you understand more and more deeply within . . . that giving to get . . . is the greatest way . . . to build a solid relationship . . . especially with yourself . . . especially . . . with yourself . . . and so . . . why not . . . selfishly and selflessly . . . sacrifice a little bit of time each day . . . to give to yourself . . . in order to get from yourself . . . a much more comfortable . . . and *much less pressured* . . . way of doing things . . . a *much less pressured* . . . way of circulating blood . . . in a body that's so healthy . . . with comfort . . . and the ability to relax deeply . . . and you know from the people that you work with . . . that there's a part of each person . . . no matter how educated or otherwise . . . that has the ability to learn . . . and to grow . . . and to change . . . and someone can work hard at staying the same . . . but you know and I know that *change is inevitable* . . . and so don't you be fooled by it . . . and I'm going to be silent for a minute . . . as you explore within yourself . . . the thoughts and feelings . . . that pass through your awareness . . . that become significant for you in ways that your conscious mind has yet to discover . . . and when I again speak to you in a minute . . . my voice can just relax you even more deeply . . . and the minute of silence begins . . . now . . . [one minute of silence] . . . that's right . . . you can just continue to relax . . . to continue to be at ease and resting comfortably . . . and you've allowed me to be aware . . . of the multiple purposes of our session . . . learning opportunities and personal growth opportunities . . . professional growth . . . and meaningful experiences . . . and I wonder how much you'll be able to discover . . . from these trance experiences . . . as you notice the different ideas and the different perspectives . . . and you can enjoy knowing . . . that each hypnosis session . . . will have a different effect . . . and generate a different pattern . . . in ways that your unconscious . . . can allow . . . while you consciously and insightfully look forward . . . to discovering . . . the range of possibilities . . . a day at a time . . . and so, take what ever time you'd like to . . . to process your thoughts . . . the different dimensions of your experience . . . and to think about your expectations . . . and which learnings will be most appropriate to utilize . . . this week . . . and which learnings can wait until next week . . . and then, whenever you're ready . . . you can begin to reorient yourself to here and now . . . this room and this place . . . and whenever you'd like to . . . you can slowly move to reorient yourself . . . and then you can allow your eyes to open.

The client reflected on the basic truth that anything he had of value, he worked hard for. He was easily able to recall what seemed like a sacrifice at the time when he was in school taking classes while others were out enjoying recreational activities. The session motivated him to directly confront the aimlessness in each of the areas of his life, and led to later sessions addressing issues of goal-setting, setting aside immediate gratification while striving for worthwhile future possibilities, and being more responsive ("giving to get") in his relationship.

Case 3: Stress Management

The client is a man in his mid thirties who presented the problem of "too many things raining down on me to cope with." He was undergoing a major shift in responsibilities in his job as an administrator in a construction company, his first child (age four) was suffering health problems, and his wife was pregnant with their third child. He felt as though every domain of his life was unsettled and a source of stress, and wanted to learn to manage stress more effectively in order to prevent any debilitating effects. He shared his fantasy of escaping to a Caribbean island, and wished there was a way to prevent stressful events from happening in his life. The following transcript represents a hypnosis session done in the first of seven sessions.

> Alright, Jack, you can begin by taking in a few, deep relaxing breaths . . . and you can begin now to orient yourself . . . to the possibility of feeling . . . very comfortable . . . and very relaxed . . . and little by little as the world goes on around you . . . why not make yourself really comfortable . . . of course the more absorbed you get . . . in your own inner experience . . . the less it really matters what's going on in the world around you . . . everybody needs a little bit of time away . . . a little bit of a break . . . to turn their attention in a different direction . . . and one of my favorite television shows is *M*A*S*H* . . . a classic comedy about a military medical unit near the front lines during the Korean War . . . you'll still find on TV on those stations that show older series people loved so much . . . and I don't know if you're a fan of that show or not . . . but it will happen from time to time . . . that the *M*A*S*H* hospital . . . will be shelled by the enemy . . . and numerous loud and scary explosions take place . . . as the shells rain down . . . and everyone runs around scared and overwhelmed . . . unsure if they'll be able to survive . . . and you can imagine . . . how fighting for your life . . . can be a very serious battle . . . and then what always happens at some point

along the way . . . is that the shelling stops . . . and someone will offer the comment . . . to *listen to the silence* . . . (pause) . . . and in living life each day . . . the shelling takes a lot of different forms . . . the shelling can be hassles with other people . . . concerns about the environment . . . doubts with one's self about what one should do . . . the battles can be inside . . . they can be outside . . . they can be brief . . . they can be tolerable . . . they can be inspirational . . . they can cause growth . . . they can foster creativity in finding ways to see beyond the moment . . . but there come quiet times . . . times when all the hoopla is over . . . when the noise stops . . . when your thoughts slow down . . . and when nothing really seems to matter very much . . . and it's *those quiet times that prepare you so well* . . . for the times that aren't so quiet . . . the few seconds that can feel like a lot longer period of quiet . . . they restore comfort . . . and balance . . . that strengthen you . . . for any . . . and all future occasions . . . where patience and understanding . . . might work quite well . . . and right now you're in one of those periods of silence . . . and the world is so unpredictable . . . it's hard to know . . . whether things will still be quiet . . . next week . . . next month . . . next year . . . and it really doesn't matter . . . all that really matters . . . is how you use your quiet period now . . . whether you *use the time to strengthen yourself* . . . and *pamper yourself* . . . to *congratulate yourself* . . . and to *appreciate your ability to grow* and do much more than just survive . . . and for a while when I was much younger . . . I had the experience of living on the island of Jamaica . . . I lived in a very small village . . . on the west end of the island . . . where very few Americans actually go . . . and nobody there knew how to read . . . nobody knew how to write . . . nobody was informed about world events . . . the Jamaicans were shocked and disbelieving . . . when I described to them how Americans had put men on the moon . . . and brought them back safely again . . . and despite their ignorance . . . there was a certain satisfaction . . . in understanding the island on which they lived . . . where most of the time the sky is so clear and blue . . . but as is typical of the tropics . . . every once in a while . . . huge clouds would roll in . . . and there would be heavy rain and thunder and lightning . . . and then the clouds would roll out again . . . and at first I found it very unsettling . . . that unexpectedly . . . my enjoyment of the sunshine . . . could be interrupted at any moment . . . and obviously, I had no control . . . over thunder . . . and rain . . . and you learn very quickly . . . that the loudness . . . can be so well appreciated by the counter

balance of quiet . . . and that it's the loudness . . . that makes the rain forest come alive . . . and allows the growth to take place . . . and sometimes it's inconvenient . . . sometimes it seems unnecessary . . . but the fact of the matter . . . is that the darkness of rain . . . leads to the lush vegetation's growth . . . that permits the pleasure . . . and all things are balanced . . . and how good it feels for you to be settled comfortably . . . and how well it prepares you for periods of being unsettled . . . just as periods of being unsettled . . . allow you to really appreciate . . . settled, comfortable times . . . like now . . . and why not enjoy . . . quiet times . . . and appreciate what they have to offer . . . and why not accept the inevitable . . . that rain falls . . . and people change . . . and things get better . . . a day at a time . . . as you *grow more tolerant* . . . and *enjoy greater periods of comfort and stability* . . . it can grow easier and easier . . . to move flexibly and fluidly . . . through the rain and through the shine . . . whether you're in Jamaica or San Diego . . . Europe or Africa . . . the sunshine on the inside . . . makes it easy to deal with the rain on the outside . . . and someone once said . . . no news is good news . . . but you'll have to make your mind up about that for yourself . . . and taking the time to *enjoy feelings of comfort* . . . to enjoy the quiet inside . . . how good it feels . . . to know . . . that the shelling has stopped . . . and experiencing the comfort . . . is certainly a privilege . . . and so why not carry it with you everywhere . . . everywhere that comfort is permitted . . . and share some of it and keep some of it . . . let some go . . . hold on to some . . . and as you begin the process of reorienting yourself . . . bring just enough back with you . . . to enjoy the quiet . . . and then when you feel like you're ready to . . . you can quietly open your eyes.

The client found the hypnotic process "a good break" from the routine pressures he faced, and found it interesting that I would reference *M*A*S*H*, which happens to be one of his favorite programs still in syndication. He thought of Hawkeye in particular, a strong-willed doctor and master of sarcasm who is the main character of the show, and how he uses offbeat humor to stay sane in an insane situation. He decided that he could act somewhat similarly, and gave himself the assignment of making a point of telling jokes to people, when appropriate, as a way of easing tense situations. He considered that approach to be a positive stress-management tool in addition to the self-hypnosis he was taught, and related it further to things he had read about humor and healing. Subsequent sessions involved addressing specific problems needing his attention.

This is a perfect example of how clients will derive unintended meanings from your suggestions that they use to help themselves go beyond what you suggest. I never suggested he use humor as a stress-management tool. But, by mentioning *M*A*S*H*, he had the insight that humor can provide you some emotional distance and comfort. He turned it into an action plan for himself to lighten situations up to make them easier to manage, certainly a viable strategy for achieving better stress management, which was his goal.

