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Indirect Hypnosis

The Training Manual for the Free BHR One Year International Online Certificate Course in Indirect Hypnosis, Ericksonian Hypnotherapy and NLP.

By Stephen Brooks

Edited by Dr Colin Baron & Dr Andrew Bradford

British Hypnosis Research

Stephen Brooks has a lifetime's experience of using indirect hypnosis with severe problems and difficult patients. Inspired and encouraged by top American Psychiatrist Milton H Erickson, he was the first person to introduce Ericksonian Hypnosis into the UK in the mid 1970's. Since then, his own innovative indirect therapy techniques have had a major influence on the health professions both in the UK and Europe and have changed forever the perception of hypnosis and how it should be used within therapy.

He is founder of British Hypnosis Research (1979) and the British Society of Clinical and Medical Ericksonian Hypnosis (1995), both major training bodies for the caring professions. His two-year Diploma courses became the standard training for thousands of health professionals and over a period of 15 years he taught indirect hypnosis courses in over 27 major British hospitals. His Diploma courses also became the standard training for hypnotherapy associations and organisations in France, Belgium, Spain, Ireland, Malaysia and Singapore. In 1991 he was awarded special acclaim when archive recordings of his work were preserved in the British National Sound Archives.

He specialised in innovative approaches to Indirect Hypnosis with an emphasis on demonstrations with real patients during his training courses, something that many trainers are still afraid to do. A common thread in Brooks' work is his humour, compassion and creative approach to therapy and his deep respect for the unique needs of the patient. He treated problems by spontaneously doing what is most unexpected but always most appropriate for the patient at the time, quickly tailoring each therapy session to the patient.

He is now responsible for the design and teaching of the British Hypnosis Research online academic hypnosis course which is available to serious

students of hypnosis free of charge. He also teaches internationally in several countries.

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The Art of Indirect Hypnosis

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Response attentiveness
Matching predicates
Sensory re-presentation
Sensational representation

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Well formed outcomes

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Stephen H Brooks

Foreword by Igor Ledochowski

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Stephen originally learned his craft at one of the old schools. He was bright enough to realise the limitations of the old system and, dissatisfied, he sought better alternatives. After much searching, he eventually found the legendary Erickson and began to learn new ways of using hypnosis to transform people. Stephen became very good with people. His practice filled to cover six different towns.

In time he mastered his craft. Like every other true master, he then started to develop the field of indirect hypnosis in exciting new directions. Many people, including health care practitioners from around the globe, came to learn from Stephen. His Diploma Course in Indirect Hypnosis became the gold standard in six countries.

His series of ebooks, audio lectures and workshops covers Stephen's patterns and discoveries in indirect hypnosis and minimal therapy. They cover over thirty years of experience in clinical hypnosis. His publications belong in every therapist's practice for two reasons:

Firstly, his archive of training materials is one of the most comprehensive sources of material to cover all of the technical aspects of indirect hypnosis as applied to therapy. It covers more than the technical aspects of inducing trance, it shows you how the pieces fit together in a therapeutic context.

Secondly, you will find within his material a way of being with your patients that is both respectful and powerfully effective. Stephen has drawn on his experiences of Buddhism and a deep respect for nature to shed light on our human nature. His approach is pragmatic, humanistic and in many ways deeply spiritual. His philosophy is at once sophisticated and simple, like his lifestyle: people are a part of nature and, like all natural systems they will find balance and harmony as soon as they get out of their own way for long enough to allow their nature to express itself unhindered.

While the structure of therapy is illustrated by the technical information,

Stephen also gives numerous case histories that bring the spirit - or perhaps more accurately the spirituality - of his life's work to life. You will no doubt find these case histories at once charming, illuminating, inspiring and thoroughly absorbing. As good as these are, they do not do full justice to Stephen Brooks and the way he finds a roadmap deep into his patient's non-conscious minds. To experience that you should really see Stephen in action.

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Introduction

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As the name implies, indirect hypnosis is the opposite from the direct authoritarian approach to hypnosis used by most therapists during the 20th century. The indirect form of hypnosis and psychotherapy taught in this book allows the therapist to by-pass the patient's normal conscious resistance to suggestions. Because this approach is so indirect, therapists can now use hypnosis effectively in areas of the caring professions previously unfamiliar with hypnosis. Through the work of Stephen Brooks in the UK, indirect hypnosis is now widely applied in the social services, nursing, counselling and psychology in addition to the more traditional contexts of medicine and dentistry.

When Brooks wrote this book he was teaching at various hospitals in the UK and this book became the standard training manual for those courses. He was working in a minimalist style using indirect hypnosis with some additional NLP. This book contains the results of that integration. Brooks had not fully developed his principles of Minimal Therapy at this time, although his work was always brief and simple. The first part of this book introduces the various principles and techniques of indirect hypnosis. The emphasis is on the application of indirect hypnosis in therapeutic settings, however the concepts and skills taught will be of interest to all serious students of communication and influence. So persuasive are the indirect hypnotic techniques taught, that the author stresses the importance of applying the skills only for the benefit of others and suggests that all serious students acquire professional training before using the skills with patients. This emphasis on integrity runs through all of Brooks' work and for the serious student of indirect hypnosis, this book should ideally be used as an adjunct to actual attendance on a training course.

A transcript of an indirect hypnosis therapy session with a commentary by Brooks is featured at the end of this book. The demonstration is also available separately on DVD and readers are recommended to acquire this if possible to refer to while reading the transcript and author's commentary.

Chapter One - Opening the door

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When two people meet for the first time they know nothing about one another. It is the therapist's job to be observant and ask questions to start things rolling. It is important to ask open-ended questions that elicit relevant information. Open-ended questions cannot be answered with a "yes" or "no" and usually start with "who, what, where, how, when etc". Questions such as "What made you decide to see me?" will elicit a relevant, content rich response. This can be used to help understand the patient's problem and build rapport. Good rapport between the patient and the therapist enables more open discussion and is itself therapeutic for the patient. Therapeutic intervention does not require detailed knowledge of the patient's problem and sometimes the patient may be reluctant to discuss their problem openly so early in the therapeutic relationship.

Define the problem

Every symptom or problem behaviour has a beginning, a middle and an end. Attempt to identify any triggers and the subsequent sequence of events experienced by the patient. By recognising the sequence of events experienced as feelings, pictures, sounds or actual experiences the therapist gains valuable insight. Identify the date or the time in the person's life when the problem first started. This includes significant times in the person's life when the problem has been at its worst. It might also be useful to identify any times prior to the problem starting when the patient felt similar feelings. Identify the frequency of the symptom or behaviour. You might also like to identify where it occurs and with whom. You need to know how long the symptom or behaviour lasts.

You should also identify any other events, happenings, experiences or traumas that have occurred at about the same time that the problem first started or developed. Maybe one of these events has indirectly triggered or started the problem. Therapy should also attempt to identify how family and friends view the patient's behaviour or symptoms. The symptom may only occur in the presence of certain family members. By identifying the relationships between the patient and the people around the patient the therapist will gain a deeper understanding.

It is equally important to identify the times in the person's life when they

have not had the symptom. This is especially important when the person had expected to have the symptom or problem and it did not occur. The patient's subjective understanding of the problem will often be vague and they will often be unable to say specifically why the problem exists, so you need refined and unobtrusive questioning skills.

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A patient needs to trust you before sharing personal information. One way to develop this trust indirectly is for you to share personal experiences in an informal and friendly way, this builds rapport. It is unwise to share information about any personal problems that you may have as this will reduce your patient's confidence in you. However, you can share personal strategies or resources used to overcome a problem.

Towards the end of the information gathering stage it is always useful to go over the important points raised. You can build rapport by re-capping on the information shared and reflecting back your own understanding of your patient's problem.

Some patients will want to know why they have their problem. Your job is to help your patient overcome their problem and this is often done without really knowing why the problem started. If your patient insists on knowing "why", then first consider whether there is any possibility of identifying the real cause, but this is not always possible or necessary. Your patient should be reassured that overcoming the problem is the primary concern and that identifying the reason why they have it can be addressed later.

After summarising, identify outcomes that your patient wants from therapy. Sometimes your patient's outcomes are not the same as your own. You can try to achieve both outcomes if they are compatible and both beneficial. Usually you both can agree on the same outcome.

Throughout therapy and especially when you are interviewing the patient for the first time, you should keep your mind open to other possible problems that may lie behind the presenting problem. If you feel there is a secondary problem then you should ask open -ended questions and not suggest in any way to the patient your suspicions about other possible problems. Remember, your patient may need time before they are willing to talk about their real problem. If they have an undisclosed problem, and if you try to rush them, they may clam up altogether and you may never

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A forty year old woman came for therapy to lose weight. She was reluctant to talk about herself and her problem. She was overweight and looked drab. Her weight problem had apparently started in her teens, yet none of her family had been overweight. She had three brothers, one sister and a psychotic mother and she was no longer in contact with her father. She was seen for a number of sessions over a period of six weeks and despite a few pounds weight loss during the first week she did not respond to any intervention with hypnosis. Despite her failure to lose weight she remained confident and kept all of her appointments.

After about ten sessions of unsuccessful therapy she mentioned that she had been abused as a child by her father. During the next six sessions she worked on her feelings about her father and the abuse. The weight problem was never mentioned again, yet slowly, as she seemed to come to terms with her feelings about the abuse, she stared to lose weight. She started to take pride in her appearance. It seemed that by becoming overweight as a teenager she had discovered a way of making herself unattractive, which stopped her father abusing her. Her fear had generalised itself to all of her relationships with men and she was never able to lose weight because of her non-conscious fear of being abused again. As soon as she was able to learn how to trust men, initially by trusting me, she was able to lose weight.

Root cause

Sometimes, when patients enter therapy, they may be afraid to talk about the problem they are most concerned about. Instead they talk about some other peripheral problem that is affecting their lives because they are too embarrassed to talk about their main problem. Often they dare not risk presenting the problem immediately because they are afraid that if therapy is unsuccessful then all will be lost. Sometimes they may want you to test your skills on a less important problem to check out your ability to help or to see if they, as a patient, can respond to treatment. Successful treatment of a peripheral problem is a good way of ratifying your skills before the serious work begins.

You are compromised if the patient withholds very relevant information. Problems rarely exist in isolation and where more than one problem exists, they are usually associated with each other in some way. It is important for you to know about all aspects of a patient's problems and to see how they are related and may be reinforcing one another.

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Secondary gain

A secondary gain is a benefit that arises from having the problem. A patient may get used to the attention from family members when they have their symptoms. Sometimes making the problem disappear means losing the attention that has been gained because of the problem. The secondary gain has hitch-hiked itself onto the presenting problem. When helping a patient solve their presenting problem you should attempt to identify secondary gains and deal with those at the same time. You should meet the needs of the secondary gain in some other way.

At this point you are still gathering information and with such little information you should not be giving advice to the patient. Any solutions can be given in the form of metaphors, analogies, tasks or with indirect suggestions. Advice or interpretations given too early in therapy will probably mismatch the patient's beliefs or needs. When attempting to identify a solution you should look for patterns. By taking in as much information as possible identify patterns regarding dates, behaviours, actions, etc. Avoid repeating the word "problem" to the patient. The word "problem" has negative connotations. Instead, emphasise positive changes in the person's life. Always be optimistic and confident in the patient's ability to change.

Observe non-conscious responses

Observe non-conscious responses

When patients enter therapy they expect action. It is better to avoid therapy based on the patients understanding of the problem, but rather focus on their non-conscious behavioural responses. If possible you should attempt to get an example of the symptom. You need the raw materials of the problem to work with. If you have good materials you can do good therapy. So for example, if a patient admits to a fear of spiders, you should ask them to close their eyes and consider imagining a spider and notice the response that follows. This will give you an example of the physiological change that occurs when the patient has the problem. If the patient's presenting problem is a fear of meeting people and being asked questions then the therapist should attempt to evoke the response in the patient. A clear explanation of this process whilst attempting to evoke a symptom will maintain good rapport with your patient.

Summary - Questions to ask and principles to remember

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When did the problem first start?
-
How often does it occur?
-
How long does it last?
-
When it does NOT occur?
-
What is the sequence of steps in the symptom or problem behaviour?
-
What other events occurred around the time of the start of the problem?

-
-
-
What are the general beliefs about the problem?
-
Summarise the problem and establish an outcome.
-
Remember the presenting problem may not be the real problem.
-
Your patient may not be aware of any other underlying problem if one exists.
-
Sometimes patients have a need to hold onto a problem.
-
If appropriate, attempt to elicit the problem behaviour or symptom or evoke the feelings.
-
Avoid placing emphasis on the word "problem" by repeating it too often.
-
Avoid giving advice, interpretations or solutions at this stage.
-
Look for conflicting non-verbal behaviour.

Chapter 2 – Beneath the surface

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When patients enter therapy they may often try to expound on their beliefs about the cause of their problem with information based on either fact or fiction. Patients interpret their symptoms and behaviours in many ways. Patients may make subjective interpretations about why other people have problems. For example a husband may interpret his wife's behaviour purely from his own subjective understanding, whilst the real causes is totally different. This "mind reading" on the part of the patient can contaminate the therapeutic process. It is important for the therapist to acknowledge the interpretations that patients make about their own and others behaviour, even though many of these interpretations are not useful to the therapist. It is often unnecessary for you to understand these subjective interpretations. It is often easier to work therapeutically with actual behaviours rather than subjective interpretations.

Patients will often discuss a lot of irrelevant details. Often you will need to intervene and interrupt irrelevancies. Suitable questions might be; "yes but how is this relevant?" Avoid being drawn in to your patient's own understanding too much as you may even end up being just as confused as your patient. If you discover yourself going off on some tangent or other, you have probably been influenced by some subjective report given by the patient.

There are a number of different subjective interpretations offered by patients, here are twelve classic forms of interpretation:

Examples of subjective interpretations

- Hereditary interpretations: "my mother had the same problem".
- Prediction interpretations: "he will say the same thing next time"
- Cause and effect interpretations: "she feels depressed when our daughter forgets to phone".
- Biological interpretations: "it's my hormones".
- Personality interpretations: "that's just the way he is".

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Medical interpretations: "the doctor says I am depressed and it could last for years".
-
Cognitive interpretations: "he's thinking about his work all the time".
-
Nominalised interpretations: "she's confused, her expectations are preventing us from communicating".
-
Judgmental interpretations: "people shouldn't behave like that, should they?"
-
Emotional interpretations: "I have always been up tight, it's my nerves
-
Motivational Interpretations: "she's trying to punish me for forgiving my mother".
-
New Age Interpretations: "my inner child lost her shamanic healing crystal in a past life".
Negate negative interpretations

Although patients often come into therapy with a firm belief about what caused their problem, many therapists tend to jump to conclusions utilising past experiences as a reference. Remember that every patient is unique. Some patients believe that their behaviour is out of their control. If your patient states a negative belief then look at it objectively and if appropriate, cast doubt on it. Ideally, play down negativity in favour of a more neutral stance. Whenever a patient gives an example of a problem behaviour or symptom, it is often useful to give a neutralising counter example. For example, offer an anecdote about another patient who had a similar symptom but who did not find it a problem or alternatively an anecdote about a patient who overcame the problem with great ease. Also play down over-ambitious positive beliefs. Persistent negative remarks should be acknowledged but ignored. Gently guide your patient in a positive direction.

Be one step ahead

Be one step ahead

Examples of challenges:

Negative subjective interpretations can often be cut short by simple questions. For example:

-Have you got evidence of that?
-How do you know that?
-How is that relevant?
-Does it really matter?
-Well you could be right, you could be wrong - we can't be sure.
-The opposite could be true.
-I'm sorry, I don't understand.
-How realistic is that?
-Yes, I have many normal friends who behave the same way.
Summary - Dealing with subjective interpretations

-Always pursue relevance.
-Suspend judgement.
-Acknowledge but ignore negative remarks.

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-
Anticipate negative standpoints.
Look and listen but mostly look.

Thoughts evoke both an emotional and often a physiological response. Patients verbally commentate on thought processes but there is also a direct observable physiological response or body language. When patients talk about their problems they often "give away" information about possible causes of their problems. They do this verbally and non-verbally. Non-verbal communication is made up of gestures, facial expressions, postures and changes in autonomous processes like breathing. Training yourself to observe any mismatch or incongruity between the verbal and non-verbal communications will give you further insight into your patient's non-conscious knowledge of the causes of the problem. Even though your patient may not know the cause of the problem at a conscious level, communication of non-conscious understanding will occur indirectly through the things they say and do.

Verbal and non-verbal metaphors

Sometimes patients may use metaphors. These are stories to help the therapist understand their problem. Patients also use a different kind of metaphor. This is called a non-verbal metaphor. They use this kind of metaphor without realising that they are doing it. Non-verbal metaphors are stories told with gestures, facial expressions, changes in voice tonality etc. Non-verbal metaphors express the patient's non-conscious responses at the time.

When a patient makes a statement that appears to contradictory to nonverbal cues, you should mentally note this incongruity and look for subsequent repetitions. Only one example of an incongruity is rarely enough for you to determine the course of therapy for the patient. Identify patterns in your patient's behaviour that indicate a mis-match between what your patient is saying and what is happening at an non-conscious level. It is your responsibility and obligation to develop your own observation skills so that you can easily recognise your patients nonverbal metaphors.

Therapists may use metaphors in therapy. Verbal metaphors are stories that parallel life situations. Stories are normally verbal accounts of chains of events and a verbal metaphor is story where the chain of events reflects a real life situation. Stories that parallel the patient's problem but then suggest a therapeutic outcome are called ﬠTherapeutic Metaphorsﬠ.

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Congruency and insight

In therapy we are looking for both congruency and incongruity. Congruent responses are more trust worthy, whilst incongruent responses cast doubt on the accuracy of the account. Often the patient will make a gesture, expression or movement of some kind when talking about a particular topic. These physical behaviours relate to what is being said. For example; people usually nod their head non-consciously when saying the word ﬠyesﬠ. Even if you draw their attention to it, it is quite difficult for them to stop, because it is such an automatic response. In this instance, non verbal behaviour is congruent with the verbal communication. Head shaking when saying ﬠyesﬠ would be incongruent.