Each of the three transcripts included in this chapter was provided for the general purpose of illustrating what forms a hypnotic process might take. You may have noticed how each session was constructed according to characteristics of the individual client being treated. It is precisely for this reason that these transcripts are not likely to be useful to anyone else, even someone with a similar problem, without considerable re-tailoring. Thus, the inability to standardize utilization approach interventions should be more readily apparent to you. Hopefully, though, your creativity may have been stimulated by thinking about what you might have said and done differently in working with such clients. *There are lots of right ways to do clinical hypnosis, and it's the result you get that lets you know whether you were on the right track.*

16

CLINICAL HYPNOSIS AND MANAGING PAIN

The heartbreaking suffering of people we love, respect, admire, and perhaps would even self-sacrificingly trade places with if only they could get some relief motivates an earnest desire to help reduce that suffering. The spouse whose body aches in ways that defy medical diagnosis, the young son or daughter who needs to undergo a lengthy and painful diagnostic procedure, the parent who suffers a chronic, debilitating disease, the close friend who was seriously injured in an accident, the co-worker who is fighting the ravages of cancer, the brave soldier from down the block who returns from war with limbs missing and battlefield injuries so horrific that even their doctors involuntarily wince when seeing them represent only a small fraction of the (too) many ways that people can suffer pain that tears their lives apart. It is difficult to imagine there being any more compassionate and rewarding experience of applying clinical hypnosis than in the relief of pain and suffering.

In this chapter, we will briefly explore the use of clinical hypnosis in helping people manage pain. *It bears repeating that unless you are a physician or are medically supervised, you should not be treating painful conditions without appropriate consultation and supervision*. Good intentions combined with ignorance can too easily give rise to botched treatment in any category of problems, but none more sensitive than medical issues. I know of no more complicated, sophisticated and urgent use of clinical hypnosis than in the realm of pain management. Extensive study of both hypnosis and pain are required to work responsibly and effectively in this domain.

The Complexity of Pain

We need a neurological capacity for pain if we are to survive. Pain has what is commonly termed a "signal value." It screams at us that something is wrong and needs immediate attention. This is termed

"acute" pain. It is generally of short duration, and leads one to take some immediate steps meant to resolve it. But, pain is not a one-dimensional phenomenon, affecting only the body in specific ways that are obvious in indicating what will help relieve it. Sometimes the pain misdirects us to focus on a site that broadcasts the pain but does so from a transmission signal that actually originates somewhere else, a phenomenon called "referred" pain.

Once pain has been recognized and responded to—the diagnostic tests have been run, perhaps the source has been identified (even though quite often it never is), and the pain persists even with appropriate treatment—the pain has now lost its signal value. The pain is termed "chronic," some would suggest after crossing a six-month timeline, and is an ongoing pain that serves no useful purpose anymore, causing a myriad of problems that spider out into all areas of the life of the patient. There is recent neuroscientific evidence that chronic pain can be imprinted in the brain, amplifying its enduring qualities and complicating its resolution. Pain can thus take on a life of its own, turning a previously healthy person into a doctor shopping, pill popping, constantly complaining desperate individual that can focus on little else but the pain, the pain.

The reach of the pain into all parts of the person's life seriously complicates the treatment process. The physiology—specifically the neurology of pain—is certainly the focus of the treating physician. But, focusing on physiology alone is too narrow a lens for providing adequate treatment. How does pain affect the individual's *mood* and vice versa? How does pain affect the person's *motivation* to pursue and follow treatment recommendations or even just to go back to work eventually? How does pain affect the quality of one's *thoughts* (cognitions), *emotions*, and *behavior*? What impact does pain have on one's relationships? What about the effect on the person's spirit and spiritual beliefs? How might it stress the person financially, or legally when a lengthy lawsuit may be involved? Any and all of these different dimensions can combine to make recovery a challenging endeavor and the management of pain a complicated but vitally important goal.

Pain clinics and treatment centers have generally been most responsive to the recognition of pain as a multidimensional phenomenon. A team approach is relatively common, with physicians, psychologists, physical therapists, occupational therapists, nurses, and other professional team members each contributing to the comprehensive care a chronic pain patient receives. Any and all of these team members may—and *should*—have some in-depth knowledge of the merits of hypnosis as part of the treatment plan. The point is clear: Underestimating the complexity of pain can too easily lead to under-treatment, either making matters worse or simply not making it possible for them to get better. Clinical hypnosis can help, but it has to be part of a larger treatment plan.

Hypnosis and Pain Management: Evidence and Current Applications

There have been many recent studies examining the merits of hypnosis for pain management. Psychologists David Patterson, Ph.D., and Mark Jensen, Ph.D., both professors at the University of Washington in the departments of rehabilitation medicine, surgery, and psychology, co-wrote a substantive review of the research in *American Psychologist* (February–March, 2014) which summarized the literature affirming that hypnosis can be effective for both acute and chronic pain. Both Jensen and Patterson are currently widely considered the leading experts on hypnosis in pain management, each also having authored recent excellent texts on the subject: Patterson wrote *Clinical Hypnosis for Pain Control* and Jensen wrote *Hypnosis for Chronic Pain Management*. Both review the evidence for the merits of hypnosis and spell out in detail numerous ways to knowledgeably apply hypnosis in treatment. Additionally, Jensen's book comes with a practical workbook for the patient.

A review of the literature provides evidence that hypnosis has been successfully used in the treatment of all kinds of painful conditions, including: headaches, fibromyalgia, burns, cancer and terminal cancer, chemotherapy-related distress, invasive and non-invasive medical procedures, dental conditions and procedures, surgical procedures, irritable bowel syndrome, labor and delivery, back pain, and many other conditions too numerous to include in this brief overview.

The Pain Narrative

Pain is a subjective phenomenon, privately suffered. Thus, if a clinician wants to help, he or she will have to ask the client useful questions about the experience of pain. The way people explain their pain, especially the specific language they use in describing its qualities, is invaluable information in helping structure an intervention with hypnosis.

There are many different characteristics one could focus upon, each influencing not only the person's way of experiencing the pain, but how the clinician must then form a tailored response. These include such characteristics as: (1) whether the client anticipates the pain will be a never-ending burden or a temporary challenge; (2) whether the pain has some meaning that makes it explainable (whether a biological explanation, such as nerve damage, a spiritual explanation, such as a punishment from God, or some other explanation); (3) whether the person senses any ability to alter his or her experience of the pain; and (4) effects of the pain on other aspects of the person's life (such as moods, ability to work, relationships, finances, etc.).

Getting Underway and Utilizing Hypnosis with the Individual in Pain

The general goal in applying hypnosis for pain relief is obvious: Absorb the individual in pain in a frame of mind and body that is sufficiently incompatible with the experience of pain to alter and reduce it. There are many different approaches to pain relief commonly described in the pain literature. Virtually all make direct or indirect use of dissociation as an initial step in the direction of facilitating hypnotic analgesia or anesthesia. Even an effective approach such as mindfulness for pain relief utilizes dissociation as the foundation: The suggestions are offered both implicitly and explicitly to "detach from the pain" and "detach from your judgments and thoughts about the pain."

The same generic structure for a hypnosis session described earlier applies when working with someone in pain as when working with any other kind of problem: after all, every hypnosis session has a beginning, middle, and end. First comes *orienting the client to hypnosis* ("you can arrange yourself in a comfortable position"), then *securing the person's attention and beginning the induction* ("as you begin to focus on my words, you can notice your eyes closing . . . and as your eyes close, you can notice your thoughts going in many different directions . . . just before they begin to slow down . . . making it even easier for you to get absorbed . . ."), and then *building a response set to introduce the general idea that the experience of one's body is variable* ("isn't it interesting how different our experience of our body can be from moment to moment . . . sometimes we feel more energetic . . . sometimes more tired . . . sometimes we feel warm . . . sometimes a little cold . . .").

At this point, with the hypnosis session now well underway and the goal of facilitating pain relief clearly established, the clinician can launch a strategy that will, hopefully, engage the client and activate his or her potential to respond meaningfully. What follows, then, are three common pain relief strategies.

Direct Suggestions of Numbness

Direct suggestion of analgesia as an approach involves offering suggestions for the lack of sensation in the specific part of the client that is painful. A direct suggestion for "that part of your body becoming number and number" can be enough for some hypnotically talented individuals to experience comfort. Can such simple, straightforward suggestions really work? Perhaps surprisingly, the answer is yes. In fact, if you are able to watch the historic films that come on DVD with his important book, *Clinical and Experimental Hypnosis* (Rev. 2nd edition), you will see hypnosis pioneer and obstetrician William Kroger, M.D.,

impressively demonstrating hypnosis during a childbirth and a thyroidectomy. You will no doubt observe that Kroger's approach is both direct and authoritarian. He literally tells his patient, "Your arm is becoming anesthetic," and somehow his patient is able to translate that into an effective response.

If, for example, a client is experiencing pain in his or her abdomen, a direct analgesia approach might be structured as follows:

> and as you feel your arms and legs getting heavier . . . you can see the muscles in your abdomen loosening . . . relaxing . . . as if they were guitar strings you were slowly unwinding . . . and as you see those muscles in your abdomen relax . . . you can feel a pleasant tingle . . . the tingle of comfort . . . and whenever you have had a part of you become numb, like an arm or leg that fell asleep . . . you could feel that same tingle . . . like the pleasing tingle in your abdomen now . . . tingling more . . . and isn't it both interesting and soothing to discover the *sensation of no sensation* there? That's right . . . the sensation of no sensation . . . a tingling, pleasing *comfortable feeling of numbness there.*

When you suggest the "sensation of no sensation" directly in the client's abdomen, he or she can experience diminished sensation and direct relief in the troublesome area.