Incongruity occurs because there is an non-conscious disagreement with the patient's conscious account of the problem. The non-conscious mind disagrees with the verbal account and offers more honest communication about the patientﬠs problems. This occurs because it arises from much deeper experience than the patient has at a conscious level. Non-verbal metaphors, once recognised, are very easy to recognise time and time again. The next case example is an account of a very successful series of therapy sessions with a family and it illustrates the importance of nonverbal metaphors in deciding a therapeutic course of action.

Case Example

Despite his difficulties with responding he did remarkably well in therapy. Within 5 sessions he had moved out of the family home and got himself a job. He had cut his hair and had dyed it dark blue. Both of his parents were surprisingly relieved that he had left home, if a little nervous of his ability to cope, and over the following months slowly ceased to be so controlling and dictatorial in their communications with him.

Joseph had led a life of confusion and uncertainty by being told one thing by one parent and often the opposite by the other parent. Not knowing what to do to please both parents, he did whatever he was told at the time according to whichever parent was in front of him. He would then do the opposite if another parent took charge. Many times he had been punished in turn for not obeying either parent and had not learnt to have faith in his own ability to make decisions. The therapeutic outcome for Joseph was to get him out of this triangle as quickly as possible. The problem was that he was unable to decide whether to leave home and how he would handle it if he did. His mother wanted him to stay for his own safety and was concerned that if he did leave that he would mix with the "wrong sort". His father wanted him to leave so that he could be more independent but preferred him to stay a while longer so that he had more time to find the right job.

His therapy worked well. I think that he had been planning his escape for some time and that all he had really needed was a caring yet responsible therapist to give him permission to flee from the grasp of his well meaning parents. The therapy kept his parents back from sabotaging his

efforts at independence. He did remarkably well, yet throughout the therapy he hardly spoke. His parents did nearly all of the talking whilst he stared at the floor nodding and shaking his head in non-conscious agreement or disagreement at what was being said. His head movements seemed to be out of his awareness. When he did speak he continued to communicate with his head movements even though often they would directly contradict what he was saying verbally. Careful observation of his non-verbal communications gave insight into the dynamics of the relationship between the three family members and helped design a task that would create an opportunity for Joseph to leave home and start to restructure

his decision making abilities. During the sessions, whenever he verbalised a response, it would match whatever he believed his parents wanted to hear at that time. But his non-verbal response always matched his true inner wishes. His non-verbal communication was a guide throughout Joseph's therapy.

Whenever there is incongruity, pay attention to the content of the verbal communication at that point. The verbal content, whether it is about the problem itself or something seemingly unrelated to the problem, is important at this stage in therapy. The patient is emphasising, by his incongruity, that his non-conscious mind contains conflicting information to what is being said.

Organic Metaphors

Patients will often include, gestures, movements or "throw away" comments about physical symptoms when talking about their problem. The patient will usually be unaware that there is any connection between the gesture or comment and the content being talked about. For example, a patient may make a "throw away" comment about the muscular tension in his shoulders as he is talking about having taken on a new job which "carries" additional responsibility. The patient is saying indirectly that he is carrying the weight of the world on his shoulders at work and that this is producing physical tension in the shoulders.

The patient may not recognise the relevance of the comment about his shoulders as he talks about his work. Alternatively, rather than commenting on the tension in this shoulders, he may just rub or massage his shoulders for a few moments as he is talking about work without realising it. The pain in his shoulders is called an organic metaphor. It is a symptom of the problem and the patient is using the commenting or

massaging as a way of communicating a message to the therapist which says; "I am having difficulty carrying all of this responsibility at work".

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Jean, who with her hair tied in a French knot on top of her head, looked a little like a 1960's French film star, wore a white button up collar blouse and pleated navy skirt. She first sat on the edge of her chair but soon repositioned
herself more comfortably as the session progressed. The day
before, she had telephoned me requesting an urgent appointment. During her visit she complained about her work. As she complained about her workload and fellow workers she appeared to be in control of her feelings and she sat in what appeared to be a comfortable posture and made appropriate yet relaxed gestures that matched what she was saying. She appeared to be congruent in what she was saying in that she clenched her fists when talking about her frustration over a certain deadline she had to meet and she relaxed back in the chair when she thought of having completed it in near future. It would have been very easy for any therapist to have been fooled into thinking that her problems with stress were related to pressure at work. When asked her how she felt about reducing her work load or changing her job she adamantly refused to accept any of these possibilities stating that she lived for her work. This gave a clue to where the cause of her problems lay.

When asked her about her home life she took on a rather rigid, posture attempting to look comfortably relaxed, brushing her hand back through her hair, looking up and smiling and then picking bits of cotton off of her skirt. Her verbal report about her home life was positive. She talked about how there had been some difficult times in the past but that these had now been resolved and that she felt very positive about things. Her language was vague yet positive with an emphasis on how things were now "better than ever before" and that she "couldn't wish for a better life".

It was obvious that she was consciously trying to look at ease but was giving her true non-conscious feelings away through her nervous nonverbal behaviour, her vague language when talking about the past and her emphasis on "things being better. When asked what "things" had been like in the past before they had got better she casually said "oh, you know, the things that happen when you first get married". When pushed a little further, she said &#65533;well that's in the past now&#65533; and gave one of those "let's drop this shall we!" kind of looks.

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It turned out that her husband had had a number of affairs when they had first got married and had told her about them each time afterwards. Although they were both older now and he had claimed to have changed, she had never been able to trust him. As she was so busy at work she had been unable to pay as much attention to her husband and she was worried at an non-conscious level that he might start straying again. In fact she later said that she had felt (although she had dismissed it) that he had had several affairs since he had first promised that he would remain faithful to her and that her work took her mind off of her problem.

Case 3 illustrates how a combination of non-verbal behaviours indicated non-conscious unease about the patients relationship with her husband. First there was the incongruity between the fact that she urgently requested an appointment and her actual account of her problem when she attended the session. During the session there was a lack of incongruity when she spoke of her stress at work. She appeared so congruent and believable that she seemed to be covering something up. Her behaviour was incongruent with the context. The incongruity was really between the way she described her problem and its perceived cause as being work related and her absolute urgency to seek therapy. The problem was not simply work related because her description of her problems with work just did not match the urgency with which she requested an appointment.

Secondly, there was the verbal incongruity between her account of her

problem as being work related and her statement that she lived for her work. If she were telling the truth, how could she could on the one hand, complain so bitterly about her work yet state that she lived for it? Any attempt to get her to reduce her workload or change job on the understanding that her problem was work related would have failed. She really did live for her work, it was her escape from the worries of her relationship and the more overworked she was the easier it was not to think consciously about her husbands possible infidelity. Thirdly, there was the incongruity between her apparent relaxed posture as she talked about her home life and her nervous gestures and fidgeting. This was paralleled by the mismatch between her verbal emphasis on everything being positive and her avoidance of talking about the past.

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She had put herself into a "double bind" by working harder to avoid the anxiety of thinking about her problem but this had prevented her from consciously keeping an eye on her husband's behaviour. This then created more anxiety which eventually drove her to seek therapy in such an urgent manner.

Summary – Non-conscious communication

- Patients give conscious information about the possible causes of their problems.
- Patients communicate verbally and non-verbally.
- Patients comment non-verbally on what they are saying.
- Non-verbal communication is usually non-conscious.
- Observe verbal and non-verbal metaphors.
- Observe organic and symptom based metaphor

Chapter 3 - The nature of the beast

It is only natural for us to try and make ourselves better, but the act of trying often only reinforces the problem. Patients should be reassured that they are doing their best. The word "try" implies difficulty, so often the harder we ‘try’ to solve our problems the more difficult it becomes. By "trying" at a conscious level only conscious resources are invoked. For example, when ‘trying’ to lose weight by not eating a particular food, the very thought of ‘not eating’ indirectly reinforces eating the food.

Often patients put themselves into situations which leave no room for success. They put themselves into a situation whereby any decision brings about a negative outcome. A patient will try to solve a problem the same way over and over again, even if it fails. Because the problem takes all of the patient's attention, the patient is often unable to step outside of the problem and look at it objectively. This saturation of subjective experience tends to severely limit the patient's awareness. In the same way, if you lose your keys you may return to the same place many, many times to look for them rather than looking somewhere totally new.

When patients saturate themselves with their subjective understanding of their problem they are unable to stand outside of their problem and look at it objectively.
Often, when patients realise how they have been trapping themselves, they find it very funny and sometimes this realisation can be therapeutic.

Rarely is this enough for the patient to make the desired change, because the patient requires new behavioural strategies. The therapist must offer such alternatives to enable the patient to behave in a different way. Alternatives can be offered in the form of tasks or new strategies. Alternatively the therapist can utilise indirect suggestion to encourage the patient’s non-conscious to facilitate this process.

Summary ‘ How patients trap themselves

- Problems often develop at an non-conscious level.
- Patients often maintain them by trying to solve them.
- Patients are usually unaware of how they maintain their problems by -trying to solve them.
- Patients often trap themselves in no win situations.

The relationship between cause and symptom.

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Subsequent experiential encounters with a dog will be influenced by the summation of previous encounters, for example a combination of the first and the second experience. Thus the quality of the first experience may change. It no longer is a simple biting experience, added to this are all of the psychological aspects of the second experience. The patient starts to look out for dogs so as to avoid them. They now give even more attention to the fear, which is feeding back the fear into itself; effectively putting fuel on the fire of experience. The simple domino theory of "cause and effect" does not apply. Previous experiences are not necessarily "fixed" back in the past but continually evolve and move ahead with the patient as they get older. In fact the cause and the symptom are the same thing. In the same way an iceberg only has a small tip sticking above the water. The "cause" of the tip of the iceberg is hidden, yet they are one and the same. The only thing that separates them or makes them separate parts is the perspective of the observer.

Non-conscious commentaries

When patients communicate they give non-verbal signals related to the content of their verbal communication. You should learn to pay attention to the non-verbal communication as often this information will give you important clues about the nature or cause of the patient's problem and how it is being maintained. You may have heard someone saying of another person "Oh he's a dead give away" or "I can read him like a book". These are phrases that describe a person who is totally unaware of their non-verbal communication to the extent that they have no control over it and others can see what they are really trying to say. These people usually have difficulty lying because their non-verbal communication does not match their verbal communication.

Think of the non-verbal communication almost as a running commentary on what the patient is actually saying. A positive phrase or statement accompanied by a negative

facial expression demonstrates incongruity between thinking at conscious and non-conscious levels. Think of the non-verbal aspect almost as a subscript to the main

communication. You can learn to recognise incongruities by watching for repeated gestures or movements. Sometimes it may be an aggressive voice tonality that is repeated or even a kind of facial expression that seems wrong. You need to see at least two examples of it occurring before you can call it a pattern. Then keep a mental check to see when and how often it occurs. Often it will be triggered by some
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A patient kept putting her hand over her mouth every time she talked about her husband. It became so obvious that it eventually became quite funny. It was quite subtle and few people would have noticed it. She was totally unaware that she was doing it. In fact she was saying "I don't want to talk about this". Covering her mouth
was an indication that she didn't want to talk about her husband and that her husband
was connected to the problem in some way. This was one of her ways of communicating non-verbally. Of course you shouldn't get carried away and think that
all non-verbal signals are an non-conscious message. A hand covering the mouth sometimes is a way of covering an embarrassing smile. A patient sitting with their

arms folded might mean they are cold (not defensive as many non-verbal communication books suggest). All non-verbal communication should be interpreted in context to be understood properly.

Whenever there is incongruity, focus on the non-conscious non-verbal component of the communication rather than the verbal component. The patient may consider that he has full conscious understanding. However, his non-conscious mind knows different (and usually better). Patients reveal their inner feelings so well with nonverbal
communication that it is often possible to identify what a patient is feeling or even thinking simply by paying attention to their non-verbal cues. By noticing a patient's facial expression when they're talking about positive things and their facial
expression when talking about negative things it should be possible for the therapist
to identify whether the patient is thinking positively or negatively in the future

simply by watching their facial expression.

Other techniques such as “ideo-motor signalling” and “automatic writing” are

hypnotic techniques for evoking non-conscious communication and are also nonverbal communications. The only difference being that they are deliberately induced by the therapist rather than presented naturally by the patient although both classes of these hypnotic phenomena can appear spontaneously during trance.

Case Example

Case Example

Her husband had regularly physically abused her. She wanted to get rid of him but was still in love with him. She had removed her wedding ring some months before but still felt that it was there on her finger. Her sore was caused by the continual
picking of the place where her ring used to be as if it were still there The digging in
of her heels could have either been a sign that she was scared to talk about her problem or that she was frustrated with her dilemma.

Words are not meaning

Some words are used to describe processes, subjective experience and concepts. The

word combustion describes a process. As long as everyone knows the meaning of the word then it can be used over and over without the need for long technical explanations. This process is called nominalisation. Communication has developed its own nominalisations, the word communication being one of them.
Nominalisations have developed out of the need to shortcut or generalise communication.

Patients will often used nominalisations to describe their experience. They may say
"This problem really bothers me, my arm won't move and I am in agony" rather than "When I lift my arm it won't reach any higher than my chest and I feel pain in my right shoulder." Their communication is often non specific because they assume that
the therapist knows what they are talking about. When a patient says that they are

depressed they believe that you understand them. When they say that they are anxious they assume you know what this means. There are many well meaning therapists who nod their heads in agreement when a patient describes his problem in
this way and they never challenge the communication.

Take this as an example: At home I have a vase with a flower in it. Can you picture what kind of vase it is? Can you see the flower? How accurate do you think you are with your guess? The chances are that you are wrong. Therapists often base their therapeutic approach on conclusions formed by the same kind of guesswork.

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Listen for words that describe a process but lack specific content. Look at the following:

" I am unhappy, I can't communicate with people, I am anxious and worried about my depression getting worst, I just can't concentrate on resolving the issues in my life."

What on earth does it mean? The person is clearly not feeling good but is not saying anything specific. Let's break the communication down into specific chunks that can be analysed and hopefully utilised in therapy. What does the patient mean by "unhappy'. When and where does it happen? Is it all of the time, even when asleep?

What does it feel like? Where is it felt? - the patient's whole body, the chest, the big toe?

Just look at these words (unhappy, communicate, people, anxious, worried, depression, concentrate, resolving, issues, life) and ask yourself what questions would evoke more information if these words were challenged. If you start each of your questions with a "where, when, what, who, how, and, if you must, why, you will start to get specific information. Bear in mind that by asking "why" you may just get another string of Nominalisations. Just look at how many different questions you can ask about the word "anxious":

-Where are you anxious?
-In what context?
-In what place geographically?
-In what part of your body?
-When are you anxious?
-Daytime or night time?

--
-Does it come and go?
-How long does it go for?
-How long does it last when it's here?
-Have you felt this before, where, when, how long for etc.?
-What does it feel like?
-Does the feeling change?
-What is the sequence of feelings?
-What happens first, next, last?
-Who knows about this?
-How do they deal with this?
-How do you feel about them?
-How long have you felt this?
-How did it start?
-How do you deal with it?
You may discover that the patient only feels anxious in a certain place and that this
then only happens when they have to communicate to a specific person. You may establish characteristics of a person that relates to the cause of the anxiety. Specific
information will reveal the patterns in the patient's life. The problem is created and
maintained by the patient's specific patterns of thinking and behaviour and it is important to understand them. At all times keep your eyes and ears open to two level
communications that come from the patient.

Therapeutic nominalisations

Nominalisations are very useful in therapy as they offer a medium to communicate in

a non-specific way e.g. communication, development, integration, discovery etc. Such words when given to a patient, especially under hypnosis, create an inner search for meaning at an non-conscious level. The therapist does not need to offer an explanation but can allow the patient to find a subjective interpretation. This inner search occurs usually without the patient's conscious awareness.

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Summary Assumptions and nominalisations

- Sometimes patients are artfully vague when they communicate.
- Listen out for nominalisations.
- Specific information will help identify the patient's cognitive and behavioural patterns
- A therapist must never assume.
- Therapeutic nominalisations are process words.
- Therapeutic nominalisations create an inner search.
- Therapeutic nominalisations should have a positive orientation.

Chapter 4 - Building Empathy

Rapport building

When two people are getting on well together they naturally tend to adopt

the same posture. This can be seen in social situations. When people walk

down the street together, as long as they are the same height and build,

they tend to walk in step with each other. Observing and reflecting a patient's body posture is an important part of building rapport. Likewise, deliberate mis-matching of body positioning will break good rapport.

they tend to walk in step with each other. Observing and reflecting a patient's body posture is an important part of building rapport. Likewise, deliberate mis-matching of body positioning will break good rapport.

Mirroring: the therapist deliberately and identically adopts every posture and movement made by the patient. The therapist's movements are like those of the patient's reflected image in a mirror. This is useful when learning how to observe body language and for stationary postures but such "mimicry" is not usually natural and may quickly become obvious to a patient.

Matching: the therapist's movements are harmonised with the patients but are not necessarily identical. For example a movement of the patients left arm may be matched by a movement of the therapist's right hand when sitting opposite each other.

Cross matching: the therapist identifies a patient's behaviour, for example the patient's breathing. The therapist then identifies some way he can match the pattern or rhythm in the patients breathing without actually using his own breathing. For example by swinging his own leg in rhythm with the patient's breathing, or gently swaying or nodding the head. Obviously movements such as swaying or nodding the head can sometimes be interpreted by the patient as messages or indications of states. Nodding the head could be interpreted as agreement with what the patient is saying and swaying could be interpreted as nervousness on the part of the therapist. So cross-matching should be "content free" to avoid misconception. For example the therapist can gently move his finger in time with the patients breathing.

Exercise

Choose a partner and hold a conversation during which each of you speaks for a few minutes on several occasions. Take it in turn to speak. The "listener" mirrors all of the postures made by the "speaker". Each takes it in turn to be the listener. Both partners should make a mental note of the feelings and the qualities during the exchange of communication. Take a few minutes to share experiences at the end of the exercise.