The Glove Anesthesia Technique

A slightly less direct approach is called the "glove anesthesia." In this sensory alteration process, the client is given suggestions to experience full numbness (i.e. anesthesia) in either or both of his or her hands. Most people seem to be able to do this, if not fully, at least in part. When the glove anesthesia has been accomplished, further suggestions may be given that the anesthesia can be effectively transferred to whatever part of his or her body he or she chooses. Glove anesthesia permits a mobility for the anesthesia when the clinician suggests that a touch of the anesthetized hand to any part of the body will directly transfer the sensation of numbness to that spot. (In contrast, a direct suggestion for analgesia does not have such mobility, since it is localized to a specific, fixed spot.) This is particularly helpful when the location of the person's pain varies: today it is here, but yesterday it was someplace else, and who knows where it will be tomorrow? Suggestions for glove anesthesia might take the following form:

> and in a moment, when I take your hand with your permission, I'm going to place it in a position in which it can stay easily and

> comfortably (clinician takes the client's hand and props it up on the elbow) . . . and you can easily hold your hand in this elevated position . . . and as you do so you can notice how . . . this hand begins to feel different from your other one . . . more distant and even removed from you . . . more distant . . . and while the rest of you remains warm and comfortable . . . this more distant hand can begin to experience a sensation of coolness . . . almost as if a cold wind were floating over your hand . . . cooling it, chilling it . . . and as your hand gets comfortably colder . . . and still colder . . . while the rest of you remains comfortably warm . . . the pleasantly cool feelings in your hand get stronger . . . cooler . . . colder . . . and as your hand continues to get comfortably colder . . . it can tingle pleasantly with a cool numbness . . . and when I touch your hand . . . you can realize that the only sensation you feel is a cool numbness . . . and you can place your hand anywhere else on your body you'd like to feel that same cool pleasant numbness.

In the above example of glove anesthesia, the sensation of numbness is built around a suggested change in perception of temperature, that is, the coolness of the hand. Descriptively suggesting in sensory detail the experience of making snowballs barehanded, or the experience of reaching into the freezer for a tray of ice cubes, can help facilitate the experience of coolness and numbness.

Indirect Suggestions for Pain Relief: Metaphor and Interspersal of Suggestions

Indirect suggestions for pain relief are generally accomplished through the use of metaphor and the interspersal or "sprinkling" of suggestions for comfort throughout the process. In The Case of Vicki, the session I conducted with a terminal cancer patient that accompanies *Trancework* (4th edition), you may notice that I utilize many indirect suggestions interspersed with comforting words, both in the interview and the hypnosis session itself.

A well-known example of indirection comes from the work of Milton H. Erickson, M.D., who described in detail an intervention with a man named Joe suffering the painful ravages of terminal cancer. (He published this approach in the *American Journal of Clinical Hypnosis* in January, 1966, in an article called "The Interspersal Hypnotic Technique for Symptom Correction and Pain Control.") Joe had been a florist most of his life, a fact that Erickson utilized heavily in his use of metaphor. Joe was most adverse to the idea of hypnosis, based on common

misconceptions, but was willing to see Erickson for pain relief. Erickson's approach was, therefore, indirect, as you will see from the following abbreviated excerpt:

> I know you are a florist, that you grow flowers . . . I'm going to say a lot of things to you, but it won't be about flowers because you know more than I do about flowers . . . Now as I talk, and I can do so *comfortably*, I wish that you will *listen to me comfortably* as I talk about a tomato plant . . . One puts a tomato seed in the ground. One can *feel hope* that it will grow into a tomato plant that *will bring satisfaction* by the fruit it has . . . *it's so comfortable, Joe*, to watch a plant grow.

Erickson explained the success of the technique utilized with Joe in this way:

> Joe had no real interest in pointless, endless remarks about a tomato plant. Joe wanted freedom from pain, he wanted comfort, rest, sleep. This was what was uppermost in Joe's mind, foremost in his emotional desires, and he would have a compelling need to try to find something of value to him in the author's babbling. That desired value was there, so spoken that Joe could literally receive it without realizing it.

As we have seen, the value of indirection is evident when more direct approaches are not viable for whatever reason. The content of the metaphor matters for engaging the client's interest, of course, but the structure of the delivery, especially making use of embedded suggestions for comfort sprinkled liberally throughout the process, is what likely makes the experience potentially beneficial.

Case Example: Pain Management

The client is a woman in her late thirties who suffers chronic pain in her neck and shoulders, a consequence of a car accident in which she was rear-ended while stopped at a red light. She had several neurological evaluations prior to consulting me, and was told that the pain would most likely eventually diminish, though not in the near future. The client is a professional woman who, as a result of her injuries and residual pain, is currently unable to work. She is married, and in all other respects is a high functioning, competent woman. She did not evidence depression or anxiety beyond what would be considered normal for her circumstances. Thus, other than instructing her in the use of dissociative

techniques of hypnotic pain management over the course of a few sessions, further therapy was deemed unnecessary. The following transcript was from the fourth of five sessions.

> Okay, Katy . . . Are you comfortable? . . . (Nods) . . . Good . . . you can begin by taking in a few deep, relaxing breaths . . . and then whenever you're ready . . . you can just allow your eyes to close . . . so that you can begin now . . . to go inside . . . to be able to explore within yourself . . . find those most comfortable . . . thoughts . . . and feelings . . . that can allow you that very, very relaxed state . . . of mind and body . . . and you might remember . . . that you've experienced hypnosis comfortably with me before . . . and so I know from at least those experiences . . . as well as other hypnotic experiences you've had . . . both on your own and with others . . . that you know from your own direct experience . . . what it's like to *breathe comfortably* . . . and to *sit comfortably* . . . what it's like to get so absorbed in your own thoughts . . . that for a little while you forget . . . that the rest of the world is going about . . . its usual business . . . and one of the most soothing, relaxing recognitions . . . is that you really don't have to pay attention . . . to anything other than what pleases you for the moment . . . and the nature of conscious awareness is such . . . that it will naturally drift . . . from here to there . . . and to nowhere in particular. . . and wherever your consciousness drifts to at any moment . . . is just fine . . . whether you notice the routine sounds of the environment . . . or your own thoughts . . . or your own reactions to the different things that I say . . . or *the pleasing changes that take place in your body* . . . as your mind drifts . . . to the different awarenesses . . . and it can be very comforting to know. . . that that is the nature of the conscious mind . . . it can drift in . . . and out . . . it can notice and not notice . . . it can think and enjoy not having to think . . . or having to analyze critically . . . and so it can accept easily . . . the different possibilities . . . and while your conscious mind is certainly capable of processing . . . whatever it happens to notice . . . the part of you that is infinitely . . . more interesting and powerful is your unconscious . . . the part of you that can listen . . . and respond . . . even when your conscious mind drifts elsewhere . . . and your own unconscious . . . has abilities that your conscious mind sometimes forgets about . . . and when you're conscious of your unconscious mind's abilities . . . and can consciously analyze and access . . . the unconscious awareness . . . of what your conscious mind knows and doesn't know . . .

and what's easier to understand consciously than unconsciously . . . that's when you can appreciate the comfort of recognizing . . . how the mind and the body . . . can work so closely together sometimes . . . when that's important . . . and how other times . . . the conscious mind and the unconscious mind . . . can drift off elsewhere . . . and the mind's greatest ability is the freedom . . . to go wherever imagination wills it . . . and some people like the freedom of having their minds float through space and through time . . . others like to drift back in time to the comfort . . . of a very special soothing place . . . that's prominent in their memory . . . and is vivid in their senses . . . and the fact *that your mind can drift off* . . . way over there . . . while *your body rests so peacefully* . . . over here . . . is certainly an interesting experience . . . and sometimes people forget . . . how when their mind is drifting there . . . and their body is resting here . . . that their body can continue . . . to take care of itself . . . the automatic, unconscious . . . self-preserving . . . nature of your body over here . . . can give your mind the comfort over there . . . that allows a comfortable distance . . . that gives you the freedom to simply know how differently . . . you can feel . . . and when your mind drifts . . . that's when it's easy to not notice things that change . . . and I don't know whether you know yet that your breathing has changed . . . that your pulse rate has changed . . . and what it feels like to have . . . your body somewhere . . . close enough . . . to use if you want it or need it . . . but without impinging on the freedom . . . to float freely and comfortably . . . that light . . . airy feeling . . . and as you experience that interesting sensation . . . it can be very interesting to discover . . . how easy it is to forget . . . to notice where your left foot is relative to your right . . . until I draw your attention to it . . . what it feels like to wear a wristwatch on your left wrist . . . it's easy to forget . . . what it feels like . . . to have earrings in your ears . . . or to have the chair supporting your body comfortably . . . and you know and I know . . . that the mind and body . . . are closely related . . . and so are thoughts and feelings . . . and so is past and present . . . but you're also very aware that things change . . . and that awareness offers . . . a buffer . . . a comfort zone . . . that leaves just enough room between the present and the past . . . to make the present of comfort a gift that you can enjoy for months to come . . . and the comfort zone . . . that rests comfortably neck and neck . . . between the present and the future . . . where the present can be just comfortable enough . . . to allow a future of feeling better

. . . a day at a time . . . and you know that sometimes . . . people don't understand the relationship between past and present . . . anymore than they understand the relationship . . . between thoughts and feelings . . . but you have a feeling that your thoughts matter . . . and your thoughts about your feelings can allow your feelings some distance . . . a safe, comfortable distance . . . between what you experience now and what you felt then . . . and between your head and your body is a space of deep comfort . . . and what you're going to think tomorrow . . . but you'll have to wait until tomorrow . . . for your conscious mind to know . . . what your unconscious has already discovered . . . that it takes far more effort than it's worth . . . to move your hand . . . when it's so much easier . . . *you can be so much more comfortable sitting beside yourself so much more comfortably* . . . when your mind is here . . . and your body is here . . . and it's just enough distance to be *so much more comfortable than you thought you could be* . . . and you can be very aware . . . of that interesting sensation . . . of being separate from your body . . . and having all of yourself . . . in the experience of deep absorption . . . and you know and I know that as distant as your body feels on one level . . . it also feels close enough on another level . . . to be aware of its need to continue to breathe . . . in . . . and slowly out . . . so effortlessly . . . and so comfortably . . . and as your mind continues to float there . . . and your body continues to rest comfortably over here . . . your conscious mind can certainly be curious . . . about the *comfortable sensations of feeling the separation existing* . . . and you don't really have to analyze too carefully which part of you is the most comfortable at the moment . . . you can simply allow yourself instead . . . to enjoy the comfort that goes along . . . without really being sure . . . exactly. . . where your fingers are . . . or where your hair is . . . it can be very soothing to know that you can drift back . . . into an awareness of your body when you choose to . . . and that for the moment . . . you can simply enjoy the choice . . . of letting your mind be there . . . while your body rests comfortably over here . . . and I know that doesn't make much sense to your conscious mind . . . but fortunately. . . even though your conscious mind is very smart . . . your unconscious is a lot smarter than you are . . . and all the learnings of your lifetime . . . allow you the *comfortable position now* of being able to drift freely . . . far enough away . . . yet close enough to your body . . . to be so comfortable . . . in ways your conscious mind is only beginning to discover . . . and each time that you listen to this

> session or each time that you sit quietly with your eyes closed . . . your unconscious can add a new and interesting dimension to the experience . . . your overall awareness . . . of your ability to be as close to or as far away from . . . your body as you'd like to be . . . and when you recognize . . . powerfully within yourself . . . how much more control you have than you ever thought possible . . . then *you can enjoy the feeling of comfort* . . . that you really can rest comfortably . . . and that you really can heal surprisingly quickly . . . now that more parts of you have begun some work on the job . . . and so, Katy . . . I'd like you to take your time . . . and reorient yourself to whatever degree that you wish to . . . in order to bring . . . yourself out of hypnosis to whatever degree you wish . . . and by that, I mean that if you choose to keep your body absorbed while you bring your mind out of hypnosis . . . I can certainly understand that choice . . . or if you choose to bring your body out of hypnosis . . . but leave the comfort intact to enjoy the rest of the day . . . I can certainly understand that choice . . . and whatever choice you make . . . you'll certainly be aware . . . that when you allow your eyes to open . . . you'll be ready to get on with the rest of today in a much more comfortable state of mind and body . . . and that will certainly be an eye-opening experience.

The suggestion of being able to keep her body comfortably in hypnosis while in a "waking" state was one that Katy found especially useful in helping her carry out routine activities. The many suggestions throughout for disorientation and dissociation (mind and body, conscious and unconscious, past and present, and body parts) facilitated a very deep experience of hypnosis that permitted substantial relief from pain throughout her lengthy recovery.

Conclusion and Future Possibilities

This chapter provided an exceedingly brief overview of the subject of pain management with hypnosis. Despite its brevity, hopefully the point came through that treating pain with hypnosis is a complex, sophisticated, powerful, and rewarding endeavor.

The evolving genetic and neurosciences see new biological treatments on the horizon. These include a possible gene-therapy in which chronic pain sufferers will be injected with genes encoding for natural painkillers, new applications of transcranial magnetic stimulation (TMS) to "reroute" nerve connections, new methods of neurofeedback to retrain the brain's processing of pain signals, and the novel use of Virtual Reality (VR)

technology. The results of these new approaches have been quite promising, and speak to how new technologies can be integrated well with the oldest technology there is for having a beneficial effect on another: A kind and meaningful word.

17

UTILIZING HYPNOSIS WITH CHILDREN AND ADOLESCENTS

In this chapter, we will explore the use of hypnosis with young people. Can hypnosis be successfully applied with children and adolescents? Yes, across a wide variety of problems, including behavioral issues, medical problems, and emotional difficulties. Are there any special considerations for utilizing hypnosis with younger clients? Yes, and these are the focus of this chapter.

While every generation has had stressors to cope with, the evidence is substantial and growing that our young people are facing a variety of stressors that are harsher, more complex, and more frequent than previous generations faced. Kids face things now that their parents never did, from cyber-bullying to having to walk through metal detectors to go to school. Where and how do they learn the skills for coping with the challenges of today such as the power and invasiveness of technology, the brute force of the media, the omnipresent electronic eyes that can capture and instantly post online their most embarrassing or painful moments for the cruel amusement of others, the preoccupied parent(s) that is too busy to notice, much less help, with the ongoing challenges of life, or worse, contributes to them through bad behavior or indifference? It *is* tougher to be a kid today.

These challenges are merely the ones posed by a fast-paced and sometimes thoughtless culture. What about the challenges of "just" growing up? Learning how to think and how to learn, how to recognize and manage your feelings, how to evolve a self-awareness and self-acceptance for your unique attributes, how to learn and take care of your body's needs, how to conduct yourself with others and meet your social needs, discovering your sexuality and how and when to express it, discovering and developing your talents, setting and protecting your boundaries, and on and on. Add to this the additional burdens of having to cope with acute or chronic illness, unexplained symptoms, injury, loss,

rejection, disappointment, humiliation, self-doubt, and the many other inevitable adversities in life. It is tough to be a kid *any* day.

Given the many challenges of childhood described above, how can we best prepare a child to meet and, hopefully, transcend them? As parents, we know we can't prevent our child from facing the challenges of life: No matter how much you love your child, you can't prevent him or her from catching the flu, falling off a bicycle, failing to make the team, being teased by other kids, and the many other much worse things that happen in normal lives that simply can't be controlled. We can't carry all the responsibilities for what happens to our kids even if we desperately try: If you break your leg, no matter how much I might love you, you're still the one that has to wear the cast. Even if we could control circumstances and prevent adversity from affecting our child, then we inadvertently create a new problem in doing so: We leave the child woefully unprepared for how to skillfully manage and bounce back from adversity.

There are skills, however, that can make growing up easier. Not easy, necessarily, but *easier*. Pause for a moment and think about what some of those skills might be. Most certainly on the list are good social skills, good problem-solving skills, impulse control, frustration tolerance, positive coping and self-soothing skills, and appropriate support seeking, to name just a few. A great variety of such skills have collectively been called "emotional intelligence" and "social intelligence." Without exaggeration, these intelligences encompass many of the key skills that can be taught early on in a child's life that can make a lifetime of difference in terms of happiness and success. Positive Psychology has also made great and still growing contributions to our understandings of what fosters resiliency and promotes character strengths and virtues in our children.

What role might hypnosis play with children? When you consider the extraordinary amount of ongoing learning and growing that children engage in, we want to structure learning opportunities in ways that engage and empower the child. Hypnosis is ideal for these purposes. Working with children, with or without hypnosis, requires a more specialized skill set, however. There are many developmental factors that influence their responsiveness to treatment. Hypnosis, with its emphasis on recognizing and utilizing the uniqueness of each person, provides a strong but flexible framework especially well suited for meaningful interventions with children.

Structuring Age-Appropriate Suggestions Is Based on a Knowledge of Child Development

The task of the clinician remains the same across all therapeutic interactions: Build a therapeutic context, especially the relationship with the

client, that makes effective treatment possible. Here it begins with the acknowledgment that a child's experience, including style of thinking and processing information, style of communicating, and style of relating are different than an adult's.

Dan Kohen, M.D., is a pediatrician who is internationally recognized as a leading expert in pediatric hypnosis. He is former Director of the Behavioral Pediatrics Program at the University of Minnesota and is co-Director, along with pediatric psychologist Pamela Kaiser, Ph.D., of the National Pediatric Hypnosis Training Institute (NPHTI), the principal national organization in America for training professionals interested in learning to apply hypnosis with young people (www.nphti.org). Asked what special considerations are required in doing hypnosis with children, his immediate and forceful answer was:

> an in-depth knowledge of child development. If someone is going to work with children with hypnosis, they better understand child development *first*. Two year olds are not the same as infants and not the same as kids who are 7 or 12 or 14.
>
> (Personal communication, June 10, 2010)

Kohen's advice is, of course, sound. Offering suggestions to a child that are behind or ahead of their developmental capacities is an obvious formula for failure. Thus, the same points about conducting good therapy in general readily apply, from responding to the person (including his or her developmental level) rather than a diagnostic label, to looking for strengths and associated opportunities to enhance a sense of mastery, to hypnotically creating a context for teaching new skills and introducing generative perceptual shifts.