Repeat this process, however this time the listener should deliberately

mismatch all of the speaker's postures. Take it in turns and give each other feedback. Play with the exercise, make mirroring or mismatching postural changes when either speaking or listening or simultaneously try to deliberately mis-match posture during the discussion

mismatch all of the speaker's postures. Take it in turns and give each other feedback. Play with the exercise, make mirroring or mismatching postural changes when either speaking or listening or simultaneously try to deliberately mis-match posture during the discussion

Breathing in harmony

Pay attention to your patient's breathing. By matching the breathing of your patient you will maintain a deep level of communication with your patient, creating an non-conscious sense of 'harmony'. By matching the breathing in this way you can start to slow down your patient's breathing. By slowing down, you will help your patient's breathing to slow down. This indirectly helps them to relax at an non-conscious level. Naturally, the therapist shouldn't match a patient's breathing if it is unusual or problematic in any way. For example if the patient is asthmatic and breathing in an accelerated or difficult fashion. Matching a patient's breathing is essential when inducing hypnosis. When patients go into trance they like to maintain contact with the therapist in some way. In fact the trance experience is exclusive for the therapist and the patient.

Talking back

In addition to matching posture you can also match your voice of the patient. You should pace exactly to what degree you match the quality of the voice of the patient. Matching the voice tonality, tempo, pitch and volume of the patient serves the same purpose as matching the breathing. The patient non-consciously feels safe with the therapist. In this way the therapist is saying that it's OK to be the patient. This is important when some patients come in troubled and concerned about their own self image

or personality. It's reassuring for the therapist to feed back these minimal cues. It normalises the patient's problem to a certain extent. Obviously matching the voice to extreme can lead to mimicking which breaks rapport.

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verbal
changes are known as minimal cues. Some minimal cues can be more difficult to spot than others. The most obvious minimal cues to look out for are change in muscle tone. This can be observed in the facial muscles. You will often see a patient's face "smooth over" when talking about pleasant memories. When the patient conjures up unpleasant memories increased muscle tension can also be observed. You should identify these minimal cues and match them if appropriate. By doing this, you will demonstrate recognition of your patient's needs and maintain rapport at an non-conscious level. This occurs because the patient's non-conscious identifies with the therapist's response. This non-conscious communication is in fact occurring all of the time in every day interactions. Important minimal cues to look for include: pupil dilation, sweating, eye watering, changes in blink rate, changes in skin colour, changes in pulse rate, changes in head position, eye movements similar to eye accessing cues and swallowing. These often accompany shifts in sensory awareness from external to internal reality similar to the experience of day dreaming.

Summary Matching and rapport

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Matching a patients body posture will enhance rapport.
-
Cross matching is the indirect mirroring of behaviour in another system or part of the body.
-
Mis-matching the patient's body posture can break rapport.
-
Matching voice tonality, tempo, pitch and volume enhances rapport.
-
Matching on a minimal level enhances rapport.

The Acceptance Set

The Acceptance Set

A person who is positively motivated in a therapy session will offer less resistance to change. Getting a patient to say "yes" a number of times will help develop a positive acceptance for you as a therapist and the ideas that you suggest. These suggestions can take the form of straight forward questions, such as "So this is your second visit John?" The patient has to answer yes. Questions should be relevant and based on the therapy. Use questions which invoke only positive responses and for which you already know the answer. Often on an initial visit the therapist has little or no information about the patient, the therapist may find difficulty in asking questions for which the answer should be "yes". So it is important that you start by asking open-ended questions to build up information about the patient on which to base your "positive frame suggestions".

Reverse frame suggestion

Obviously if you keep asking questions that elicit "yes" responses, your patient may become suspicious. So every now and then it's important to put in a "reverse frame suggestion". This enables your patient to answer "no" but retain agreement. For example: "Tell me John, you wouldn't expect to go into a deep hypnotic trance before you have sat down in the chair would you'?" Here John has to answer "no" but what he's actually saying is "I agree with you". This maintains the agreement set but gives the patient a chance to actually put in a negative. This then neutralises any uncomfortable feelings that the patient may have had by having to continually say "yes".

Tag Questions

Negative suggestions or "tag questions" offer both agreement and negative suggestion simultaneously. They are too complex for the patient's conscious mind to figure out. So the patient just finds themselves agreeing or nodding or saying "yes" without really having time to think about it. For example: "So John you would like to go into a trance today, would you not?" Here the "would you not" is the tag question. Other examples are: "You can, can you not?" "You are, are you not?" "It is, is it not?" "I am, am I not?" When a patient hears one of these tag questions they find it very difficult to resist. This is possibly because the tag

question contains in itself a negative. As this negative is said by the therapist, it possibly neutralises some of the active positive agreement. Negative suggestions shouldn't be used too often. They should only be used at special times when the therapist really wants commitment from the patient.

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You can usually tell good hypnotic subjects by observing for their minimal cues. Within the context of a group conversation you can usually identify the most responsive hypnotic subjects by watching for a combination of pupil dilation and head nodding. Pupil dilation is a good indicator of trance responsiveness. The person with the largest pupils who is also appearing to listen intently by nodding their head is the most likely hypnotic subject. The term "Response Attentiveness" describes the collective minimal cues of trance. In the context of a therapy session you will see the patient "drift off" from time to time during the conversation. This is usually accompanied by a shift in the facial expression, a softening of the facial muscles, sometimes looking away, de-focusing and a slowing of the respiration. When you see this special combination of cues you can encourage trance to develop further. This can be further facilitated by adopting a "trance style" of communication. The patient will associate your shift in communication style with their shift into an altered state and its associated minimal cues.

Hypnotic Induction Exercise

Eye Fixation Induction

Ask a partner to focus their eyes on a spot or a certain place in the room just above eye level. Ask your partner to notice three objects that can be seen. Then ask your partner to notice three sounds that can be heard and then ask your partner to notice three feelings that can be felt at that moment. Ask you partner to say each one (for example: "I can see the wall, I can see the door, I can see the floor; I can hear the clock, I can hear the central heating, I can hear the birds outside; I can feel the chair beneath by thighs, I can feel the carpet on my feet, I can feel more relaxed"etc.). After vocalising each of the sensory experiences repeat the process without interrupting your partner"s concentration. Observe your partners responses.

Eventually your partner's conscious mind will grow tired of the external search allowing the non-conscious state to facilitate a trance induction. The upward tilt of the eyes induces eye fatigue and hence eye closure. Narrowing the focus of attention reduces the amount of available external stimuli. The focus of attention will be directed internally as the conscious mind searches both external visual and auditory sensations and then for internal 'feeling' states (e.g. 'I can feel sleepy').

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We use our senses in order to understand and make sense of the world. We take information in through our senses and we process information internally inside our head, in our sense systems. We have developed descriptive vocabulary to describe our sensory experiences. A predicate is the term given to a particular word that is sense orientated. For example the visual sense offers the predicates: to see, to view, to look, etc.

Examples of predicate based statements:

Visual:

-It looks good to me.
-I can picture it.
-From my perspective.
Auditory:

-It sounds good.
-It's as clear as a bell.
-I ask myself.
Kinaesthetic:

-It feels right to me.

--
-I am under pressure.
As you can see from the above examples people use sensory specific predicates in every day conversation. Here are some examples of other sensory based predicates in visual, auditory and kinaesthetic systems.

Listening for these predicates offers the therapist a further opportunity to enhance rapport. When a patient talks about his experience and uses specific predicates such as "I see" or "I hear", then the patient may well be actually thinking in pictures and/or in sounds that relate to the predicates being used. By feeding back these words the therapist aims to convince the patient at an non-conscious level that he also is seeing and hearing in the same manner. This simultaneous seeing and hearing suggests to the patient, that both parties are in rapport with each other. It is difficult to tell whether the feeding back of predicates and the subsequent rapport that follows is the result of matching of ways of thinking, or simply the matching of language.

Patients who have a limited vocabulary and who are unable to express themselves in all of their sense systems may be stuck in a particular sense system. For example a person who can talk only in auditory terms may be stuck in this particular mode because of an inability to communicate or think in other ways (senses). For example a person talking in mainly auditory predicates may not be able to visualise particularly well. One approach commonly used in NLP (neurolinguistic programming) is to help the patient experience the problem in other sensory modalities. By taking a different viewpoint, by talking it over or by feeling in a different way, the emphasis is shifted from one sense system to the other. In this way the patient can learn new insights into why their problem exists. These new insights help the patient learn to change by giving them more choices on how to behave.

Certainly it is true that some patients are able to associate or dissociate from their problem depending on their visual ability. We could also argue that some patients may appear to be limited in their vocabulary not because of their inability to access a particular sense system but because of their education or because of the way that they have been brought up,

e.g. a child who's father thought primarily in an auditory modality.
Here are some examples of other sensory based predicates in visual,

auditory and kinaesthetic systems.

auditory and kinaesthetic systems.

See, Picture, Imagine, Bright, Sparkling, Perceive, View, Focus, Shimmering, Clear, Clarify, Hazy, Blurred, Bleak, Dull, Image, Misty, Fuzzy, Foggy, Speculative, Hue, Hindsight, Obscure, Reveal, Panoramic, Magnify, Glassy, Huge, Minute, Steamy, Colour, Dim, Shady, Cloudy, Stormy, Precipitous, Distant, Brilliant, Radiant, Blinkered, Blindfolded, Gloom, Doom, Starry-eyed, Tunnel-vision, Outlook, Transparent, Translucent, Opaque, Fluorescent, Glaze, Small, Big, Glimmer, Rainbow, Vision, Vista, Hallucinate, Dream, Perspective, Visualise, Landscape, Deep, Bleak, Light, Dark, Perceptive, Flash, Proportion, Reveal, Telescopic, Kaleidoscope, Shimmer, Shine, Glossy, Huge, Bright light, Bright spark, Flash of inspiration, A flicker, I see red, Seeing ahead, I've gone a blank, See through, Draw back the curtains, Rose coloured glasses, See the horizon, Blind spot, Draw up agenda, Sketch out/Map out my future, Clear as crystal, Looks like...., To reflect, To mirror, Mirror image, Eyeball to eyeball, A sight for sore eyes, Black and White, Visual aid.

AUDITORY

Hear, Sound, Pitch, Tone, Volume, Noisy, Buzz, Raucous, Ringing, Loud, Soft, Listening, Whisper, Speak, Whistle, Hum, Drumming, Bell, Rattle, Song, Lilt, Band, Music, Orchestrate, Crescendo, Crashing, Musical, Harmony, Still, Echo, Rustle, Resonate, Twang, Jingle, Jangle, Clatter, Pitter-patter, Chord, Amplify, Scream, Bellow, Roar, Screech, Yell, Squeal, Silence, Thunder, Drone, Reverberate, Discord, On the wavelength, Announce, Broadcast, Talk, Tick, Crying Shame, Interpret, Click, Clear, Bang, Beat the Drum, Tune in, Fade, Note, Rhythm, Whisper, Crack, Moan, Clarity, Whine, Shriek, Quiet, Overtone.

KINAESTHETIC

Feel, Pressure, Stress, Settled, At ease, Relaxed, Cushioned, High, Oppressed, Under the weather, Oh top of the world/things, Up in the air, Flat on the Floor, Down in the dumps, High as a kite, Ecstatic, Away with the fairies, Touched, Detached, Tired, Tread the boards carefully, Walking on eggshells, Delicate, Fragile, Robust, Determined, Fidgety, In bits, Hurt, Cold, Over the edge, Low, Sharp, Feel Beaten, Tender, Succulent, Soft, Clingy, Funny, Back to the wall, Burdened, Trapped, Hemmed in, Heavy handed, Swamped, Drowning, Dependent,

Abandoned, Gutted, Fighting fit, Tight, Fragmented, Drifted, Sexy, Things are moving, Pain in the arse, Raises my hackles, Empty, Slimy, Flip my lid, Heavy, Touch, Caring, Sick, Dull, Pressure, Wound up, Drag, Rushed, Intense, Heavy as lead, Spacy, Feel grey, Tight, Centred, Closed, Handy, Thick, Put upon, Tense, Twitch, Anxious, Jumpy, Angry, Moving, Floating, Light, Elated, Show, Cool, Happy, Excited, Stuck, Sharp, Overwhelmed, Sensitive, Blunt, Cracking up, Breaking apart, Up tight, Falling to Pieces, Over the edge, Snappy, Feeling high/low, Flexible, Under par, Drained, Exhausted, Depressed, Out of/In hand, Burdened, Out of control, Sick of it, Makes me want to throw up, Gut feelings, Makes my flesh creep, Electrified, Sets my teeth on edge, Grates on me, Makes me feel creepy, Slide into things, Collapse, Break down, Feels empty, Things are a bit slow, Feel cold inside, Slippery slope, Mixed up.

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Patients use sensory based words that represent the way they are thinking at the time.
-
Therapists can feed back predicates to build rapport.
-
The patient can sometimes become stuck in a particular sense system.
-
Predicate identification can help in diagnosing a patient's limitations and/or resources
Hypnotic Induction Exercise

The Staircase Induction

Explain to your patient or partner that you will be taking them on a journey along a staircase. Determine whether your patient would find it easier to go into trance by descending or by climbing such a staircase. If you are counting, then each number that you count should be associated with an exhalation. By telling your patient they can go deeper with each number, indirectly they will be helping themselves to go deeper simply by breathing. You do not have to count with each breath, you may prefer to count every' other breath. This will give you the opportunity to intersperse suggestions along with the counting. As your patient/partner

exhales, give suggestions for going deeper into trance. By counting and pacing your suggestions with the patient's breathing you will be reinforcing rapport.

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These changes should occur gradually as the induction progresses. The therapist starts the induction at normal volume and tempo etc. At the deepest part of the trance the therapist should have the maximum alteration to his voice. By changing his voice in this way the therapist is matching the patient's experience of going deeper into trance. This also helps the patient anchor the trance experience to the therapist's voice. In future sessions the therapist need only talk in this special way and the patient will start to go back into trance again.

As you are pacing your suggestions and counting with your patient's breathing it will be difficult for you to rush. It's very important that you give the patient as much time as is necessary to experience the trance state. When you talk to your patient you should appear confident and knowledgeable. If you communicate doubt through hesitation or lack of confidence then your patient may pick this communication up. This will cause a loss of rapport and a lack of trust. So always appear confident and take your time.

When you decide to bring your patient out, usually after about five minutes, ask your patient to watch the picture on the screen and then to experience standing up from the imaginary chair, walk out of the room, out of the door and slowly come up the stairs. As your patient comes up the stairs, count backwards from twenty to one. Remember that when there are twenty stairs the therapist counts from one to twenty to go down into trance and from twenty to one to come out of trance. As you count from twenty to one, bring the patient out of trance by timing the numbers

with your patient's inhalations. Likewise alter your tonality, pitch, volume etc. in accordance with the depth of trance as your patient comes out. Your voice should get louder, the tonality should harden, the pitch should rise until the voice sounds perfectly normal as in everyday conversation. When the trance has been terminated thank your patient and ask for their experiences.

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-
Time your suggestions to your patient's breathing.
-
Utilise all of your patient's sensory systems.
-
During the induction you should slow down your voice, lower your volume, lower your pitch and deepen your tonality
-
Appear confident and take your time.
-
Bring the person out of hypnosis by reversing the induction procedure.
Sensory processing

All information that passes from our external reality to our internal reality has to pass through our sensory systems. Without an ability to see and visualise internally it would impossible to think with pictures. Likewise it would be impossible to talk to yourself if you were unable to hear language internally. Much of our thinking is processed this way.

Our experiences are mostly internal and only represent the ﬠrealityﬠ occurring outside. Reality is ﬠre-presentedﬠ in our brain and body. Many problems are ﬠre-presentedﬠ by patients in their sense systems and this is why it is possible to change a person's beliefs by changing the way they represent their beliefs with their senses.

NLP has suggested that people who are visualising tend to change their physiology in the following way: their breathing appears to be higher in the chest; their voice is higher, faster with a somewhat breathless quality; they draw pictures in the air with their hands as part of their gesturing; their posture is upright sometimes with tension in the shoulders and their skin appears often pale with a tightness around the mouth. People with a

predominately auditory modality: breath more in the middle of their chest; speak evenly and rhythmically; hold their head often resting on a hand with their head tilted almost as if they were talking on the telephone; hold their posture often asymmetrically with normal skin colour. People who are kinaesthetic breath low in the stomach with a voice, which is deeper and slower with gestures that are solid, holding or gripping; their posture is often down sometimes round shouldered with muscles relaxed; the skin colour often appears flushed. Observation of these particular shifts in minimal cues can help the therapist gather information about the particular sense system that the patient is accessing at a particular time.

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NLP has suggested that people move their eyes in certain directions related to the sense system they are using at the time. It has been suggested that when people look up to their left they are visualising memories. When they look up to their right they are constructing pictures. When people move their eyes down to their left they are talking to themselves internally. When they move their eyes down to their right they are experiencing internal feelings. These four primary positions are known as "eye accessing cues"

NLP has suggested that by observing the patient's eye movements and dialogue as they communicate, the therapist can identify the particular sense system the patient is operating in. For example if the patient is talking about a particular experience and is looking up to his left the therapist can conclude that the patient using visual memory. If the patient is looking down to his right whilst talking the therapist can conclude that the patient utilising internal feelings.

In addition to these four primary accessing cues, additional accessing cues have been observed as follows: looking straight ahead usually suggests that the person is visualising but not in any specific past or future context. Looking to the immediate left suggests that the patient is hearing sound with a past orientation. Looking to the immediate right suggests that the patient is imagining sounds from a future context. In addition to this it is suggested that people who spend most of their time looking upwards either left or right or defocused ahead, are visualising. That people whose eyes move from left to right whilst communicating are auditory. And lastly that people who spend most of their time looking down to their right whilst talking are primarily kinaesthetic. General

observations do not apply to all individuals. It is interesting to observe the relationship of an individual's eye movements and their internal sensory coding. Once simple associations have been identified, an individual's entire sensory experiential strategy can be observed and utilised for therapy.