Knowing that the world of a child is different than the world of an adult requires an ability on the part of the clinician to set aside his or her adult frame of reference. A realistic approach to children comes about from studying and learning about children and their development. Based on that information, then, a clinician can design an age-appropriate treatment while still recognizing that age matters less than the child's capabilities. Thus, it helps to have an organizing framework for how to interview the child, establish a therapeutic alliance, and utilize that alliance as a primary force driving the therapy forward.

Kohen suggests assessing children on a number of specific criteria: Their cognitive ability, level of emotional development, degree of social development, and level of intellectual development. As an example, Kohen described how a child of five or six suffering with primary nocturnal enuresis (i.e. bedwetting at night) is unlikely to grasp the concept of "future." To a child of five or six, "the future is tomorrow,

or tonight. You talk about having a dry bed *tonight*, waking up *tomorrow* in a dry bed."

As with adults, children, especially older children, often know *what* they want (e.g. "I want my parents to get off my back") but not *how* to obtain it. The more globally someone of *any* age defines a goal (e.g. "I just want to feel good"), the less likely they are to reach it. Thus, the primary task of the clinician is to help build a bridge between where the child is now and where he or she wants to be. Identifying and developing the steps the child can follow and gently encouraging taking those steps is pivotal to co-creating the therapeutic context. Identifying the child's resources that can help facilitate this process is what makes the treatment personal, compelling, and more likely to succeed.

Engaging with the Child-Client and Establishing the Therapeutic Context

Dan Kohen has a deceptively simple approach he often uses with kids, typically opening up the interaction by asking, "How come you came here?" He said, "Kids know why they've come to the doctor. I just want to find out what they already know." He prefers this kind of spontaneous intake to receiving parental reports first that might bias his clinical impressions. To set the presenting problem aside and engage with the child, he'll ask questions such as, "What do you like to do that's fun? What do you like to do that you're not allowed to do?" Perhaps his most compelling question, though, is this one: "So, what do you do best?" At a time when the child may be feeling frustrated, hampered by some symptom, Kohen's question introduces a shift in focus from the negative to the positive. It presupposes and thereby indirectly suggests that the child is much more than his or her symptoms. It gives the child a chance to talk to a doctor about something other than a problem, expanding their relationship. It gives the child an opportunity to acknowledge a strength or resource and simultaneously gives Kohen the content basis for the therapeutic suggestions to follow.

Similarly, when simply asking questions about the child's history in general and problem history in particular, the way questions are phrased and the way the child's answers are responded to can be powerful in establishing a therapeutic context. Pediatrician Ralph Berberich described some useful examples of this point in regards to conducting routine examinations of children. Whether using toys or drawings with younger children to help identify and express their concerns, or using numerical rating scales with older kids to indicate their qualities of distress, the clinician can maintain an awareness to regularly communicate that symptoms are malleable, not fixed. How hypnosis is introduced

(e.g. perhaps as an exercise in imagination), how the child's role in the experience is defined ("you get to decide which channel you want to watch on your imaginary TV"), how the child's questions or fears are answered, and how the parents (and their anxieties about their child's issues) are dealt with are just some of the variables that give definition to the therapeutic context. The merits of hypnosis, whether applied directly or indirectly, will only be evident to the extent that the therapeutic context fully supports its use.

Hypnotic Methods Utilizable with Children

Hypnotic methods will necessarily vary according to a variety of factors, including the age, verbal level, personality, interests, responsiveness, and attentional style of the child-client. Bearing in mind that the induction is meant to focus and relax the client in order to build receptivity to the suggestions and experiences to follow, creatively utilizing what the client has offered is generally a more reliable path than using structured techniques.

One of the most common reasons why some practitioners come to question the responsiveness of young children to hypnosis is because of their active nature. Adults generally inhibit voluntary activity when in hypnosis, called "catalepsy." In contrast, children often fidget and outwardly appear restless even though they may be very involved with the clinician and what he or she is doing. If one has an inflexible expectation of how a client in hypnosis must look and behave, a fidgety child will seem unaffected by hypnotic procedures. Sometimes, perhaps much of the time, a procedure with children can encourage and make use of the child's energy by engaging him in some activity such as a game that distracts him or her from what the clinician intends to communicate. Observation of the child's interactions with his parents and siblings can provide a great deal of useful information about the kind of relationship—friend, ally, teacher, doctor—one may build with him or her in order to best help. Knowledge of his interests and emotional needs will also help one discover the best avenue of intervention.

An exceptionally creative example of an engaging approach to a child's problem is one of Milton Erickson's cases, described by Jay Haley in *Uncommon Therapy*. A young boy with the problem of enuresis was literally dragged in by his parents to see Dr. Erickson. Alone with the child in his office, Erickson angrily complained aloud about the audacity of the boy's parents. How *dare* they order him to cure the boy's bedwetting! Erickson went on complaining about the parents for quite some time, and meanwhile the boy was entranced by this strange doctor's unexpected rants against his parents, whom, *not* coincidentally, he was pretty angry with, too. When Erickson finally said he'd prefer not to deal

with the boy's bedwetting at all, he shifted their "conversation" to talking about the muscle coordination necessary for the sport of archery, an interest of the boy's. By talking at length about growing up and the development of muscle control, Erickson was able to indirectly offer suggestions for the boy establishing control of his bladder muscles. Erickson's unusual intervention was a successful one, and it began by utilizing the boy's anger, first forming an alliance with him against his parents, or so it seemed, and then using the alliance to teach something the boy wanted to learn that was a perfect parallel to solving his problem. Such a case example illustrates points made earlier about using states of absorption to build new associations within the client, even associations not immediately in the person's awareness.

Working with Younger Children

Use of Play: With younger children play can be an experiential means of connecting with a child and building responsiveness. Dr. Pamela Kaiser, a pediatric specialist and hypnosis expert who is co-Director (along with Dan Kohen) of the National Pediatric Hypnosis Training Institute, suggests that children under age eight often prefer "bridging" toys, such as a shy turtle finger puppet hiding in its shell. The turtle has a story to tell while playing with the puppet, and the therapeutic message may get across through the telling. Holding a doll or stuffed animal, or playing games of any kind the child finds engaging, can promote the absorption that leads to greater responsiveness to your suggestions.

Use of Imagination: Some experts have suggested the use of television imagery, in which children are asked what their favorite TV show is and are then asked to imagine watching that show. The show can be general or may include a suggestion to watch a character solve a similar problem. When the program is over they are urged to tell the therapist all about it. A similar technique is to ask the child to role-play in his or her imagination the part of a favorite character.

Magic Tricks: The use of magic tricks to engage attention and build a connection is another technique. Making things "disappear" is a thinly disguised suggestion for symptom remission.

Stories: As child therapist Joyce Mills said, "*Play* is the language of children, and *story* is the language of play." Stories capture the imagination of children. Stories are wonderful at any age, but obviously must be age appropriate and told in ways that appeal to the unique attributes of the individual. Some kids will get the lesson embedded in the story right away, some with a little encouragement to give the story

some thought, and others will need some help grasping the message. Does it ruin the story to explain it? There is no evidence to support this concern. To the contrary, for it is a potentially powerful suggestion to affirm a helpful new possibility: "So, when you face that difficult situation, you can instantly remember this story I told and it will remind you that you can do something similar in order to feel better."

Working with Older Children

Formal Hypnosis: Older children and adolescents can usually be engaged in a more formal hypnotic process. Suggestions for focusing, relaxing, and getting into a good frame of mind are usually readily accepted.

Focus on Breathing: The breath is a natural and easy focal point. Suggestions to "just notice the breath and to come back to it whenever the mind wanders" is a good focusing strategy, one shared by practitioners of mindfulness.

A Safe Place: Creating an internal safe place, someplace inside to go to can be a positive coping mechanism when used as a vehicle of detaching from stressful feelings or circumstances.

Success Imagery: Create or co-create a sequence of behavior the child can follow that will lead to success in some important area of his or her life. Suggestions to relax, focus on this new approach, and "make it a part of you" can help establish the quality of positive expectancy that motivates the client to experiment with new ideas and helpful behaviors.

Accessing Good Feelings: Suggestions to go to a favorite place (a concert, a party, a vacation spot) and recapture the good feelings of that place and time.

In their comprehensive textbook, *Hypnosis and Hypnotherapy with Children* (2011), pediatricians Dan Kohen and Karen Olness detail a wide variety of induction and treatment processes. All share the same optimism and permissiveness that transmits the messages to kids that *they matter* and *they're capable of improving their lives* by using more of their personal resources. This is the core of self-mastery, and it's one of the greatest gifts a clinician can share with a young person.

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RETHINKING "RESISTANCE" TO HYPNOSIS, POTENTIAL HYPNOTIC HAZARDS, AND ETHICAL GUIDELINES

By now you have most likely had the experience of performing hypnotic inductions, facilitating hypnotic phenomena, and structuring and delivering suggestions to other people during hypnosis that were meant to be helpful to them. As you have no doubt discovered from your direct experience, peoples' responses to your hypnotic processes can range from minimal to dramatic. And, the person who responded minimally in one session might well respond powerfully in the next, or vice versa. You can now better appreciate why assessing hypnotic responsiveness has been the subject of serious inquiry as researchers and clinicians attempt to understand why people differ so substantially in their abilities to respond. Hypnosis as a vehicle for delineating individual differences is a very active and interesting domain of research into the areas of human personality and cognition.

The main focus of this chapter, though, is addressing these two questions: How shall we interpret either a lack of responsiveness to hypnotic suggestions (i.e. an inability to manifest a particular suggested hypnotic phenomenon or an inability to integrate and apply a suggested resolution to a problem) or, worse, a negative response? And, how might we effectively respond to those individuals who are not particularly responsive to our hypnotic procedures?

Clinicians' responses to minimal or negative responses to their hypnotic suggestions have ranged from labeling unresponsive clients "resistant" to labeling the clinicians inept (or worse). These extreme views reflect interesting attributions (i.e. explanations) that reveal a pattern called "attributional style," a person's characteristic way of explaining the meaning of life events. An *internal* attribution is one that suggests the

reason something happened the way that it did is somehow "because of me." An *external* attribution says, in essence, that it happened the way it did "because of the other person" or "because of the circumstances."

In the realms of hypnosis and psychotherapy, the attributions that clinicians make for unsuccessful hypnosis sessions or therapies tend to be external, that is, it was the client's fault. Clinicians routinely say things such as, "The person wasn't ready for change," "The person was getting too many benefits from having their symptoms" (called "secondary gains" and refer to things such as getting extra attention and being able to avoid uncomfortable situations), "The person was too threatened by the therapy," and the ever-popular, especially in hypnosis, "The client isn't hypnotizable," or, "The client is resistant." Might any of these external attributions for a lack of client responsiveness be true at times? Yes. But, might they also be blaming the client unfairly at times for what may be a limitation in the clinician's approach? Yes. I strongly encourage clinicians to recognize, *before* they reflexively declare a client resistant, that they may have played a bigger role in the client's responses than they at first realized. *When there are two people (or more) in an interaction, there is a shared responsibility for the outcome.* This point is true enough to discourage entirely internal attributions as well, that is, "It's totally my fault the person reacted that way."

Resistance in Hypnosis

The literature pertaining to clinical hypnosis has generally had quite a lot to say about the issue of client resistance. Historically, resistance was considered to be a manifestation of the client's defenses for coping with sensitive or unresolved intrapsychic conflicts, and thus perceived as a psychological vulnerability of the client's. "Proper" treatment was a confrontational inquiry about the appearance of the resistance, first acknowledging it, next attempting to uncover its origin and function, and then collaborating on its resolution.

From this perspective, resistance was always the client's problem. When it interfered with the progress of therapy, as it inevitably did, the client was blamed as the saboteur. Accusations and interpretations were thrust at the client who obviously "really didn't want to change," or perhaps was "too resistant to succeed."

Resistance can be described, for all intents and purposes, as a force that works against the aims of therapy. Resistance has long been recognized as an integral and unavoidable component of the therapeutic process, and virtually every therapeutic approach I am aware of has roughly equivalent recognitions of its existence. Only the rationale for its presence and the techniques for its acknowledgment and treatment differ from approach to approach.

Describing resistance as a force that works against the aims of therapy doesn't place blame on either the clinician or client. Rather than view people who come in voluntarily (dealing with persons in treatment involuntarily differs in some ways) for help as not really wanting help when we try things that don't work very well, it seems much more practical to view resistance as a communication from the client about his or her limitations in relating to the world (of which the clinician is obviously a part). *In other words, resistance isn't a fixed property of the client, but rather can be viewed as a dynamic communication indicating the limits of what the client can and cannot do.*

It is frequently the case that the client is simply making a choice at some level not to respond in the desired way to suggestions for any of a variety of other reasons, each of which has a common denominator: *The suggestion simply does not fit with the person's experience, and, in fact, may even contradict it.* Resistance may be viewed as an *inter*personal statement which says that whatever therapeutic strategies and maneuvers are being performed are not acceptable at some level(s) to the client.

Resistance is a real force to reckon with in treatment, and can be tied to one or both of the two main areas of treatment: resistance to hypnosis, and/or resistance to therapeutic progress.

Resistance to Hypnosis

Origins of resistance to hypnosis can be numerous. Probably the most common point of origin is the fear of what will happen during hypnosis. If the client is misinformed about the nature of the hypnotic experience, he or she may fear it. Misconceptions may be all that someone has about hypnosis. If you thought you might divulge sensitive information, be coerced into doing things against your will, or be controlled by someone you really don't know much about, would *you* want to be hypnotized?

Resistance to hypnosis may also arise because of past failures associated with it, either from personal experience or the experience of credible others. Furthermore, resistance may also arise from negative feelings toward the clinician (thus highlighting the value of rapport), and from contextual variables such as the immediate environment, the client's mood, health, and even the weather (such as sinus headaches triggered by weather conditions).

Some of the resistance to hypnosis, however, is attributable to the quality of the clinician's suggestions, specifically how well they match the client's experience. If I give a client a suggestion to feel his or her muscles relaxing, and he or she isn't experiencing that sensation, then my suggestion does not fit with his or her experience and is easily rejected. Furthermore, your client may be in so comfortable a state of mind and body that your suggestions for specific responses, simple as they may

seem, are too much a strain for him or her. Even beyond that, your client may be giving him- or herself suggestions that are more meaningful than yours! Why shouldn't the client be free to have that independent experience without being deemed "resistant"? To expect unquestioning obedience on the part of the client is wholly inappropriate in the clinical context, where collaboration in the service of therapeutic goals is vital.

Resistance to Therapeutic Progress

Origins of resistance to the aims of treatment can be numerous. Blocks may arise because of the fear of change, since for many people change is considered a risky, scary process of giving up the known for the uncertainty of the unknown. Small changes can gradually give rise to big changes in one's life, and for many that is a frightening prospect. The reluctance to let go of the old, albeit dysfunctional, but familiar is a classic sign of resistance. Most often, perhaps, is what seems like resistance that comes from a belief that nothing *can* change, a deeply embedded belief that no amount of effort can truly make a difference, so "why bother to try?" Hopelessness saps the will to fully engage in treatment. Learning how to motivate people is a complex art, a clinical skill beyond the scope of this book. Learning techniques of motivational interviewing, behavioral activation strategies, feedback gathering, and hypnotic strategies for building positive expectancy can go a long way in improving treatment results.

Responding to Resistance

How to deal with communication deemed "resistant" is, of course, a function of how you conceptualize it. How you define resistance and to whom you reflexively assign responsibility for it will determine whether you tend to view resistance as a property of the client, a property of the clinician, or an interactional outcome of the two.

Accepting resistance as a valid communication from the client prevents having to ascribe blame to one or the other person in the relationship. More important, it paves the way to elevate the relationship to a new level of collaboration through what Milton Erickson called the "utilization of resistance." Erickson's unique perspective on resistance makes a great deal of sense. Better yet, it *works* by diffusing and redirecting people's resistance to hypnosis and therapy.

The basic utilization formula of "accept and utilize" applies here. In practice, it takes the form of being able to skillfully *accept* the client's response as a valid one while developing a way to *utilize* the response in service of further suggestions. For example, if Erickson was performing an arm levitation on someone, offering suggestions for his or her arm

becoming lighter and lighter, and the person reports experiencing his or her arm as getting heavier and heavier, Erickson would say something like, "That's right, that's fine, and your arm can get heavier still." *By accepting the client's response as a valid one, it can be built upon, redefining a seemingly resistant behavior as a cooperative behavior*. If the goal was to get arm levitation, that is, a sensory alteration in the person's arm, then a "heavy arm" is an acceptable alternative in the same realm of response. It just wasn't a compliant one with the clinician's arbitrary demand for levitation. If the clinician defines whatever the client does as cooperative, then where is the resistance? Finding a way to make the nonconforming behavior seem an asset to the person can also change the feeling he or she has attached to it in favorable ways.

Another technique for managing resistance is more of a preventative one: Employing process suggestions, that is, suggestions without specific content. By not asking for a specific response and covering all the possible responses, whatever the client does is cooperative. For example:

> You can notice the temperature in one of your hands, and as you continue to breathe in and out at your own comfortable rate, you may notice how your hand becomes warmer, or perhaps cooler, or you may notice how the temperature remains the same.

The person's hand is going to either get warmer, cooler, or stay the same. What other possibilities are there? Therefore, *any* response the client generates can be accepted and utilized as a cooperative one.

Erickson was of the belief that clients need to be able to resist directives in order to maintain a sense of autonomy, rather than adopting a position of mere obedience to authority. Thus, one of the strategies he often employed was offering the client multiple directives simultaneously so that the client could resist one and accept the others. For example, I may direct a client to, "Sit down, close your eyes, uncross your legs, take a deep breath, focus on my voice, and remember an experience from childhood you can talk about." By offering so many directives at the same time, the probability is I will get most or all of the desired responses. Even if the client resists one, I will have gotten the other responses and can re-suggest the other in a different form later if I care to.