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Observation of sensory preferences at given times during an interaction can allow the therapist to learn more about the patient and the problem, for example:

- To identify the sensory coding used by the patient at the time and therefore gain a deeper understanding as to how the problem being discussed and processed.
- To recognise incongruity in the way the patient represents the experience.
- To feed back relevant sensory based predicates to the patient to enhance rapport.

Summary - Sensory Representations

- People often 'think" using their sense systems.
- Sense systems can be viewed as representational systems.
- Representational systems can be recognised by watching people's eyes movements.

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Chapter 5 - Motivational Perception

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The following sent of questions are useful for therapeutic interactions. By their nature they often evoke an non-conscious response by the patient. The answers they

evoke will provide useful material on which to structure your therapy.

1. What positive change do you want?
When patients enter therapy they are not always certain about the outcomes. Often patients think of what they want to stop happening rather than what they want to achieve. For example a smoker might want to stop smoking rather than to be healthier. It's important to frame the outcome positively. By asking the patient "What positive change do you want?" you are directing the patient towards identifying a positive outcome rather than a negative one. It is a lot easier for a patient to look at positive outcomes rather than to look at stopping a behaviour. If the patient wishes to stop doing something he first has to be aware of what it is he is trying to stop. The awareness of this activity or behaviour often reinforces the activity or behaviour. If someone wants to stop eating chocolate they often tell themselves to not eat chocolate. On the surface this seems to be fine, however, the very act of trying to not to eat chocolate involves first thinking about it in order to negate it. Always keep your patient directed towards positive outcomes.

2. How will you know when it has happened?
Many patients enter therapy, get better and yet not know that any change has occurred. A patient needs to know how things will be different when they are better.
If a patient makes changes yet has no way of identifying that these changes have occurred, they will never know that they have got better. So it is important for the therapist to help the patient identify some way of knowing when they have reached their outcome. Often this will be a change in the way they feel. It might also be a change in the way they see things. It might also be a change in the way they look. It is very important to identify how the patient will know that changes have occurred.
Some people become "professional patients" in that they seem to spend their whole time going around from one therapist to another. Although, for some this is a way of getting attention or building up a network of "caring friends", for many it is because they cannot recognise the changes that are happening to them.

Case Example

I knew of one patient who had lost weight so successfully with a colleague of mine that she had told all of her friends about her wonderful "cure". I was horrified when I saw her because she was very thin. Her friends had told her that she would become Anorexic but she didn't understand. She had lost weight and that had been her plan.
The trouble was that she had gone too far and had passed beyond her healthy weight because she hadn't specified her goal to start with. If her therapist had asked her to state her desired weight before the treatment began he would then have realised that her problem was one of obsession and not obesity. He could have then added some clause to the therapy contract whereby she agreed to receive help with her obsessive dieting in addition to her perceived eating problem.

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What has stopped you from changing so far?
By asking your patient to identify the things that have stopped them from making the changes they require you are asking your patient to go on an inner search through the past strategies that have sabotaged their attempts to change their behaviour. It may seem strange to think of patients actually trying to sabotage their recovery, but it is a real phenomena that has to be appreciated and dealt with. Patients are not used to identifying the things that stop them from achieving. They are usually more familiar with just not being able to achieve. By asking them to go back one step, you are helping them to see the cause and effect relationship between their problem and the possible cause. In addition to this you are also identifying potential situations or behaviours in the future that might prevent the person from changing.

When you ask "What has stopped you from changing so far?" the answer is rarely available at the conscious level. This is because answers of this nature are not

in the
patient's conscious frames of reference. If they were already able to identify what has
stopped them from changing so far they would have already made use of that
information and started to change by themselves. The therapist's role is to tease out
the non-conscious processes that lie behind the problem and then re-model the
strategy or "problem maintaining pattern" so that it no longer occurs.

Case Example

I had a patient who wanted to be a little healthier and work out at the gym but who
just couldn't get motivated. I asked him what had stopped him from going to the gym
in the past and he thought hard but couldn't answer the question. So later when he

was in trance I asked him the same question again and then he said "Oh I tell myself
that I will never make it as a body builder".

So, although on the surface (at the conscious level) he was telling himself that he
ought to work out. At the non-conscious level he really saw himself as a would-be

�Mr Universe� but knew that he would never make it. So he had sabotaged his visits

to the gym every time by finding some "very urgent work" that needed doing instead.

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4. What do you get out of what you're doing now?
When answered consciously, most patients will say that they get nothing out of what
they are doing now. However most problems have a function of some kind. A person who shakes involuntarily in public might be creating a symptom that prevents him from going out and so will be protecting himself from possible humiliation or embarrassment in front of others. A patient who wets the bed may well be getting attention from others. By asking your patient to identify what they're getting out of
what they do now you are also starting to recognise possible secondary gains. Secondary gains are the benefits that patient get from having a problem. They often
reinforce the problem because they make having the problem more bearable and sometimes even desirable.

Case Example

A patient worked in a pub and was very concerned about being overweight. He was always being bought drinks by his customers. His wife worked in the bar also but had
learnt how to say no. He felt obliged to say "yes" because he didn't want his customers to be offended. The fact that his wife usually said "no" made him feel even more obliged to say "yes" to a couple of drinks each night. He then discovered
a curious problem developing. He found that he would blush very easily whenever he

was offered a drink. This seemed to coincide with his increase in weight. The problem became so severe that eventually he felt too embarrassed to work in the bar
and spent most of his time in the back. This was about the time he first visited me
with his problem. I listened carefully and asked to see his wife also. She said that she
was happy with him working in the back as he was out of her way and they had employed younger staff who were bringing more younger people into the pub. She would like him to get over his blushing though because it was affecting his confidence. I listened vary carefully and concluded that I need not do anything and
that the problem would probably disappear by itself. I taught him a relaxation

technique which he dropped after a few days. Within one month the problem had disappeared. The secondary gain of staying in the back of the pub so as not to have the conflict of either offending his customers or putting on weight was brought on by the blushing.

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5. Do you want this change in all contexts?
Generally speaking it is usually desirable for patients to have their changes occur in all contexts. However there are exceptions to this. For example if a man wishes to be more assertive at work you may well be able to help him achieve this, but unless you put constraints on the contexts in which he is assertive, he may well also be assertive at home. This new assertive behaviour may lead to a break-up in his marriage. It is important for therapists to identify all of the contexts in which the patient requires his new behaviour and only help him achieve this in all contexts if it is ecological to do so.

Case Example

One of my sons was taught by his Nanny to hit one of his toys the wall or the floor with his fist if he tripped up. Blaming the floor for his fall was her way of distracting him away from the pain or embarrassment of falling over. I was horrified to see him doing this because I didn't like the idea of him being taught to blame others for his own mistakes. Very shortly afterwards he started hitting his friends or his parents whenever he made a mistake or fell over. I quickly stepped in and corrected his behaviour by threatening to sack the Nanny. She soon put him right and he has now forgotten that he used to do it.

Her attempts to help him in the context of that particular time frame were fine, but she never looked at how that behaviour could affect him within the context of relationships or within the context of adult life. So when you consider the other contexts in which your patient has to live do not only think of the contexts that exist at present. You should also consider your patient's future contexts as well.

Future Pacing is the name given to the principle of getting your patient to step into

their imagined future and try on their new changes. The patient is asked whether the
changes seem to "fit" and whether any adjustments need to be made. Future Pacing
can in fact be applied at any time throughout therapy as a way of checking that the
intended therapeutic outcomes are congruent with future contexts. Usually Future
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questioning skill.
What could go wrong?
This may seem like a negative question. However we are not actually suggesting that
things could go wrong, we are attempting to recognise, ahead of time, any situations
that might trigger a re-occurrence of the problem. This question is very similar to the
question "What has stopped you from changing in the past?" the main difference
being that this new question is future orientated. Because it is about the future,

Patients often find it easier to answer because they don't have to remember the non-
conscious ways they used to sabotage. Here they are being asked to be creative and

imagine how things could go wrong. However, both questions will often bring up
similar answers because their imagined responses are usually based on how they did

it non-consciously in the past.
When you ask this question you are attempting to identify patterns of sabotage. By

recognising these possible occurrences ahead of time, the therapist can plan ways of
either avoiding the situations which allow sabotage to happen or giving the patient
resources with which to handle the situation in a better and healthier way. If this
question is asked a second time at the end of therapy (as a kind of future pacing
question) the answers will most likely be different from the first time because the
patient will then have, ideally, the resources to prevent any sabotage.

You might be surprised at first by how many different ways patients have of
sabotaging therapy. Asking "what could go wrong?" usually brings up a whole list of
ways they might prevent themselves from getting better. Usually they don't
recognise

that these ways of preventing success are of their own making. They will usually blame other people or contexts. It is your job to make them realise that these "events"
that seem to suddenly step spontaneously in the way of success are in fact attempts
on their own part to allow their own success to be sabotaged. patients sabotage in two
ways. They either do something directly that gets in the way of success or they do it
indirectly by allowing something or someone else do it for them and then deleting their awareness of how they have in fact created the situation.

For example, a patient wanting to lose weight might sabotage directly by going to the
refrigerator in the middle of the night. Or they might sabotage indirectly by creating
a context where someone else feels compelled to buy them chocolates and they,

therefore, are obliged to eat them or risk offending their "accomplice". When patients are able to generate lots of alternative ways of sabotaging therapy or excuses for explaining why they cannot get better you should investigate their secondary gains more closely. When patients have problems they try and cope which creates secondary gains. Sometimes patients even invite the problem into their lives in order to have the benefits of the secondary gains. You should look closely at their level of motivation in association with their degree of secondary gain (see "what has stopped you from changing so far" and "what do you get out of what you are doing now - above), because secondary gains reduce the level of motivation for therapeutic change. You have to either change the secondary gains by finding equally rewarding substitutes or remove them by re-framing the patients beliefs about the value of the secondary gains. When patients create lots of examples of how they cannot get better you will notice that some examples may seem quite ridiculous. For example a patient sabotaging a diet might say "When my children can't manage to eat the cakes I have bought for them I just have to eat them myself because it would be such a waste of money to throw them away". The possibility of saving the cakes for the next day or simple buying less cakes doesn't seem to occur to the patient. This is an example of indirect sabotage where the patient deletes their awareness of their own sabotaging strategy.

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indirect sabotage where the patient deletes their awareness of their own sabotaging
strategy.

-What positive change do you want?
-How will you know when it has happened?
-What has stopped you from changing so far?
-What do you get out of what you're doing now?
-Do you want this change in all contexts?
-What could go wrong?
Polarity responses

Some patients have an in built strategy that makes them do the opposite from what you tell them. This kind of patient has a polarity response. This kind of response is often learnt in childhood either through modelling a parent or created by the child as a defence or coping mechanism. Also a child may see the parent as too weak and unassertive. The child senses the parent's difficulty with control in communication

and develops the opposite strategy and often one in which they over assert themselves through a process of denial.

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Responding to Polarity Responses

When the therapist states a fact or makes an observation the polarity responding patient will often deny it or find a counter example often without any rationale. To counter this behaviour the therapist needs to learn how to phrase statements negatively so that the polarity responder rejects the negative bias in the therapists statement and so moves in the direction desired by the therapist. For example, if a patient always sabotages the therapist's attempts at trance induction, the therapist could start a session by stating. "I was going to suggest that today we do some therapy with hypnosis but then I thought that you might sabotage it". A true polarity responder would respond with "I don't think I would sabotage it!

Later in the session, when the therapist starts the hypnotic induction, the patient has to enter hypnosis to prove that they will not sabotage. The polarity responding patient has to be right and will go out of the way to prove that they are right, even if it means agreeing to something now that they earlier may have refused. Whether they keep to their original denial or change to the new denial depends on the benefits and losses associated

with each choice. Whichever gives them the greater benefit or the least loss will win. Of course this non-conscious choice is also influenced by their personality orientation. If they normally reduce their anxiety by avoiding loss then they will chose a choice that accomplishes that outcome. If, however, they reduce their anxiety level by achieving benefits then they will base their choice on that criteria.

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Severely depressed patients seem to have a homing device installed in their subjective
perception that seeks out negative interpretations and then latches onto them. They usually negate any positive suggestions offered to them by the therapist and agree with any cleverly designed anti-polarity strategies the therapist may have dreamed up. So the above strategy for dealing with polarity responders rarely works with severely depressed patients because they tend to agree with any opposing or negative comments that the therapist makes.

Summary - Polarity Responses

-
Some patients have an in built strategy that makes them do the opposite from what you tell them
-
Polarity responses are sometimes learnt through role modelling.
-
Polarity responses are sometimes learnt as a way of coping with difficulty.
-
Therapists have to develop a therapeutic strategy to be able to build rapport and negotiate with the polarity responding patient.

-
-
-
Severely depressed patients may appear to have a polarity response.
Accessing resources

Most patients have within them the resources to be able to change. Whenever possible we must attempt to identify these resources, if possible, before therapy starts. Your job is to help the patient apply their own resources to their problem. Resources should be stacked whenever possible. Stacked resources are a series of good feelings literally stacked one upon the other. You should continue stacking positive resources until the positive feeling is stronger than the negative feeling.

Patients often are not aware of their resources because they are hidden at an non-conscious level. Patients try to get better by applying their conscious resources to solving their problem but this is not enough and this is why they usually enter therapy. Because "trying" occurs at a conscious level the patient usually only has conscious resources available for problem solving and any non-conscious resources become more and more elusive because of the conscious effort of trying.

There are a number of different ways of accessing resources. Review any "exceptions to the rule". These are times when the problem did not occur even when the patient expected it to. The therapist asks the patient to remember such times and then investigate what was different on that occasion. Another approach is to look at contexts. The therapists attempts to identify a context where the problem could not happen. Either because the patient would not allow it to happen or because he would be unable to experience it happening. Another approach is to ask the non-conscious to identify the resources and apply them to the problem. This can be done without the patient knowing what the resources are or how they are being applied to the problem. Patients may find that as a result of carrying out an ambiguous task that they remember skills and talents that they had long forgotten. They remember positive life experiences. Sometimes the task itself can lead the patient to experience resourceful experiences that they never thought possible.

Case Example

Case Example

I hypnotised her and asked her to recall every trance she had experienced with some five different hypnotists. She was able to recall in trance what they had told her. She said that each one had said more or less the same thing. They had told her that if she drove into the middle of the road she would surely kill herself so she must always tell herself to "not drive into the middle of the road". One hypnotist had told her that this thought would play on her mind and so would stop her from killing herself. I told her that I didn't want to speak to her mind, that I didn't even want to speak to her. I wanted to speak to her hands instead. I then asked her hands whether she had ever broken a finger nail and felt embarrassed about it. She nodded. I told her that when she came out of trance she would feel as if one of her beautiful finger nails had broken and that she would feel very upset and self conscious. I told her that the more she tried to cover it up the more she would feel that I could see it and that she would feel even more compelled to cover it up. I told her that as her feelings got worse she would feel more and more like she wanted them to stop but that the more she wanted them to stop the worse she would feel and so on until I did something "dramatic" to stop the feeling for her.

When she came out of trance she responded exactly as I had asked and became very fidgety all the time playing with her hands. I asked her what was the matter but she didn't want to tell me about her nails. I said to her "It seems like those hands are driving you crazy". She didn't appear to hear me as her mind was totally focused on her hands. I then shouted

"LOOK OUT!" and she suddenly jumped out of her chair and looked totally confused. I put her back into trance and asked her to review the whole experience in relation to her driving and to make a commitment to do something positive.

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Chapter 6 - Visible trance

Deeper trance states

In hypnotherapy there is a pre-supposition that the patient has a conscious and an non-conscious mind. Of course this is only a model. Sigmund Freud believed that the non-conscious mind was a cesspit of repressed sexual memories. Nowadays the non-conscious is believed to be a storehouse for positive resources. In hypnotherapy we take account of both of these views. The non-conscious minds functions as a security guard protecting the conscious mind from traumatic emotions. It may hold back unpleasant memories to protect the patient from pain. It also stores and sorts positive memories. It is from this "store" that the therapist takes his ideas for therapeutic interventions. The non-conscious mind also oversee the body s autonomic processes and healing mechanisms.

Therapists prefer talking to the non-conscious (rather than the conscious) mind. The conscious mind contains the patient's learned limitations which often get in the way of successful therapy. After all, if the patient knew how to get better consciously they would not need to come to a therapist. Despite this obvious revelation many patients like to participate consciously in their own treatment. Patients often like to help themselves through conscious effort so the therapist has to educate the patient about the functions of the conscious and non-conscious minds and play down the former whilst praising the latter. Analogies about the patient "taking for granted" abilities such as being able to write their name without effort or tie a shoelace without thinking serve to highlight the enormous competency and dexterity of the non-conscious mind.

Some patients have difficulty with the concept of mind. As the mind has no physical form it is often hard for them to accept it as a reality. Of course they are quite justified in doing so as it is only a model. With some patients it is useful to talk about the mind in terms of the brain. The brain has two hemispheres. The two sides of the brain have different functions. The right brain is the creative, dreaming and imaginative brain whilst the left brain is the analytical, logical and reasoning brain. Because the "wiring" from the brain's two hemispheres crosses to the opposite side of the body we can surmise that one side of the body (the left side) is more closely linked via the right brain to non-conscious processes. The reverse is true for the conscious mind which is connected via the left brain to the right side of the body.

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When people go into trance many physical changes occur. These changes

" which are called "minimal cues" - are the observable signs of hypnotic trance. These changes do not happen in every hypnotic subject but most will be seen at some time during the trance experience.

1. Eye fixation.

One of the main principles of hypnosis is capturing the subject's attention. If you are telling a compelling story or are using direct eye contact the subject will often defocus their gaze and fix their eyes on either a spot in the room or on your eyes . In these cases you will often see a lack of blink reflex and open eye catalepsy which is an inability to blink or close the eyes.

2. Pupil dilation.

When the subject's eyes defocus you may see a relaxing of the muscles

around the eyes and pupil dilation, depending on the amount of illumination in the room.

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Change in blink reflex.
Often the subject's blink reflex will start to slow down. This is a sign that the subject is going into trance. You can utilise this slowing down in two ways:
You can match the movement of your own eye blinks to that of the subject and then gradually slow down your blink reflex to non-verbally suggest to the subject that their eye lids will shut.
You can associate a hypnotic command such as "deeper", "heavier" or "comfort" to their eye blinks. This will induce further blinking and then eye closure.

4. Rapid Eye Movement
When people dream their eyes move rapidly from left to right as they visualise images associated with their dream. The same phenomenon happens in trance. Often you will see this rapid eye movement (REM) when you ask the subject to visualise something.

5. Eyelid Flutter
Some subjects develop an eyelid flutter. This is an automatic response in some people and does not indicate nervousness. If the subject is concerned about it you can utilise the flutter as a ratification of the trance by commenting on how this particular phenomena is characteristic of a good hypnotic subject.

6. Smoothing of facial muscles.
The muscles in the face will smooth out. They will lose signs of tension in their face and their jaw or shoulders may drop a little. Sometimes subjects hold on to the tension in their jaw or shoulders and you may need to encourage them to relax these muscles with some gentle suggestions.

7. Slowing of respiration.

The subject's breathing will usually slow down and may get deeper. If the breathing becomes too laboured then this suggests that they may have fallen asleep. If this happens you should gently wake them and start the induction again. Usually they develop a nice slow comfortable breathing rate and you can link words like "comfort" and "deeper" to this rhythm to encourage these feelings. It is better to link these words with the subject's exhalations as the body is naturally relaxing more on the out-breath.

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Reduction of the swallow reflex.
People normally swallow about once or twice every minute. In hypnosis this can stop altogether. It is not unusual to find a subject not swallowing for half an hour. If the swallow reflex does not stop altogether there is usually a slowing down of the reflex. If you see an increase in swallowing it is a sign that the subject may be a little nervous. The increase in swallowing can be caused by a dryness of the mouth. This oral dryness is often caused by apprehension or fear and swallowing is generally a conscious response made by the subject to prove to themselves that they can still swallow comfortably. Sometimes very nervous subjects get quite concerned with this difficulty in swallowing. You should re-assure the subject that it is normal (or desirable) during trance induction.

9. Body Immobility.
The subject will develop a comfortable immobility of the body and limbs. They may adjust their position once or twice to get comfortable but after that they usually relax into a comfortable position. If the subject continues to fidget they may be nervous or perhaps the chair may be uncomfortable. If they are nervous you can give suggestions that they need not go any deeper into a trance than is right for them at that moment.

10. Inner absorption.
When people daydream they appear very absorbed in their inner thoughts. They will often demonstrate all of the above minimal cues. So inner absorption is a term used to describe the collective cues of trance.

Everyday trance

Most people are hooked on leisure activities. One of the reasons for this is that these leisure pursuits are often trance inducing. For example, dancing and sports have a trance component in the same way that watching television or listening to music have trance components. Because most people enjoy leisure pursuits they are familiar with the trance experience associated with them. However patients are not usually aware that this particular state of reverie is the same one required for hypnosis. By asking the patient to think about their favourite leisure activity and informing them that the state associated with this is the one required for hypnosis the therapist helps the patient to achieve a trance. Thus trance can be induced by recalling a leisure activity.

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Trance may be associated with certain activities The same is also true of hypnosis. When a patient re-enters trance he re-enters the same psychological and physiological state that occurred the first time he went into a trance state. By asking the patient to recall a leisure activity he automatically recalls the state associated with it. Therapists should always remember this principle whenever communicating therapeutically.

Examples of leisure activity trances:

-Daydreaming.
-Watching television.
-Listening to music.
-Reading a book.
-Concentrating on a task.
-Enjoying a sport.

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-Dancing.
-Performing music.
-Painting, drawing etc.

Utilisation

One of the most important principals of hypnosis is that of utilisation. Always utilise your patients response and feed it back to them in some positive way. This is a very powerful technique and reinforces the level of connection that you have with your patient. Utilise unexpected events, noises interruptions to further deepen your trance induction. Utilisation is also important for therapy as sometimes patients strategies for change are partially effective and can be utilised to create greater levels of change.

Tailor therapy

Two people never have exactly the same problem. When a new patient comes in and complains of the same problem as the previous patient it is never exactly the same problem because it is not the same patient. Every patient is different. Some of the principles that work with one patient may be able to be employed with the new patient but not necessarily the same techniques. People are individual and have different needs. The therapist's job is to identify those needs and change what he is doing to meet the needs of the patient. There are far too many therapists trying to pigeonhole patients. There are therapists who try and get the patient to fit the model of therapy they are using. Why is this? Maybe because they have invested time and money in their own training and feel it must be right or because they are lazy and don't wish to tap into their creative potential. Techniques are helpful for training but it is also important to realise that it's OK to not know what to do next, to feel free to go against the theories taught and develop the flexibility and willingness to change the treatment modality to meet the needs of the patient.

Leisure Interest Hypnotic Induction

First you would question the subject about various hobbies and leisure pursuits which you think might be trance inducing. After explaining that trance is a naturally occurring phenomenon you would ask the subject to remember a time when they were engrossed in a leisure pursuit and possibly were in trance . Then you might proceed as follows-

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Contraindications to a leisure trance induction.

Some people experience trance when driving a car, especially on long journeys. It is inadvisable for the therapist to use such a naturally occurring trance as it can be dangerous as the patient may re-enter trance while driving and crash . In fact patients should be encouraged to rest before driving home. Everyday leisure activities should only be used to induce trance when these leisure activities do not involve danger.

Chapter 7 - Therapeutic Strategies

When patients enter therapy they either want to change what they're doing into something totally new or to alter the degree, duration, or general experience of their problem state. Sometimes it is more appropriate to help a patient improve rather than change e.g. if a heavy smoker requires smoking as a crutch to help relax. A reduction in smoking (an improvement) may be more appropriate initially than getting the smoker to quit altogether.

Once the secondary gains that smoking gives the patient, have been satisfied with something more therapeutic and healthy, smoking can then be terminated. In some cases it's more appropriate for the patient to change completely. For example a nail-biter may wish to just stop biting their nails. As long as there are no secondary gains left unidentified the patient can be helped to stop.

Case Example

A man came to see me complaining of stomach pain. He had been to a number of Doctors and the local hospital and they had told him that it was all in his head. He came to see me because he thought he would try and "get his head fixed". This man was in his seventies and did not have enough money to pay me for my services. Neither did he want to come for many sessions as he was afraid his wife might fin out. I was stuck with the choice of trying to work with the pain directly or work on what might be causing the pain at a deeper level. After the first session I suspected that the problem might have something to do with his wife. As she wasn't to know about his therapy I couldn't see how I could get her to come and see me. Besides he didn't have the time or the money. So I decided to work with the pain directly using Ideo-motor signalling.

First I asked the pain to move down his leg which it did. This confirmed the Doctors' diagnosis that it was probably psychological. He wasn't a particularly good hypnotic subject and I concluded that to be able to move a real physical pain around his body so easily would be very difficult for someone not trained in deep trance phenomena. On the next session I then moved the pain to his shoulder and down his arm into his

wrist. On the following session I moved it into his little finger where it became a mildly irritating throb. Before his next visit he telephoned me saying that he did not want any more help, that he was happy with the pain in the little finger and wanted to keep it like that. This patient was helped through improvement not change. Change would have involved the removal of the symptom altogether, probably by directing therapy at the possible source of the problem, his relationship with his wife. I figured that he had made the right decision to finish therapy when he did. I believed that if he had taken it further it may have led to a split in his marriage. As both were in their mid seventies I saw no point in working on this aspect of the problem purely for the sake of therapy. He still had his pain but it was now manageable and he still had his wife. Presumably she still had what she was getting from the relationship too.

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When deciding whether to initiate or terminate behaviours you should consider your patient's own orientation to the problem. For example if cigarettes are seen as a means of support and maybe even like a friend then despite wanting to stop smoking the patient is going to feel a sense of loss when they give up. This will make relapses more likely. If, however the patient can be made to think of quitting smoking as an opportunity to feel healthier, more active, and socially acceptable then the loss will not seem so great.

The problem with this approach is one of maintaining rapport. If the patient believes that they will be more successful by stopping or losing a behaviour you will have to pace this and appear to agree with them up to a point. Often they will have tried many courses of action and will now be frustrated and so will just want the problem taken away. If you start telling them that this is the wrong way to think about things you will probably lose rapport. You should appear to agree with them and then start to reframe their beliefs. Avoid acknowledging their perspective too

much. Maybe a head nod here and there is enough. You can then get them involved in discussion about the benefits of stopping whatever it is they want to stop doing. You can then turn the discussion around so that both of you are only focused on the achievements and benefits of therapy and the thought of losing or stopping is no longer relevant.

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It should be remembered that patients need motivation to stay in therapy with a particular therapist. If they feel they are getting nowhere they will leave. So go for small changes (improvement) at the start if the problem seems complicated or too big. In these cases always go for the smallest easily obtainable change for the patient first. You need to convince the patient that something positive is happening and this has to be a big enough change to impress them so that they stay in therapy with you. So you have a conflict here. What change will be small enough to accomplish easily yet be big enough to impress them? You will know this answer through experience because it depends totally on your patient, their particular problem and their resources.

Sometime you may spend all of the first therapy session asking questions. If your questions are searching ones and open doors for your patient this may be all you need to do on the first session to impress them. If you seem to be getting nowhere with your questions then spend the last 15 minutes or so inducing trance you at least let your patient know that you can do something for them. The aim is to keep them in therapy long enough for you to help them. It can take a lot of courage for a patient to enter therapy so they want to see something positive for their efforts. It is

important to impress your patient on the first visit, but for any personal gain on your part. You shouldn't attempt to give the impression that you have the answers to every thing or that you are some guru like figure. You just want them to feel secure in knowing that they have made the right decision in seeking help. If you don't appear to be able to help them they will probably leave and may never have the confidence to see any other therapist again. You have no right to treat your patient in this way. So do something for them right away and make sure that it's an improvement.

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When patients communicate information about their problem they will often metaphorically describe the cause of their problem. They may not be aware that they are doing this. The therapist should listen to the kind of language the patient uses, the phrases, the vocabulary and feed this back to build rapport. When the therapist creates a suitable therapeutic metaphor for the patient the therapist can utilise the same statements or vocabulary. This will help the therapeutic metaphor parallel the structure of the patient's problem and be more acceptable to the patient. For example a female patient may talk about letting her hair down. Taken literally this can imply a relaxing of her attitudes and/or a need to maybe appear more physically attractive, but both resulting in greater enjoyment.

A patient presenting with a pain in the neck may be making a statement about themselves or another person. An inability to talk maybe a metaphor for an inability to express anger. There can be any number of interpretations and the therapist should avoid interpreting metaphorical components of symptoms without first having confirmation of repetition of patterns. If a patient presents a problem of bed wetting and continually talks about his inability to express himself and about feelings of being trapped by those around him the bed wetting may be interpreted as a metaphor for expressing himself in an alternative way.

When given a metaphor, the patient goes on a transderivational search. This is search through his sensory Systems and representational Systems. This search happens at an non-conscious level. The patient attempts to find meaning in the metaphor by going inside into a trance state. Within the context of therapy the patient attempts to understand why the therapist is telling a metaphor. The patient realises on one level that the metaphor must have therapeutic value and so searches for structure or resources in order to help himself with his problem.

Because the metaphor is given at the conscious level but contains a deeper structure at the non-conscious level the patient is unaware consciously of the implications given by the therapist in the metaphor. For example if the therapist talks about a tree and how a tree can bend in the wind, the patient may not consciously interpret the metaphor as being a model for new behaviour. If the patient presented a problem of being rigid and unable to be flexible in relationships then the metaphor would be quite appropriate. Ideally a metaphor should make sense at a conscious level but the meaning should only make sense at the non-conscious level.

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When the therapist constructs a metaphor and offers it to the patient, the therapist may not fully know at that time whether the metaphor is right for that particular patient. The metaphor will be designed with the patient's problem in mind. By watching the response of the patient as the metaphor is told, the therapist will be able to calibrate and identify whether the meaning in the metaphor has meaning at an non-conscious level for the patient. This is a very useful way of diagnosing whether the therapist's assumptions are correct. If the therapist's assumptions are incorrect nothing is lost. The patient just feels they've been told a nice story. If the therapist's assumptions are correct then a response will be evoked within the patient and recognised by the therapist. This is usually followed by a change in behaviour.

When designing the metaphor the therapist should attempt to create a story or cast of characters that somehow parallel the structure of the patient's problem. The difference between the patient's problem and the metaphor is that the metaphor has a happy ending. The ending of the metaphor usually suggests new ways of behaving or ways out of the problem situation. These ways have been calculated by the therapist as being the most appropriate behaviour or action to take as a way of resolving the problem. These ways of behaving have usually never been considered by the patient previously. If given to the patient directly in the form of advice, the patient then has the opportunity of rejecting them or sabotaging them. By giving these suggestions or possible solutions to the patient metaphorically they are received by the patient at an non-conscious level. The non-conscious mind then utilises these potential

solutions if they are appropriate and brings about change.

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The Four Seasons Hypnotic Induction

Patients are frequently asked to focus their eyes on a spot or some neutral place and to notice changes in their own physiology as part of the initial stages of trance induction. Patients are most likely to notice alterations in the visual and kinaesthetic experience first before auditory, gustatory and olfactory. Hearing often follows closely behind the visual experience of trance as mental images are formed creating internal representations of sounds that are associated with the mental imagery.

With the four Seasons induction the patient has a three dimensional internal experience of walking through the different seasons of the year. The patient has to see, hear and feel the experience. This overlapping of internal sensory experience deepens the trance state. Whenever the patient has representations of an internal remembered event in all of the sense systems there is a deepening of trance experience.

The therapist should always endeavour to overlap the sensory experience of the patient whilst they are entering trance. In everyday life we see, hear and feel things so why not in trance? It is only natural that a full sensory imagined experience is going to seem more real that a fleeting imagined experience. So attempt to give your patient a full sensory experience of whatever it is they are imagining. However, do not be too specific. You cannot see what they can see inside their head so do not suggest things that may not be part of their imagined experience. For example if you expect them to see a tree. Do not give it a name or describe it in any

detail. The chances are that they are seeing an entirely different tree from you anyway and a too specific description will break rapport and make your patient feel that they are not following your instructions properly. The rule is "be general".

detail. The chances are that they are seeing an entirely different tree from you anyway and a too specific description will break rapport and make your patient feel that they are not following your instructions properly. The rule is "be general".

The four seasons induction can be used as a metaphor for life. It can be suggested that as the patient travels through the various seasons of the year going deeper into trance he can utilise the learning's on this journey as they parallel his life experiences. As a metaphor this is very nonspecific. When a metaphor is open-ended in this way the patient can apply it to their problem or life experience without fear of manipulation on the part of the therapist. Patients will make sense of metaphors in their own way.

A metaphor given to a group of people will have a different meaning for each person. The meaning will come through recognition of parallel structures identified in the metaphor and each person's life experiences. When the metaphor parallels the person's life experience he will make sense of it and maybe use it therapeutically for change. If a metaphor does not parallel the person's life experience nothing is lost. The patient just thinks it's a pleasant story or in this case a pleasant induction.

When this induction is also used as a metaphor for life the patient often sees the experience as a kind of "taking stock" experience. You can

suggest to the non-conscious that it should allow useful therapeutic learning experiences to happen on this journey so that your patient can utilise these learning's for himself in some way. When you do this you should give your patient plenty of time to enjoy the experience (at least one hour).

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-
Therapy is based on either change or improvement
-
Change involves initiating new positive behaviours or terminating old negative behaviours.
-
Improvement involves increasing existing positive behaviours or decreasing existing negative behaviours.
-
Patients often talk in metaphors.
-
Patient's symptoms may be organic metaphors
-
Metaphors can be applied as a diagnostic tool to test the -therapist's hypothesis.
-
Therapeutic metaphors parallel the structure of the patient's problem and lead to solutions.

-
Tasks can be given as metaphors.
-
Therapeutic metaphors by-pass the patient's conscious limitations.
Symptom substitution and resolution.

The therapist can either create a "designer symptom" for the patient and then implant suggestions under hypnosis that the symptom occur as an alternative to the old disabling symptom. Or the therapist can ask the non-conscious mind of the patient to create an alternative less disabling symptom. Sometimes this is enough to deal with the problem that is presented in therapy. If the cause of the problem no longer exists then alteration of the symptom is usually enough to bring about a change. The therapist gradually replaces one symptom with another until the symptom in fact becomes an asset. For example the symptom of psychosomatic

pain could be altered to become an ache. The ache can then be altered to become an itch. The itch can become a pleasant feeling. The pleasant feeling can become a friendly sensation of comfort

pain could be altered to become an ache. The ache can then be altered to become an itch. The itch can become a pleasant feeling. The pleasant feeling can become a friendly sensation of comfort

Altering the intensity, position or form of a symptom is the pre-requisite to actually removing a symptom. By moving the symptom from one location to another in the patient's body the therapist is proving that the symptom is psychological and that it is open for change. Likewise if the therapist reduces the intensity of the symptom in some way. If the therapist is able to actually change the shape of the symptom or transform it from one symptom to another, this then ratifies the therapist's skills and the patient's potential for change.

There has long been an assumption in psychotherapy that every symptom must have a cause. A second assumption is that a symptom cannot be removed whilst a cause still exists, the result being that a second symptom (sometimes more severe) pops up in place of the first one. In effect what we are doing here is utilising this principle or assumption by offering a designer symptom to replace the disabling symptom. However to get back to this assumption that a cause must have an effect this particular model of treatment presupposes that a symptom is difficult to remove whilst a cause still exists. Some causes to problems of course may no longer exist at all in that they have since burnt themselves out and the person is responding habitually to old patterns of behaviour. In such a case the symptom should be easy to remove. This is the principle behind a lot of the NLP techniques.

Symptom substitution cannot occur if the cause of the problem no longer exists. The cause can only be removed if it still exists. We are also saying that spontaneous symptom substitution can occur if a symptom is removed without the cause being handled adequately.