Notice also in the above suggestions the phrase "an experience . . . you can talk about." The implication to the client is that he or she can refuse to talk about some experiences, allowing him or her to resist telling me something while simultaneously following my guidelines.

Another technique for managing resistance is the strategy pioneering family and directive therapist Jay Haley described as "encouraging resistance." When you encourage resistance, usually with an intentional

use of negative suggestions, in order for the client to resist resisting, he or she must cooperate (sort of a "reverse psychology"). For example, if I'd like the client to sit down, but anticipate that a straightforward directive to do so will be met with resistance, I can instead suggest: "You don't have to [pause] *sit down*. I don't expect *you can make yourself comfortable* [embedded command] here. It will be much better for you to stand just as you are.

By encouraging him or her to resist sitting and remain standing, the person's resistance to me can now allow him or her to be seated. Either way, sitting or standing, the person's behavior is defined as cooperative (sitting is what I want him or her to do, standing is what I've directed him or her to do).

Responding to a client's resistances in a way that is accepting and nonconfrontational requires considerable flexibility and respect for the integrity of the client. Not many people like to be told exactly what to do, so commanding someone to respond obediently, as in direct authoritarian suggestions (i.e. "You *will* do this"), generally encourages resistance. A helpful guideline is this: *The more resistance you anticipate getting or actually derive from the client, the greater the need for permissiveness and even indirection in your approach*. As psychologist Jeffrey Zeig pointed out, if a client is going to be obedient and highly responsive, the use of indirect techniques isn't really necessary. But when you have someone who is wary, or uncomfortable with hypnosis and/or therapy, or simply isn't very cooperative for *whatever* reason, then permissiveness and indirection become invaluable mechanisms for attaining increased responsiveness.

Resistance to change seems a basic feature of humankind. We spend so much of our lives trying to build a ritualized pattern of behavior so as to expend the least amount of physical and mental energy, and after developing such a pattern we frequently complain of "being stuck in a rut."

Resistance doesn't always show up in detectable ways (some forms are so unconscious and subtle), and resistance can't always be used in the service of change. Some clients simply will not change, others only slightly. The discussion of resistance in this chapter is intended to present the idea that much of resistance that has usually been thought of as *intra*personal is actually *inter*personal, arising from a demanding, or somehow incompatible approach to the client.

Potential Hypnotic Hazards

One of the misconceptions I discussed briefly concerned the potential harm to a client undergoing treatment through hypnosis. I made the point

then that hypnosis could be applied skillfully and helpfully, or it could be misused and potentially cause harm to the client. In this section, I will briefly consider some of the potential hazards associated with doing hypnosis that make it absolutely essential to exercise caution and sensitivity in its use.

I have purposely left this discussion until near the book's end. I have clearly mentioned many times the responsibilities a clinician has to a client, and the range of skills necessary to function competently and ethically. I have tried to inspire rather than frighten you with scary hypnosis stories. Are there such stories? Yes, there are. And when you hear them, you will likely recognize that when problems have arisen, they haven't been due to hypnosis itself, but rather to the way someone who was either ignorant or malicious applied it. I cannot emphasize this point enough. *There is a high level of consensus after all these years among hypnosis researchers and practitioners that hypnosis holds no inherent dangers when used appropriately by a well-trained clinician.* Paraphrasing Martin Orne, the sensible guideline should be that *if you're not qualified to treat the problem* without *hypnosis, then you're not qualified to treat the problem* with *hypnosis*.

The potential hazards people most associate with hypnosis, rightly or wrongly, include: spontaneous regressions and intensely emotional reactions, symptom substitution, confabulations, and failure to remove suggestions. I will address these hazards and whether and how each might be a legitimate concern. Before you begin to fantasize unspeakably horrible possibilities, let me assure you of one thing: These are clinical issues that arise in using *any* treatment approach, and require good training to manage them as one would manage any such clinical issue.

Spontaneous Regression and Strong Emotional Reactions

This represents the most common hazard of doing hypnosis, and it isn't a question of *whether* you will encounter it, but *when*. If you have been practicing your skills in hypnosis with different people, then you probably have had the experience of discovering that people respond in unexpected and even unusual ways even to the most straightforward, seemingly one-dimensional hypnotic suggestions. *The fact that people will interpret what you say from their own frame of reference, and will therefore associate meanings to what you say that you never intended, is a given in doing clinical hypnosis*. It's to be expected, planned for, accepted, and utilized. Sometimes the unexpected responses you get are actually *better* than what you had hoped for: The person finds a simple word, phrase, or concept you mentioned deeply enlightening and transformative, and radiates that wonderful perception. When that happens, it's *wonderful*. Other times,

however, the unexpected responses you get are almost the opposite: The person finds something you said offensive, threatening, insensitive, or merely irrelevant. Sometimes it's because what you said really *was* offensive, threatening, insensitive, or irrelevant.

More often, though, the person's association to what you said was unique (i.e. idiosyncratic), and simply couldn't have been predicted by you or anyone else. For example, you might offer suggestions for the purpose of inducing hypnosis employing imagery, meant to be soothing, of being at the beach. As the person begins the process of relaxing, he or she nearly has a panic attack, simply because you didn't know that he or she had nearly drowned in the ocean as a young child. And that's even after you had the foresight to ask, "So, would it be all right to begin this process by having you focus on relaxing at the beach?" and the person replied, "Yes, that's fine." Could the person really have forgotten that drowning episode, only to have it come up seemingly out of nowhere as you start to do hypnosis? *Yes*.

Memories can come up through structured age regression sessions, but most often they simply arise spontaneously for people during hypnosis, hence the term "spontaneous regression." That's natural and to be expected. After all, the events in a person's personal history have shaped their very lives. Sometimes the memories are pleasant ones, but sometimes what comes up are unpleasant memories that surface dramatically and with considerable emotional intensity. Historically, these have been termed "abreactions." Personally, I find that label too pathologizing, so I prefer to call it what it is: *getting emotional*.

A spontaneous regression back to some unpleasant memory is an indicator of what is commonly called "unfinished business," personally significant experiences that didn't reach an adequate resolution and thus require further attention. Sometimes the suppression or repression of significant memories is so great that the material remains out of consciousness even during hypnosis and instead of there being an overt abreaction, the person complains of a headache or some such discomfort during or after hypnosis.

Even the most skilled clinician cannot know what landmines are in the client's unconscious waiting be tripped in doing therapy or hypnosis. What seems like a neutral term to one person may be the trigger to some intense personal experience for another. Therefore, the possibility of doing hypnosis without ever experiencing strong emotional reactions is very unlikely. Be ready by having good training in handling intense affect, the kind of training you are most likely to receive in advanced clinical workshops on working with people who have endured traumas of one sort or another. This book doesn't teach these skills, but alerts you to the need for obtaining them.

Any sign of discomfort on the part of the client signals a need for you to clarify what's going on with him or her. "Checking in" with the client as I have encouraged you to do many times is a good thing to do anyway, since one of the things well established through the research is that someone can report being distressed even while maintaining an outward appearance of seeming calm and comfortable.

The first and foremost thing to remember in dealing with spontaneous regressions and strong emotional reactions is this: *You can feel comfortable directly asking your client to describe his or her experience.* Give protective suggestions, and be supportive of his or her experience, using the general "accept and utilize" formula. *Allow the reaction, but be calming and helpful to the client in helping him or her reach a new perspective on the experience.* (After all, that's what therapy is for, isn't it? One can't change the past, only attitudes toward it.) Use calming suggestions, make sure your voice is soothing and confident, and move in a casual way as opposed to abrupt, rapid movements. In general, the best thing you can do is use hypnosis to resolve the situation and attain some closure. You do that by first supporting the emotional release, and then guiding the client's attention in the direction of considering new perspectives, developing necessary coping and transcending resources, and helping the person to integrate them. Even if your client's hour is up, your responsibility to that person isn't over. Make certain he or she can leave in a collected manner.

If a client opens up with some sensitive information that you are simply not equipped to handle for whatever reason, I suggest that you make sure the client is immediately referred to an appropriate helping professional (thus the value of a good referral list). A suggestion such as the following may be employed in such instances:

> And you've become aware now of some feelings that are very strong and some memories that are needing some attention . . . and you can know comfortably that as these images and feelings drift into your awareness that they can be handled skillfully and that you can help yourself by keeping this information in a safe place within you until they can be brought out with the person best able to help you with them, and so you can let these images and feelings drift to the safe place within you until you are ready to share them when the time is right.

Essentially, the suggestions above are telling the client that he or she can "put the information away safely for now and deal with it later" in a context that is more appropriate. Such protective suggestions can have a very soothing effect on the person, and can build even greater trust for

your open acknowledgment of your limits in intervening. Follow-up to make sure the person gets in to see someone qualified right away is critically important, as is staying aware of and supporting his or her overall well-being.

Symptom Substitution

Historically, the most common criticism leveled against the use of hypnosis concerned the potential for "symptom substitution." Symptom substitution refers to the onset of a new symptom, perhaps, but not necessarily a worse one, in the place of the old symptom removed during treatment.