Sensory dissociation techniques

Sensory dissociation techniques

The therapist may ask that the patient imagine a disturbing scenario on a cinema screen. The patient is asked to then see themself sitting in the cinema watching the cinema screen (second position), usually in the projection booth. The patient is then asked to watch themself, watching themself on the screen going through the experience that is traumatic. The patient is dissociated and is free of the uncomfortable kinaesthetic response that is normally associated with the memory.

By dissociating the patient to an observational position, it is possible to watch without negative feelings and learn that is possible to remember the experience with out feeling uncomfortable. This new learning is then carried over into everyday life and more specifically, into the situation in which the phobia occurs.

Exercise - The VK Dissociation Structure.

- Anchor the resource (comfort) on the shoulder.
- See the younger self immediately prior to the trauma projected as a still picture on a cinema screen.
- Float out of body into the projection booth and see the self sitting in the cinema.
- Anchor the dissociation as for the resource (on shoulder).
- Hold the patient's hand and tell them to squeeze it if traumatised.

-
-themselves
on the screen in black and white.

-
At the end of the movie get the patient to associate with the self on the screen and run the movie backwards in colour.
-
Dissociate the patient back to the projection booth and re-run -the movie in colour at normal speed re-associating with the self each time it is run. It is important to give the patient time to accomplish this particular exercise.
Summary Symptoms, cause and dissociation

-
New symptoms can be prescribed to replace old, more disabling ones.
-
Symptoms can be moved, reduced and transformed into more manageable symptoms as an initial stage in symptom resolution.
-
Symptoms can be resolved when there is no remaining underlying cause.
-
Removing the cause of a problem is important because it prevents the patient spontaneously substituting another symptom.
-
Dissociation protects the patient from feelings.
-
The further a patient is dissociated the more remote are the feelings.
-
Dissociation is a natural phenomena.
-
The technique can often treat phobias in one session.
Scrambling symptoms

As stated earlier, every symptom or behaviour has a beginning, a middle and an end. The scrambling technique aims to identify the different stages in the sequence of a behaviour or problem and then literally scramble the different stages so that the patient no longer has access to the smooth

running cause and effect relationship inherent within the pattern. The scrambling process is fairly straight forward; the first step being that the therapist identifies the first step in the symptom or behaviour. For example with a problem such as blushing, the therapist identifies the five stages in the symptom; The first step may be accelerated respiration. The second step may be sweating palms. The third step may be a tightening in the upper chest that the patient interprets as panic. The fourth step may be hot feelings in the face. And the fifth and final step may be feelings of possible blushing or sensations of redness in the face. If we look at this particular sequence we can see that step one is a prerequisite to step two, step two a prerequisite to step three etc., etc. We can see there is a definite sequence of events that occurs as this symptom develops.

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1. Accelerated respiration,
2. Sweating palms,
3. Tightening in upper chest,
4. Hot feelings in the face,
5. Feelings of possible blushing or redness in the face.

Whenever the therapist says number one the patient should be able to go to the step called number one, that is the patient should be able to recall the experience of having accelerated respiration. If the therapist were to say step number four the patient would also be required to recall the experience of step number four: that is hot feelings in the face. Having established this cause and effect relationship between the number and the particular step in the sequence the therapist moves on to the next stage.

This next stage involves the patient re-experiencing the actual internal state associated with the particular step which has also subsequently been associated with a particular number. To do this the therapist asks the patient to experience step number one. As the patient experiences or recalls the accelerated respiration he also attempts to step into the internal state associated with this step of the symptom. The therapist is expecting the patient to induce the kinaesthetic experience of accelerated respiration. Having established this first step the therapist then repeats the same process with step two asking the patient to step into the internal state known as sweating palms. And so on, and so on until the patient is able to re-experience the internal state associated with each step in the

sequence in the symptom.

sequence in the symptom.

By scrambling these steps the patient finds it very difficult to have the pattern run through in chronological order as before. The next phase would be for the therapist to request that the patient experience the different steps in other random orders. This is continued until the patient becomes exhausted. After this point the therapist asks the patient whether they can re-access the original sequence. The patient usually finds it very difficult to do so. In future situations when blushing should occur the patient usually finds that the pattern does not run. Simply because the brain has learnt many other ways of handling the different steps.

Summary – Scrambling

- Symptoms or behaviours have a sequence.
- The therapist can anchor and/or number each step in order.
- Each step is anchored to a different internal state.
- The sequence can be scrambled to disrupt the old pattern and/or sequence from re-occurring.

There is a definite cause and effect relationship between the recollection of an unpleasant memory and the associated feelings. Usually the picture is the pre-requisite to the feeling. The mental image triggers the unpleasant kinaesthetic responses. Likewise patients feel good when they see a pleasant image. The Swish Technique involves asking the patient to access the suitable resource required to erase or neutralise the negative traumatic memory. The patient is first asked to see the behaviour they want to change and then asked to see and feel the positive resource they would like as an alternative. It is assumed that the patient can already see and feel the negative feeling. If the patient does not have access to the picture responsible for the negative feeling then a different therapeutic approach should be applied.

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This swishing process also swishes on a kinaesthetic level. The positive feelings from the resourceful picture neutralise the negative feelings from the negative picture so that the patient has difficulty in re-accessing the original negative feelings. Usually the patient has difficulty in re-accessing the negative image also. As patients rely on their internal images of reference in order to make decisions in the future, the new swished image and related feeling replaces the earlier negative feeling and image as a form of reference. When the patient approaches similar events in the future there is only a neutral response.

Exercise - The Swish Technique

Summary of the Swish Sequence.

-Close your eyes and identify a behaviour you want to change and

visualise the moment prior to the behaviour you want to change. Attempt to feel as if you are actually there in the experience - be associated. You should notice an uncomfortable feeling associated with this picture.

-
Create a positive outcome picture of yourself doing what you would rather do as an alternative to the negative behaviour. See yourself in the picture - be disassociated.
-
See the negative picture big and bright in front of you and put the positive picture into a small space in the bottom corner of the negative picture.
-
Now do the Swish by enlarging and swishing the small positive picture up behind and through the negative picture whilst pushing the negative picture away so that the positive picture replaces the negative picture. You should discover that you shift from associated to disassociated as the positive picture swishes through the negative.
-
Open and close the eyes to "break state" and repeat the above swish several times opening and closing the eyes between each swish.
-
Test - open the eyes and try' and remember the old negative picture.

Chapter 8 - Artful Suggestion

Serial suggestions

Serial suggestions link together specific events from a behaviour that is familiar to the patient For example the patient may be asked to imagine picking an apple from a tree. The therapist then describes in great detail the act of picking the apple: the experience of lifting the hand, feeling the change in muscle tension then releasing the fingers and forming a shape that can hold on to the apple pulling on the apple, testing the grip and the strength of the apple stem feeling the apple pull from the branch as the branch springs back. Hearing sounds and seeing the experience simultaneously.

When used as an induction the patient enters trance as he becomes more and more absorbed in the experience of picking the apple - the more real the therapist can make it the better. By overlapping all of the sense systems, including smell and taste if possible, the patient goes deeper into trance.

If the therapist wants the patient to experience achieving something specific, either in the future or in the past, he can take the patient a step at a time through the experience of the specific event or act. For example, if the patient needed to identify and utilise a resourceful feeling from the past the therapist could take the patient through each step of the memory of having achieved that resource using the serial suggestion technique. Likewise if the patient was having difficulty achieving something in the present, the therapist could take the patient through each step of the behaviour as if it were happening in the future. By filling in all of the specific details of the behaviour the patient can then identify more easily with the experience as if it were really happening.

The main benefit of this is that the patient gets to rehearse the behaviour in great detail. This creates the feeling of already having accomplished it. In the future, when the time arrives for the patient to actually carry out the behaviour, it is done so effortlessly because the patient already knows how to do it and that it will be successful.

Dependent Suggestions

Dependent Suggestions

-Go deeper into trance as you breathe out.
This suggestion hitchhikes the hypnotic response of going into trance onto the ongoing behaviour of breathing out.

Dependent suggestions utilise a link word. This usually occurs in between the suggestion for a hypnotic response and the mention of the ongoing behaviour. Words

such as "until" may also be used when prefixed by a negative, for example "don't go
into trance, until, you close your eyes."

When dependent suggestions are used as an induction technique, the therapist should
observe the minimal cues of ensuing trance and feed them back as dependent suggestions. For example:

-As you breathe you can feel comfortable.
-When your facial muscles relax you can go into trance.
-Don't go deeply into trance until you know you are comfortable.
All of these minimal cues have to be identified by the therapist before they can be fed
back to the patient. The therapist acts as a kind of bio-feedback machine reflecting
the minimal cues as they occur. As the ensuing trance is dependent upon the development of these minimal cues the trance becomes self-generating.

Adjunctive Suggestion

An adjunctive suggestion is an important form of indirect communication. It helps the therapist to bring about changes in awareness while inducing trance or changes in
behaviour. An adjunctive suggestion consists of a truism (a true statement which cannot be denied) followed by a suggestion, although sometimes a suggestion can be

followed by a truism.

For example the truism: you can see your hand. Can be followed by the suggestion: and notice how it feels.

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The following example is a suggestion followed by a pause, followed by a truism:

You can experience a happy feeling pause everyone has some happy memories.

Here the suggestion to have a happy feeling is followed by the truism that everyone has happy memories. The decision on whether to put the truism first or last depends upon the patient's response to the suggestion. If the therapist notices a better response to the truism-suggestion format then he should use that particular structure.

Adjunctive suggestions are so simple and indirect that they can easily be practised in everyday conversation. In fact it is good practice to apply all of the indirect forms of suggestion in everyday speech so that they becomes second nature. If you are only practising only one form of indirect suggestion (the adjunctive for example) then you may seem a bit repetitive.

Indirect suggestions are most effective when used together. If you really want to develop a hypnotic personality you should learn to use indirect suggestion in your everyday conversation.

The word "and" acts as a link between the truism and the suggestion. A pause has the same effect as it represents an implied "and". The "and" and the pause both imply a relationship between the truism and the suggestion though no relationship need really exist.

A non sequitur example of an adjunctive suggestion might be as follows:

You want to get better and your arm can lift all by itself.

Here there is no real relationship between the truism, "you want to get better" and the suggestion: "your arm will lift by itself". However there is an implication that there is a relationship.

Indirect suggestions are used for inducing trance but they should also be used for

inducing therapeutic change. An adjunctive suggestion for induction of trance would
be as follows, "You can notice you're blinking and feel that heaviness in your
eyelids". An example of an adjunctive suggestion for therapeutic change could be as
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be as follows, "You can notice you're blinking and feel that heaviness in your
eyelids". An example of an adjunctive suggestion for therapeutic change could be as
follows;

Naturally, the therapist would only give this kind of suggestion if he has knowledge
that the patient has previous experience of feeling relaxed. A truism cannot be denied
and is a statement of fact. The truism always ratifies the suggestion. It helps bind
beliefs together. It helps build rapport and helps build trust. Without the truism the
suggestion has no firm foundation.

If the therapist gives the patient an adjunctive suggestion consisting of a truism about
an undeniable, external, observable behaviour followed by a suggestion for a
possible, yet internal and as yet, unverified behaviour the patient will experience a
shifting of awareness from external to internal reality.

For example in the following adjunctive suggestion the truism is an observable,
verifiable behaviour and the suggestion an internal, unverified experience,

You're looking out into the distance, and, all kinds of memories come to mind.

If the therapist gives a series of these adjunctive suggestions the patient has to make
a shift in his awareness from an external to an internal reality. This is trance
inducing. So a trance can be induced using only adjunctive suggestions. Each
suggestion should overlap the preceding one and take the patient on an internal
journey from observable truisms to non- observable experiences. For example the
following are a series of adjunctive suggestions that could be used together with
others of the same class for inducing trance.

-
You can see your hand - and - feel the texture of your trousers.
-
You can feel the texture - and - feel a warm sensation in your body.
-
You can experience those sensations developing now - and - remember some
place that was warm and comfortable.
Here we see the first adjunctive suggestion as a truism about an observable
experience - "see your hand", followed by a suggestion about an observable
experience - 'feel the texture of your trousers". This truism and suggestion paces the
patient's ongoing experience and helps to build rapport as well as directing the

patient to focus internally. It is followed by the observable truism to 'feel the texture"
and then the non-observable suggestion to 'feel a warm sensation in your body". This
adjunctive suggestion takes the patient one step closer to trance. It does this first by
pacing their previous experience by stating a truism about their response to the first
adjunctive suggestion. Then by offering the new non-observable suggestion to be
aware of a warm sensation in the body it takes the patient further into trance.

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adjunctive suggestion. Then by offering the new non-observable suggestion to be
aware of a warm sensation in the body it takes the patient further into trance.

a. Observable - Observable
b. Observable - Non-observable
c. Non-observable - Non-observable.
There are two ways in which these series of adjunctive suggestions can be used as an
induction procedure. Firstly they can be used as above in groups of three. In this

instance the therapist would give three suggestions starting with observable and
finishing with non-observable, thereby directing the patient's attention inward by

repeating the pattern with new suggestions that follow the same structure, the patient
is taken in and out of trance many times.

Alternatively the therapist can offer many kinds of observable - observable
suggestions, followed by many kinds of observable - non-observable suggestions,
followed by many non-observable - non-observable suggestions. In this case the
patient should gradually go into trance over the course of the repetitions.

The latter may seem a better approach because it always moves the patient in the
direction of trance. The former has the advantage of continually re-inducing trance
over and over again and putting the patient into a double bind. Continual re-induction
of trance is a deepening process but is also quite tiring for the patient. If patients pay
strict attention to the therapist's suggestions, they are taken in and out of trance many
times but never quite deep enough to satisfy them. This creates frustration for the
patient and makes the prospect of trance more compelling. On the other hand, if they
find the suggestions too tiring they will want to ignore them.

As patients are already fatigued by accepting suggestions, it becomes easy for

them
let go and enter trance fully. Normally you would not limit yourself to adjunctive

suggestions alone as an induction procedure. However, it is good practice to limit yourself to only a few hypnotic tools for training purposes and see what you can accomplish. Many therapists tend to throw their entire tool box at the patient and hope that somehow it will all come together. The real art is to apply the right tools at the right time with the right patient. This develops with experimentation.

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This induction is based on a shifting of awareness combined with eye fatigue. Your patient is asked to direct their attention to the external world and focus on one spot just above eye level. Also ask your patient to listen for external sounds and be very sensitive to tactile feelings. When you are certain that your patient is directing their attention externally, then ask your patient to slowly close their eyes once you have counted from one to three. On the count of three ask them to close their eyes. You should then ask them to visualise some relaxing scene. Your patient should relax their muscles and experience the sights, sounds and feelings associated with their relaxing place.

Once your patient is focussing internally you should ask them to try and open their eyes once you have reversed the count. You then count backwards from three to one and emphasise the difficulty in opening their eyes. Your patient should then be asked to try and sharpen up each of their senses in turn. This pattern is repeated with your patient closing and opening their eyes whilst simultaneously shifting their awareness from internal to external awareness and back again until their eyes are too tired to open again.

Passive Response Suggestions

When patients experience hypnosis they sometimes fidget or talk and become too actively involved at the conscious level. Passive response suggestions request that the patient do nothing consciously. These suggestions emphasise the activity of the non-conscious mind. As therapists we do not want our patient interfering on a conscious

level. Sabotaging of therapy is often done at a conscious level so ideally we want the
conscious mind out of the way. Here are some examples of passive response
suggestions:

-Nothing is important except the process of your non-conscious mind.
Here we see a suggestion that emphasises the non-conscious mind whilst
simultaneously playing down the conscious mind.

-
-
This suggestion emphasises the spontaneity of the patient. It actually asks the patient
to wait to experience an non-consciously generated trance experience. The only conscious activity suggested is wondering which is itself trance inducing.

-
You don't have to try to change that problem, your non-conscious mind can do it for you.
Here again we see the emphasis on the non-conscious mind's involvement in problem solving. As stated earlier in the book, patients often reinforce their problems by

trying to solve them. Here we are suggesting that the patient does not try to solve the
problem and leaves it up to the non-conscious mind. This developing trust in the non-
conscious mind is an important part of therapy. Patients should be encouraged to trust their non-conscious mind more and more. If this trust can be maintained and carried over into everyday life when the patient finishes therapy then they should feel
more responsible for their own personal change.

Open Ended Suggestions

Open - ended suggestions offer the patient a number of mutually appropriate choices.
Open - ended suggestions usually give a number of choices rather than just two. The
therapist covers all kinds of response in order to re-frame any response as being appropriate. Here are some examples of open - ended suggestions:

-
You can dream, imagine, picture, visualise, any memory you like.
So here we see a suggestion for some kind of internal imaging. It does not matter which option the patient chooses, whether to dream, imagine, picture etc., he has to
visualise an image of some kind.

-
Your hand can lift, move to the left, the right, press down or stay as it is as you
go into trance.
Here we see an open - ended suggestion related to hand or arm levitation. The patient's non-conscious mind is free to move the arm in whatever way it wishes. However notice that even no movement is included as a valid response.

-
Will you smoke six, eight, three, ten or even two cigarettes a day as you practice your self hypnosis?

So here we see the open - ended suggestion applied to therapy rather than to hypnosis. This open - ended approach uses a post - hypnotic suggestion that appears
to give the patient a choice in how to respond. However there is a presumption that
the patient will cut down on smoking.

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the patient will cut down on smoking.

A double entendre is usually the name given to any phrase which has a double meaning. Suggestive jokes often have this particular structure. Maybe one word or phrase in the joke can be re-interpreted as being something rude. The effect of the
potential misunderstanding caused by the double meaning in a joke is what makes it

humorous. Here are some examples of double entendre suggestions.

-
Sit in this chair and take a weight off your mind.
Here we see a double meaning in the word "weight". This would be an interesting suggestion to give to a patient who was obese.

-
As you wonder where the feelings have gone in your hands there's no arm (harm) in looking.
Here we see a play on words. The word "harm" is mispronounced to sound like arm". This would be a useful suggestion when attempting to promote anaesthesia in the arm or a negative hallucination for the arm.