In order for one to charge hypnosis with this potential liability, hypnosis must be viewed as a symptomatic treatment as opposed to a more dynamic or depth-oriented approach. The dynamic theory is that there is a psychic energy associated with internal conflicts that is relieved by the development of a symptom—an outlet for the energy. By removing the outlet, the energy must be redirected elsewhere and a new outlet developed. Other "symptomatic" approaches have faced this same charge.

In the case of hypnosis, there is a twist that makes the response to the criticism somewhat complex. Hypnosis *can* be used superficially and symptomatically (scripted approaches, for example), and, in my opinion, is used this way all too often. Simple, direct suggestion aimed at a target symptom can be used with no real understanding of the relevant deeper clinical issues. Without an understanding of the role of a symptom in a person's life and the related dynamics, symptom substitution can be (but isn't necessarily) an unwanted, unexpected outcome.

The primary issues associated with the potential for unwanted symptom substitution are first, a symptom's function (*if* it has one, and it is not safe to assume it always does), and second, the associated secondary gains, *if* any. The idea of a symptom frequently, but not always, serving a useful purpose even though it may be uncomfortable to a person is probably not a difficult idea to grasp. To view it as a way of coping, a way of controlling others, a way of getting what one wants, a way of avoiding responsibility, and a way of maintaining a stable position in an erratic world are all ways of giving the symptom a special respect for its value instead of derogating it as stupid and meaningless. The idea of responsible treatment is to acknowledge the function of the symptom and to develop alternatives that will satisfy the underlying dynamics in a more constructive way.

Closely related is the issue of "secondary gain." Secondary gain refers to the "payoff" for a symptom, that is, the advantages the symptom allows the person. The payoff is rarely, if ever, a conscious one. Rather,

it is an unconscious system that supports the symptom's existence. Realistically, the symptom has an impact on the person's personal and interpersonal worlds, including his or her family, friends, spouse, therapist, and whoever else might be in the sphere of the symptom's influence. If the impact is one that encourages the symptom, the symptom is easier to maintain. Symptom substitution need not occur if the client is educated about treatment, and if the symptom's purpose(s) and secondary gain(s), if any, are identified and resolved within the treatment process. If symptom substitution should arise for some reason, the new symptom can be addressed more directly in terms of its origin, purpose, secondary gains, and meaning to the client.

Developing an appreciation for the complexity of these therapeutic issues will facilitate not only clinical hypnosis in particular, but therapeutic intervention in general. The issue of symptom substitution associated with the use of hypnosis has declined in recent years as clinicians better understand treatment dynamics as well as the dynamics of clinical hypnosis. Not only is symptom substitution not inevitable, it should be regarded as an uncommon phenomenon.

Confabulations

Having described the vulnerability of memory processes to suggestive influences previously in a number of places, it seems unnecessary to go into great detail about this particular hazard. I do, however, want to reiterate some of the key points anyone doing hypnosis should know about this issue.

When someone doesn't remember some event or some fact, he or she may fill in the memory gap with misinformation (i.e. fantasy material, inferences, misremembered information, etc.) without realizing he or she is doing so. The material projected into the memory gap is called a confabulation. Confabulations may be self-generated, or they may be suggested memories that may not even be directly suggested, but merely implied. In the course of hypnosis, when the lines separating fantasy from reality may be even more blurred, the danger is increased that someone will mistake a confabulation for truth.

The means to avoid making the mistakes associated with the suggested memory problem should be obvious: Don't infer a history of abuse or trauma where none is stated, don't offer leading suggestions to a client in hypnosis about what and how to remember, don't assume a "root cause" for every problem, do know the workings of human memory, do know the limits of hypnosis, do know that memories can be detailed and emotional and still be wrong, and be clear about the distinction between supporting versus validating your client's memories.

Be reminded, there is no technology currently available to distinguish between truth and confabulation. No clinician doing hypnosis should hold the terribly erroneous belief that hypnosis will reveal the truth.

Failure to Remove Suggestions

A common fear expressed to me by students new to the field concerns the failure to remove suggestions. With all the things there are to occupy your mind while doing hypnosis (formulating meaningful suggestions while closely observing and utilizing your client's responses), what happens if you forget to remove a suggestion? Will your client stay age-regressed indefinitely? Will your client stay anesthetized and live life "comfortably numb"? The answer is no.

The failure to remove suggestions *is* a somewhat serious concern. It is possible that a suggestion may have a delayed or hidden effect, and so your suggestions to the client, if meant to be temporary, should be structured to say that they are temporary. While it is rare for a suggestion to linger beyond the time it is needed, it remains important to deliberately annul suggestions. Why are hypnotic responses generally temporary? Because they are "state specific." In other words, they are operative only as long as the person is in hypnosis. There is little or no carryover of the hypnotically obtained responses into the client's "waking" state *unless* there has been a post-hypnotic suggestion to do so. Without the post-hypnotic suggestion (either from the client to him- or herself or from the clinician) to carry the hypnotic response over to some other context, the response is just an interesting one observable only temporarily during hypnosis. Thus, if you forget to remove suggestions given during hypnosis at the end of the hypnosis session, the suggestion is highly likely to dissipate automatically upon disengagement.

If the exception occurs and the client continues to experience a suggestion that was not intended post-hypnotically, it is a safe bet the client has given him- or herself the post-hypnotic suggestion to do so (perhaps by simply assuming the suggestion was supposed to endure). Hypnosis may be re-induced and the suggestion directly removed if so desired.

Another possibility to consider in such instances is that the suggestion might have some special significance to the client or he or she would not have maintained it. Hypnosis may be re-induced in order to explore its significance. Suggestions are generally followed only as long as they are appropriate, that is, beneficial.

The point to remember is that any suggestion can be accepted or rejected, and the maintenance of a suggestion not intended to exist outside of the hypnotic experience represents a choice at some level by the client. Suggestions will most probably dissipate on disengaging from

hypnosis, but in the exception where this does not occur, the client may be re-hypnotized and the suggestion removed in whatever manner is deemed appropriate.

Ethical Guidelines

The descriptions of potential difficulties that may arise in the use of hypnosis indirectly comment on the need for formal education in the dynamics of human behavior, patterns of mind–body interactions, the intricacies of treating various clinical conditions, and the need to be deeply self-aware of one's own issues, needs, and motivations, as well as knowing one's own limits in providing therapeutic interventions to others.

There are many ways to get into trouble in clinical practice, virtually all of them avoidable by being well-educated and emotionally intelligent enough. Every professional association in the United States, and as far as I know, internationally as well, has a code of ethics. The code of ethics spells out what constitutes appropriate and inappropriate conduct in exhaustive detail, and each person is tasked with knowing and honoring the code.

I assume that you are a helping professional and that you have only the best of intentions for your clients. I also assume, therefore, that the understandings of human nature and the capacity for interpersonal influence you learn here will be used in benevolent and even noble ways. Therefore, there is only a superficial coverage of the most basic ethical guidelines provided here.

The number one priority is to help, not hurt. If you feel that, for any reason, you are unable to work well with either the person or problem presented to you, then evaluate honestly whether it would be best to refer that person elsewhere, and do so when appropriate.

A professional's responsibility is to educate, not show off. Hypnosis lends itself to both. It is my sincere hope that the hypnotic phenomena you are learning to induce are used and/or demonstrated only in appropriate clinical or educational settings. Furthermore, I would hope you are able to distinguish between your personal interests and what you teach your clients.

Have your relationship with your client(s) as clearly defined as possible, including the nature of the intervention, the duration, the cost, the expectations, evaluation points, and so on. Involving and educating your client will almost certainly make for a better, more productive relationship, and will also meet the legal requirement for an informed consent to treatment.

Do not go beyond your range of expertise, or misrepresent yourself. Human problems are very complex and can't be reduced to a paragraph of dynamics. If you feel you are out of your league when presented with

a problem, refer the person to someone better able to meet his or her needs. Discussing cases with colleagues, continuing to get your information updated, and having peer supervision may help you keep your boundaries clear.

Presenting misinformation and/or the use of indirect techniques will sometimes be judged to be the best clinical approach. Be careful—such approaches can help a client, but they can also backfire. Have alternatives prepared every step of the way by thinking your intervention strategy through and taking all steps necessary to prevent untoward effects. In other words, be prepared!

Always involve, when appropriate, the proper qualified health professionals. When working on a physical symptom, for example, unless you are a physician you should have a medical referral and medical clearance to work with the problem. Practicing medicine (psychology, nutrition, etc.) without a license or without advanced clinical training, knowledge, and backup is illegal, unethical, and irresponsible.

There are many, many other considerations that go into conducting a competent, legal, and ethical clinical practice. Clinicians are generally well-intentioned people who want to do the highest quality work with their clients, but they sometimes get into trouble when they underestimate the complexity of what they're dealing with, or when they don't know the hazards of a particular type of problem or treatment approach, or when they overestimate their skills.

Final Thoughts

It is a formidable challenge to condense the fascinating, rich and complex field of hypnosis into only its *essentials*. As you can appreciate, many interesting facts, methods, and scientific studies were excluded from this book in order to keep it brief. But, I have covered what I believe to be many of the fundamental necessities about hypnosis in order to inform you, guide your practice, and, hopefully, inspire you to learn more. Focus on the positive possibilities . . .

Appendix

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International Journal of Clinical and Experimental Hypnosis (www.ijceh.com)

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bold type=extended discussion or term highlighted in text