-
Your non-conscious mind has a gift for you, you can feel its presence.
Once again there is a play on words . The word "presence" sounds almost identical to
"presents" and this also echoes the word "gift".

Summary - Suggestions

-
Serial suggestions link together specific minimal events from a behaviour that is familiar to the patient
-
Serial suggestions can be used as a trance induction.

-
-
-
Dependent suggestions "hitchhike" a hypnotic response onto an ongoing behaviour.
-
Words such as: "until", "when", "as", link the ongoing behaviour to the request for a hypnotic response.

-
Dependent suggestions can feed back minimal cues.
-
Adjunctive suggestions contain a truism and a suggestion.
-
The truism and suggestion are linked by an "and" or a pause.
-
Adjunctive suggestions can be used for inductions or therapy.
-
Adjunctive suggestions can help shift the patient's awareness from external to internal reality.
-
Double entendres deliver two simultaneous messages, one for the conscious and one for the non-conscious mind.
Illusions of choice

Binds and Double Binds

Double binds are one of the most effective indirect language skills we have available
for inducing trance or encouraging therapeutic change. The double bind appears to give the patient a choice but the choice is only an illusion. The prerequisite to structuring a double bind is the embedded presupposition that something will occur.
When the patient is asked to choose between two or more alternatives it is already

presupposed that the behaviour being suggested by the therapist will occur as a result
of either choice made by the patient. For example to ask "do you prefer tea or coffee?" is to presuppose that the person is going to drink. Because the question does
not ask whether the person wants a drink but is more concerned with what kind of drink the patient wants, the patient answers the question without being aware that

they have committed themselves to drinking something.

1) Binds

These are questions that can be answered consciously by the patient. For example "do you want to go into trance in this chair or that chair?" The therapist is asking a

simple question which can be answered consciously.

simple question which can be answered consciously.

A double bind requires that the response or choice be made at an non-conscious level. For example if you say "are you going deeper into trance as you inhale or you
exhale ?" then the patient becomes more aware of changes in his own internal experience. There is a presupposition that the patient is going to enter trance. In order to answer the question the patient has to pay attention to the changes in his
internal state. These changes can only occur on an non-conscious level so he has to
wait for the hypnotic response before he can answer the question. The experience of
waiting and focusing attention inward is itself trance inducing.

3) Conscious / Non-conscious Double Binds

Suggestions such as "you can remember certain memories and your non-conscious mind can remember others, which come first?" require the patient to not only wait for
an answer at an non-conscious level but to emphasise the difference between conscious and non-conscious processing. In therapy it is always useful to separate the
non-conscious from the conscious mind to avoid sabotage by the conscious mind or recall of communications directed solely to the non-conscious mind. It also helps to
promote a structured amnesia for traumatic memories repressed at an non-conscious level.

Many of the forms of hypnotic suggestion are designed to dissociate the conscious from the non-conscious mind.

Examples of binds

-
Would you like to go into trance standing up or sitting down?
-
Do you prefer to have your hands on your lap or on the arms of the chair to go into trance?
Examples of double binds:

-
Do you begin to feel a numbness in the fingers or in the back of the hand first?
-
Will it be the right or the left hand that lifts first all by itself?

Examples of conscious/non-conscious double binds

Examples of conscious/non-conscious double binds

-
I can talk to you (conscious) and I can talk to you (non-conscious) and you (non-conscious) can respond without you (conscious) knowing how you are doing it.
Arm Levitation Hypnotic Induction

One of the most classic inductions is the Arm Levitation Induction. This form of induction has been used by most hypnotists at some time, however Erickson refined it and applied his indirect hypnotic skills, developing it into a utilisation approach.

Previously, the hypnotist would suggest levitation in a direct and authoritarian manner - unfortunately this gave the impression that the arm levitation was caused by the "power" of the hypnotist. Erickson's approach allowed the patient to experience the arm levitation happening from inside himself as if the response was the result of non-conscious processes caused by the association of ideas.

Erickson would often "seed" suggestions for hypnotic phenomena long before he asked for them to happen . By offering casual anecdotes, analogies and metaphors about lifting, lightness and levitation he would seed the idea of arm levitation so that the patient's non-conscious mind picked up on the indirect suggestion for arm levitation to occur.

Anticipation and expectancy compound the success of arm levitation. You should expect the arm to lift whilst leaving a little room for escape in case it doesn't. The patient will usually pick up on apprehension and doubt communicated by an unconfident therapist. When you attempt an arm levitation you should pace yourself

so as to be one step ahead of the patient. You can do this by paying attention to the experience and physiology of the patient. If an arm is going to lift the patient will tell you in their own way either verbally or non-verbally.

First you should draw their attention to any difference between their right arm and left arm. You should do this in an enquiring way and with an anticipation that there will be a difference. Your anticipation of a difference will be picked up by the patient at an non-conscious level and this will create expectation. Further requests to pay attention to the difference will compound the sensations in either arm.

You can use almost any difference in sensation as a starting point. Warmth, cold, lightness, heaviness, numbness, pins and needles etc. As soon as the patient recognises one sensation in one arm you can imply that they will experience the opposite sensation in the other arm. You can further suggest that the more one arm

feels one sensation the more the other arm will feel the opposite sensation. So you
work one sensation against the other. Warmth and coolness, heaviness and lightness,
sensitivity and numbness etc. This is called the law of reversed effect. Obviously if
one hand feels heavier than the other then the other will feel lighter. You are only
capitalising on naturally occurring phenomena. The next step is to lead the patient
into expecting the arm to lift. You can do this by overlapping your suggestions of

sensations to suggestions of lifting in one arm more the other.

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sensations to suggestions of lifting in one arm more the other.

Summary Bind and Double Binds

-
Binds give a patient a conscious choice
-
Double binds give an illusionary choice.
-
Conscious/non-conscious double binds are the same as double binds but emphasise the dissociation between the conscious and the non-conscious mind.

Chapter 9 - Trance Phenomenon

Chapter 9 - Trance Phenomenon

In hypnotherapy, therapists can communicate with the patient's non-conscious mind by instructing it to move a finger. A usual pattern is that a finger of the right hand lifts for a "yes" answer, while finger movement on the left hand indicates a "no" response to questions directed to the non-conscious. Ideally there should be no conscious participation by the patient as they are usually unaware of these finger movements. It is easy to tell the difference between a conscious and non-conscious response. A conscious response is a direct, immediate lifting of the finger while an non-conscious response is a slow, minimal, often jerky movement that may take some time.

Sometimes the patient may also nod or shake their head without realising it. Because head nodding and shaking is a part of our everyday life it can happen quite naturally. However head nods, when non-consciously generated, are slow and barely noticeable. If a patient nods their head in a very enthusiastic way then the response is probably a conscious one and should be disregarded. The same can be said of a foot movement or maybe a movement of facial muscles. With true ideo-motor responses there is often a delay before a response is seen and this is usually jerky. An instant smooth response suggests that the patient is responding consciously. You may see only a twitching of the muscles in the back of the hand or a lateral movement of one of the fingers. Sometimes a movement may occur in different parts of the hand in consecutive sessions.

Ideo-motor responses are used to communicate directly with the non-conscious, the part of the patient that knows more about the problem than they do. The patient usually has their problem because they try to solve it consciously. By communicating directly with the non-conscious mind the therapist is able to call upon relatively unlimited non-conscious resources for problem solving. In this way some negotiation can be carried out between the therapist and the patient's non-conscious. The patient need not have any conscious knowledge of the communication. However, patients will often remember part of the communication.

The patient's non-conscious mind will rarely give an explanation for the

problem. Any attempt at evoking direct answers via finger signalling is severely limited especially as the fingers can only say "yes" or "no". When recording information obtained via finger signalling the therapist should list the questions and answers on a sheet of paper. Sometimes the responses can be quite confusing and contradictory because the non-conscious mind has its own sense of logic and these response can be entertaining and challenging for the therapist. Keeping a clear written record of the responses as the session progresses will usually help you to keep track of the non-conscious communication.

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An ideo-motor response is evoked at an unconcious level
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Ideo-motor signalling is usually an non-consciously - controlled movement of a finger
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It can also be an non-conscious movement of the head, foot or other part of the body.
-
There is usually a delay in an ideo-motor response.
-
An ideo-motor response can often be a very minimal movement.
Anchoring

Anchoring is an NLP term used to describe a form of classic conditioning. It involves the setting of a particular trigger, maybe a touch on the arm, a particular word, or a visual stimulus. When this trigger is given the patient responds accordingly. Anchoring follows a similar principle to post - hypnotic suggestion in which the patient responds automatically to a cue given initially under hypnosis by the therapist. In NLP we give the patient the initial trigger either indirectly or directly in the conscious state. Triggers given under hypnosis are usually more powerful. An example of anchoring would be one where the therapist touches the patient on the shoulder as the patient laughs about a happy memory. This should be done several times in order to create an association between the touch on the shoulder and the feeling of happiness. Later in the session the therapist can casually touch the patient on the shoulder - at critical moments in the therapy session - and so evoke

the good feelings associated with the touch on the shoulder. Because most of our learning occurs in this way through simple stimulus - response mechanisms most patients are familiar with anchoring though they may not be consciously aware of it. As anchoring is an everyday occurrence it is quite natural for the therapist to use this form of association when helping patients make important changes. To get a good response from a patient the therapist needs to give an effective and precise trigger and this should be in the same place every time the patient is anchored.

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Anchoring can be done in an overt way when the patient requests it or when the therapist considers that the patient should be made aware of it, for example in any case where a patient is particularly analytical and likes to have an awareness of therapeutic processes.

The purpose of anchoring is to evoke a response of some kind. There is no point in giving an anchor and then just wondering whether a response has developed. A congruent, definite response must be observed before the therapist terminates the anchor. There are two stages to anchoring - the initial placing of the anchor and the subsequent triggering of it. In both cases anchoring should be precise and continued until a response develops.

In anchoring we anchor negative feelings and positive feelings. These positive feelings are called resources. Often patients have very strong negative feelings so the therapist should make sure that any positive feelings that are anchored are as strong (if not stronger) than these negative feelings. The therapist does this by stacking anchors. Stacked resources are a series of good feelings literally stacked one upon the other with the same positive anchor. This stacking process reinforces the good feelings. The therapist should continue stacking the positive resources until the positive feeling is stronger than the negative feeling.

The Stop Smoking Strategy

This strategy has four specific steps and these have to be followed in order. Each step involves a different feeling, picture or auditory component and each step automatically triggers the next.

This strategy has four specific steps and these have to be followed in order. Each step involves a different feeling, picture or auditory component and each step automatically triggers the next.
The first step is the trigger.
The first step involves asking your patient to visualise their own hand reaching for a pack of cigarettes. You should not use the image of a pack of cigarettes on its own as the strategy may then become generalised to all contexts in which packs of cigarettes feature like shop windows or packets in another person's hands. The idea is that the patient sees their own hand reaching out for their own cigarettes. Because this is a universal behaviour for most smokers it should be easy for the patient to recall. For smokers who roll their own cigarettes the image should be of their hand either rolling a cigarette or of their hand lifting a cigarette to their mouth. The same applies to pipe smokers. You can use changes in sub-modalities if you wish to intensify the image of the cigarettes. For patients who are poor visualisers you can use the feeling of reaching for a pack of cigarettes as the trigger.

2. The second step is the aversion.
Now you ask your patient to let the picture/feeling of the pack of cigarettes fade into the background. Once this has happened ask your patient to think of the worst consequences of continuing smoking. Most patients think of a deterioration of health or death as the worst thing that could happen. Often this is not sufficient because the smoker has already learned to put a psychological distance between the act of smoking and death or poor health. Most smokers have not taken this to its next logical step and considered how it would affect others in their life. Usually when the therapist suggests how it could affect others (especially children) the patient experiences quite intense distress. This is exactly the feeling you want them to achieve at this point. You should anchor this feeling with a touch on the shoulder, if appropriate, and reinforce the intensity of the feeling by either describing it in visual, auditory and kinaesthetic terms or by just talking about how awful it must feel.

3. The third step is the statement.
Your patient says "No" out loud . If this is inappropriate he can say it

quietly internally. Your patient says "No" to the idea of dying and others suffering. By saying "No" they are pushing the negative picture and feeling out of their mind. Allow your patient to let his "No" push away the picture and its associated awful feeling.

quietly internally. Your patient says "No" to the idea of dying and others suffering. By saying "No" they are pushing the negative picture and feeling out of their mind. Allow your patient to let his "No" push away the picture and its associated awful feeling.
The fourth step is the positive consequence of quitting.
Your patient is asked to see and feel the benefits of having said "no" to the negative consequences of smoking. For example they may see themselves happily playing with their children or even grandchildren. This implies that they have lived long enough for this to happen.

If you use this approach with a younger person they may have difficulty accessing an aversion related to death or poor health. The loss of income or savings caused by an expensive smoking habit may be more appropriate. You should really ask your patient what they feel would make them think seriously about quitting. If they cannot think of anything then a different approach may be more appropriate.

In general it is a bad idea to suggest that a particular patient should be scared of dying unless you know that is how they already feel. Some patients are not afraid of death but do fear poor health. Some do not worry about either but are afraid for others who might suffer as a consequence. Patients should be encouraged to be unafraid of death and see it instead as a natural, inevitable process and possibly the start of a new spiritual journey. By asking your patient to think of the effect their death will have on others you are avoiding suggesting that they should personally feel afraid of dying.

Naturally they may also wish that others have the same perspective and also be unafraid of death. In this case focus more on the loss of social contact they may have if they kept smoking, or the smell on their clothing and hair or the loss of self - esteem they might suffer if they were unable quit.

Summary Anchoring

-Anchoring is an everyday occurrence.
-Anchoring should be precise.

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-An anchor should be reinforced until a response develops.
-Resources should be stacked.
Abreaction and Trauma

Abreactions are sometimes produced deliberately or they may occur spontaneously. They usually involve a total re-experiencing of an early life trauma in great detail which can often be dramatic and frightening - not only for the patient but also for the therapist. Some people are aware of early traumatic events while others have forgotten them. Amnesia usually exists when the trauma is so severe that the child blocks out the experience as a way of surviving. This is particularly true in the case of multiple personality. Multiple personality, often caused by abuse, is the experiencing of many sub-personalities caused by continual abuse followed by dissociation from the traumatic experience. The child learns to dissociate from the memory and create an amnesia for the experience. When the child is subsequently abused he follows the same pattern until a number of personalities exist, each with their own unique experience and their own personality. These personalities usually have no knowledge of each other at a conscious level. Once an abreaction has occurred patients usually remember the event although sometimes a spontaneous amnesia occurs as well.

In therapy we can work with the raw materials and emotion - which can be provided by an abreaction - is the rawest material of all. If an abreaction starts to occur spontaneously the therapist should allow it to develop. If the abreaction is prevented from occurring it is usually very difficult to access at a later date. The reason for this is that the patient now has an awareness of a hidden traumatic experience. The patient is aware that at any time these feelings could overwhelm. Any attempt to evoke the abreaction will usually result in intense resistance to any efforts by the therapist. Once an abreaction does occur it should not be terminated halfway through. This would only leave the work half done. Abreaction should be carried through to the very end. By going through the whole cycle of experience the patient is able to express the feelings fully. Usually when this is complete the patient experiences a release of feelings, intense exhaustion, and extreme stress.

As well as being terrifying for the patient abreactions can be frightening

for the inexperienced therapist. Sometimes patients may even become violent. This is especially true when the patient identifies the therapist as a participant in the traumatic experience. If a transference occurs so that the patient imagines the therapist to be an active participant in the early life memory he can become aggressive towards the therapist. In these cases, both the therapist and the patient should be protected.. Whenever possible the therapist should remain calm and detached from the experience whilst maintaining control of the situation and support for the patient as they abreact.

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Usually traumatic memories have a cast of characters. In the case of abuse it may be one person. In the case of humiliation, for example a child at school being laughed at, it may be a number of characters. The patient will usually have intense feelings towards the characters in the trauma. These feelings may be anger, resentment, and possibly even revenge. The feelings that the patient has are usually negative and aggressive in some way. Patients are quite justified in feeling like this as they have probably carried around the symptoms of this event for most of their life. Sometimes it is positive to allow the patient to keep these feelings. Usually it is more therapeutic to reframe these feelings in some way.

For example a child abused by a parent will feel very angry and resentful yet at the same time want to be loved. The needing to be loved is an important element in Reframing the patient's beliefs about and attitudes towards the parent. The parent may be alive or dead but the patient's feelings of anger may still be the same. One approach might be for the therapist to suggest that the parent had a reason for abusing. Usually the patient has information about the parent received non-consciously in childhood. The patient may even be able to give valid reasons why the parent abused. Bearing in mind that the patient wishes to be loved he may

be willing to look at ways of understanding why the parent abused.

be willing to look at ways of understanding why the parent abused.

Summary Abreactions

- An abreaction is the reliving of traumatic early life experience.
- These traumas have often been repressed and amnesia for the traumas may exist prior to the abreaction.
- An abreaction should be carried through to the end.
- An abreaction can be dramatic and the therapist should stay calm throughout.
- An abreaction can sometimes lead to realisation but rarely resolution.
- Patients often feel vulnerable after an abreaction - this is when therapy should occur.
- Where the abuser is no longer alive, the guilty parties / negative experiences / events can be reframed to "heal the memory".

Chapter 10 - Multiple mirrors

Multiple dissociation

Hypnotic hallucination is one of the classic hypnotic phenomena. Patients can be persuaded to see things that are not there (positive hypnotic hallucination) or fail to see things that are there (negative hypnotic hallucination). Hallucinations occur through a fairly deep trance state

involving suggestions that the patient sees something or fails to see something on a given signal.

involving suggestions that the patient sees something or fails to see something on a given signal.

Dissociation is a useful therapeutic tool. A patient may experience new insights through the experience of observing themselves from a dissociated position. Additional insights can be achieved through a further dissociation to a second position in which they see themselves watching themselves. Thus the patient experiences an objective perspective. If the patient is dissociated once more to the third position (in which he has stepped out of his body three times) additional objective insights can be obtained. This process of stepping out of the body up to three times causes a dissociation from their feelings. This allows the patient to experience stressful situations without experiencing any of the unpleasant emotions; this is particularly useful when treating phobias or traumatic memories. The advanced therapeutic hypnotic induction regression method known as "The Multiple Mirror Technique" is such a dissociation technique.

For a hallucination to qualify as one of the classic hypnotic phenomena it has to be experienced by the patient with eyes open. Often this kind of phenomenon will be achieved with a post - hypnotic suggestion. The therapist may suggest that the patient will notice an alteration in his visual field when he comes out of trance. Hypnotic hallucination can be useful for ratifying or deepening trance, and for therapy. It can also be employed as a form of Gestalt Technique in which the patient is asked to see a relative or friend when that person is not present. In Gestalt the patient imagines the other person whereas in hypnosis the patient really believes that the other person is in the room.

The therapist might want to induce a negative hallucination to teach the patient to be unaware of stimuli. This would be particularly useful in pain control cases.

This technique can also be used to allow the patient to enter into potential phobic situations and test their response without having to enter the real life situation, for example, with a fear of dogs. Having created a positive hallucination of a dog, the therapist can then make changes to this image

which help the patient to lose the phobia.

which help the patient to lose the phobia.

This technique is excellent for patients who are confused or lack direction in life. A trance is induced and the patient then hallucinates either a group of crystal balls or a number of movie screens on which they see various important life events. The therapist asks the patient to allow their non-conscious mind to choose the events that are most relevant to their problem. While in this dissociated state the patient cannot feel the unpleasant emotions connected with these memories. This allows a safe review of early life experiences without much stress.

The result of this technique is often that the patient is able to move forward in life having reorganised their previous life experiences, "sorted through old files" and re- appraised some life experiences. By viewing several events simultaneously patients may recognise new behaviour patterns and this allows them to reinforce useful ones or alter others which are of no value.

A review of positive life experiences can be as therapeutic as an appraisal of negative ones. Some patients will have had few negative experiences and may only be in therapy because they lack direction - in this case it can be rewarding to sort through the files. However most patients see negative and positive experiences simultaneously in different balls - an experience which can be very therapeutic.

The patient's ability to hallucinate crystal balls and multiple screens usually depends on their hypnotic personality and depth of trance. A relatively deep state of trance is needed if patients are to hallucinate with their eyes open. If you think your patients are unable to experience this kind of phenomenon then you can suggest that they imagine the crystal balls while their eyes are closed. It is my experience that those patients who are able to hallucinate with their eyes open usually find the experience more rewarding and more effective

Exercise - The Multiple Mirror Technique

In this particular technique your patient is encouraged to see himself/herself in a mirror whilst stepping out of their body to either the left or the right. Further dissociation can be achieved by either asking the

patient to step out of the self that has previously stepped out of the body (like a set of Russian dolls) or by having many different sub-selves stepping out of the patient in turn. This particular technique is fairly useful for inducing age regression whilst inducing trance.

patient to step out of the self that has previously stepped out of the body (like a set of Russian dolls) or by having many different sub-selves stepping out of the patient in turn. This particular technique is fairly useful for inducing age regression whilst inducing trance.

The selves can be encouraged to form a committee of selves to work on the patient's problem. The patient can be encouraged to converse with the different selves or give support to each self as part of the healing process. This process of therapeutic negotiation can be very powerful for the patient. It uses non-conscious processes that give the patient the feeling that their non-conscious mind is an important part of the healing process.

The selves should always be re-integrated before trance or therapy is terminated. You should not leave your patient in a dissociated or regressed state. You should always ask that they put themselves back together. The taking apart and re-integrating is an important part of the healing process. It helps the patient develop insight into the structure of their problem and gives them the opportunity to give resources to the self at different ages. Therapy can also be given to the self at these different stages of development. The technique should not be used with psychotic patients or patients with multiple personality disorders.

Summary Hallucination

-Patients can hallucinate in hypnosis
-Hallucinations can be positive or negative.
-Hypnotic dissociation is a from of hallucination
-Dissociation protects the patient from feelings.
-Dissociating the patient to the second or third person position can

lead to insight or new understanding.

-
Patients can be asked to see important life experiences in hallucinated crystal balls or on multiple movie screens.
-
Patients are dissociated whilst viewing.
-
Patients re-organise or take stock of their life experiences whilst and or after viewing.
-
Life experiences can he positive and/or negative.
-
Viewing can he done with eyes open or closed.

Distorting time

Time distortion was one of the first hypnotic phenomenon to be explored by Milton Erickson. Erickson applied time distortion to identify how much time was required by patients to accomplish tasks which normally would involve many hours of work. Perhaps he was looking into the possibility of accelerated learning though he did not acknowledge this openly. Hypnotised patients can be given a task and be told that they have been working on it for a number of hours. The therapist then gives the patient only a few minutes of real time. The subsequent distortion of time under hypnosis allows the patient to gain the experience normally associated with training of a longer duration.

Obviously no person can store information that takes time to comprehend. You cannot ask a patient to read a book and expect that new information which normally takes hours to acquire will somehow magically be remembered. However for the revision of previously learned material it is possible to convince a patient under hypnosis that they have revised a certain topic (which would normally take hours to do). This is possible because information is stored at an non-conscious level and the revision process is just a way of bringing this material to the surface.

This retrieval of non-conscious information is often difficult in normal consciousness because so much effort is needed. However if the patient is asked to allow the process to occur non-consciously in trance then the information is readily available. If this is suggested within the context of

a time distortion exercise then the patient believes consciously and non-consciously that the outcome of accelerated learning has occurred.

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We have already talked about using time distortion for accelerated learning. It is also possible to use the technique for desensitisation. The therapist asks the patient to re-experience a traumatic event or fear in slow motion. By giving the patient control over the speed of remembering or replaying an event, the therapist gives the patient more control of and responsibility for their own treatment. Patients can freeze-frame an event or speed it up. In pain control work you can suggest that the duration of the pain lessen using a "fast forward" technique. The patient can also be taught to lengthen the pain - free intervals in cases where the discomfort is intermittent

Summary – Time Distortion

- In hypnosis time can be contracted and expanded.
- Contracted time distortion is a common spontaneous hypnotic phenomenon.
- Time distortion is useful for accelerated learning, desensitisation and pain control.

Chapter 11 - Snowballing effects

Chapter 11 - Snowballing effects

Most therapy happens between sessions because of the ﷺsnowballingﷺ effect that occurs when a therapist intervenes in a patient's life. A healing hypnotherapist will intervene so as to cause a chain reaction, which of course is therapeutic as it allows some changes to occur in the patient's life between sessions and after therapy is finished. The therapist is not just a problem solver but should also a teacher. The patient must learn how to solve problems in the present moment and also understand how to avoid future problems and accomplish long- term goals.

One day all patients have to terminate therapy. The duration of therapy can vary and some Patients may be in therapy for just three or four sessions. Even if therapy is of a short duration there may be a ﷺsnowballingﷺ effect after therapy has finished. It is not unusual to find dramatic changes happening much later in a patient's life as a result of therapy during the problem phase of the patient's life. These changes can sometimes be the result of the therapist's intervention though often there may be no direct cause - and - effect relationship. However when the therapist or patient reviews the past it is often clear that certain events or situations only occurred because of the therapist's intervention.

As healing hypnotherapists we do not want our patients to become dependent on us. Patients should feel responsible for their own changes whilst acknowledging the participation of the therapist. When the therapist considers that treatment is nearly over he should start weaning the patient off therapy. This is done in two ways -

a) Re-framing therapist/patient relationship.
b) Clearly defining long term goals for the patient.

Normally the patient considers that the therapist is at least partially responsible for any therapeutic changes that occur. Usually a friendship develops and while this is useful for building rapport it should not become so strong that the patient feels reluctant to finish the therapy. It would be wrong for a patient to remain in therapy simply because he or she is afraid of losing a friend, so the therapist has to re-frame the relationship. The patient needs to know the therapist is always going to be there even if the patient no longer attends. The patient should feel

responsible for their own recovery, yet also acknowledge the help of the therapist. Just knowing that the therapist is available if required, should encourage the patient to feel more independent and able to leave the therapeutic partnership.

responsible for their own recovery, yet also acknowledge the help of the therapist. Just knowing that the therapist is available if required, should encourage the patient to feel more independent and able to leave the therapeutic partnership.

Future planning criteria:

- The therapist should pay attention to the snowballing effect of his interventions.
- The therapist should develop ways of helping the patient to decrease dependency on the therapist.
- The therapist should learn how to re-frame the therapeutic relationship.
- The therapist should help the patient plan realistic long - term goals that match the patient's revised positive beliefs and values and their criteria about what is important for them in the future.

Future Pacing

When patients leave your consulting room they often have no idea whether therapy has worked. The patient and therapist can be hopeful but can never really be sure until the therapy has been tested in real life. At

the end of the session you should ask the patient to come out of trance and then test the therapy. You should ask him to imagine entering a context, which previously would have triggered the old problem behaviour. If therapy has been successful there should be no signs of stress or symptoms related to the problem.

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Pseudo-orientation of time

How often have you said "If only I had known then what I know now, I would do this.'' When people are involved in a problem it is difficult to be objective. All they want to do is change the situation at that moment. They spend very little time looking into the future at the possibilities available to them. Conscious fantasies represent accomplishments divorced from reality - they are complete in themselves yet are no more than wishful thinking. Non-conscious fantasies are incomplete and are not divorced from reality. They are partly completed strategies which the non-conscious wishes to make part of reality. They do not merely signify wishful thinking but rather the actual intention to act at the opportune time. So non-conscious fantasies are not people's imaginations running away with them, but a serious non-conscious appraisal, in fantasy form, of possible realities which are in keeping with the subjects own understanding of themselves.

In Neuro - Linguistic Programming (NLP) this is often called future pacing, although this is not quite the same thing as pseudo - orientation in time. The difference between pseudo orientation in time and future pacing is that pseudo - orientation in time is carried during a therapy session whereas future pacing is carried out at the end of therapy.

If the therapist is stuck and unable to decide how therapy should progress he can ask the patient (in hypnosis) to go into the future, and imagine

receiving successful therapy. The therapist can then ask the patient what was done to help during treatment. The patient then tells the therapist what happened and the therapist can then carry out the treatment created by the patient's non-conscious.
The therapist then asks the patient to go into the future to find out whether these therapeutic interventions will work. The therapist is actually asking the patient to rehearse the successful result of the treatment. The patient imagines a situation that previously would have caused difficulty. Ideally the patient experiences new behaviours in the future. This rehearsing of a new behaviour is a way of compounding the success achieved.

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Exercise - Steps for Pseudo-orientation in time.

- Be conversational and give analogies about dreaming and how it is possible to dream of something that occurs a few days, weeks, or even months later, almost as if the future is non-consciously planned.
- Tell stories about personal experience and future orientation experiences of patients or friends.
- Give metaphors about amnesia, forgetting those dreams, and experiences of knowing what you have to do - and then discovering that you have already done it.
- Introduce a good reliable trance possibility by asking the subject to consider plans that he had in the past and has for the future, pacing and leading the subject into a state of absorption.
- When future pacing and leading remember to utilise your experience in pacing the subject's primary representational system (identified by predicates) and then leading them into a different system.

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-
Orientate the subject into the future (not specifying the exact time at the present) by offering confusing yet explicit suggestions for age regression.
-
Introduce the implication that the subject can discover himself in the near future at some time when he has overcome his presenting problem.
-
Continue the progression/confusion techniques introducing visual/kinaesthetic experiences of walking into the future or seeing the pages of a calendar flip over into the future.
-
If possible establish verbal contact with the subject and confirm the date of the future orientation.
-
Utilise the subject's previous experience with dissociation during hypnosis to review all of the positive changes that have contributed towards resolving the problem.
OR

-
When the subject is orientated in the future offer him a challenge to build motivation and then utilise 'shock' to bring about a sudden realisation at the non-conscious level that he has overcome his problem in some way. This should be followed by discussion of the changes that may have contributed towards resolving the problem (these will consist of the various therapeutic interventions that the therapist was considering introducing).
OR

-
Give extensive post-hypnotic suggestions for a chain of new behaviours that will accomplish resolution of the conflict, then project the subject further into the future and have them tell you about the completion of the new behaviours and successful results of therapy. Re-orientate the subject to the present and give extensive suggestions for amnesia.
Summary Future Pacing and Pseudo-orientation.

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-
Future pacing is also a class of post - hypnotic suggestion.
-
Differentiate between conscious and non-conscious fantasies.
-
Pseudo-orientation is a rehearsal of new behaviours.
-
Pseudo-orientation is an ecology check.
-
Pseudo-orientation ratifies therapy.
-
Pseudo-orientation identifies new therapeutic approaches.
Lingering suggestions

Post - hypnotic suggestions are given in trance and suggest that a particular outcome or behaviour should occur after trance is over. This is done so that the patient receives benefit after and between therapy sessions. While some changes occur during therapy sessions most therapeutic changes occur after or between sessions.

Post - hypnotic suggestions usually require a trigger which is often something that is part of the patient's everyday life. The trigger can be part of the patient's habitual behaviour like smoking a cigarette. It can also be something that happens to the patient and is outside of his normal control, like the time of day. You should choose a trigger that is likely to happen and is not too unusual, for two reasons . Firstly, the trigger has to be a part of the patient's life and secondly, if it were unusual the patient might twig what was happening and sabotage the therapy.

Patients re-enter the hypnotic state when the trigger initiates the post - hypnotic behaviour.
A brief trance of approximately the same depth and quality develops when the patient carries out the post - hypnotic suggestion. Even though they may have their eyes open in order to carry out the behaviour they will still have entered a hypnotic state similar to the one they experienced when the post - hypnotic suggestion was first given.

Post - hypnotic suggestions can remain active for years. As long as the

context and conditions are right, the patient will respond to the post - hypnotic suggestion in the distant future even without any conscious memory of it being given. However, if the context is not right, the suggestion will be ineffective. For example, if the therapist asks the patient, in hypnosis, to automatically re-enter trance on each subsequent meeting, the patient will probably respond positively and re-enter the hypnotic state as soon as they enter the consulting room. This could happen even if the return visit were to take place several years in the future. If, however, the therapist and patient met by accident in a social setting then the patient would be unlikely to re - enter hypnosis because the context would be different and inappropriate.

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Trance can be induced by recalling appropriate trance contexts and associations. Therapists can bring about a trance state by talking to the patient about previous experiences of hypnosis. The therapist asks the patient to remember what happened when they were hypnotised. This brings back memories of trance which lead to the return of feelings associated with the hypnotic state. This in turns leads to the patient reentering trance. It is possibly the quickest form of hypnotic induction available. Simply by requesting that the patient recall a previous trance the trance is re-induced.

Always use a positive and successful example of a previous trance. When you first meet your patient ask them if they have previously been hypnotised successfully . Ask them what it was like and whether it was beneficial. If the previous experience was positive then you can use that trance as a re-induction procedure. All you need to do is ask the patient to recall the induction as you slowly feed back their words, re-capping the stages of the previous trance and compounding their experience by emphasising their minimal cues.

Chapter 12 - Perceptive guidance

Chapter 12 - Perceptive guidance

Self - hypnosis can be taught to patients receiving progressive future - orientated therapy. When a therapist is confident that the patient requires help in achieving positive future outcomes, which do not involve digging up past experiences, self hypnosis can be taught. The therapist must be sure that the patient does not have difficult, repressed, negative early learning experiences. Self-hypnosis normally does not cause the resurgence of early traumatic experiences unless directed towards that goal. It should not be taught to abreactive patients or patients receiving regressive therapy. If patients use hypnosis when there is a danger of abreaction then the therapist is acting dangerously and unethically. Patients should not even use self - hypnosis if they are undergoing any form of age regression. Many patients are keen to help themselves but the last thing any therapist wants is for the patient to go home and regress themselves to early traumatic experiences.

Sometimes patients need additional encouragement, reinforcement and help between sessions. This is especially true when patients are being reprogrammed to change habits. It is also true when patients need to relax themselves and self-hypnosis is ideal for this purpose. Often all that is needed is a number of simple open-ended suggestions implying that any previous therapy can continue between hypnotic sessions. The patient can thus reinforce everything that the therapist has been doing.

Self-hypnosis tapes are useful when a lot of information has to be given to the patient between sessions. The tape should be designed specifically for the patient, based on the structure of the patient's problem and should be future - orientated with only positive suggestions.

Tapes are also useful for patients who have problems hypnotising themselves. Some people need to maintain a degree of conscious awareness in order to give themselves therapeutic suggestions - by listening to a tape they can just let go. Mass produced, manufactured self - hypnosis tapes are not as effective as personally designed tapes for obvious reasons. Mass produced tapes have to be so general that they match everyone's needs as a patient. Because these tapes are so general their healing potential is limited.

Many patients have difficulty motivating themselves to play their tapes or practice their self - hypnosis. To increase the possibility that they will practice, it is a good idea to suggest that the patients feel more and more compelled to practice their self - hypnosis between the sessions. The therapist can give these suggestions during the therapy session or put them onto the tape as part of the exercise. In addition to this written suggestions

can also be given to the patient to give to himself during the self - induced trance. It is rarely necessary to explain to the patient why they should give themselves these suggestions.

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- Self hypnosis can be taught to patients receiving progressive future orientated therapy.
- Self hypnosis as homework can reinforce therapeutic progress.
- Self hypnosis tapes can be given if designed specifically for the patient.
- Self hypnosis should not be taught to abreactive patients or patients receiving regressive therapy
- Patients often forget to practice so suggestions to practice should be included during the session, on the tape or as part of the self-hypnosis exercise.

Hypnotic Amnesia

How often have you been absorbed in a conversation and then someone has interrupted your flow by distracting you? After the distraction it is often difficult to remember the gist of the original conversation. If you deliberately distract your patient during or after trance they will often develop a spontaneous amnesia for the therapy that happened before the distraction.

You can take your patient on an inner journey through various trance scenarios. When you are at the deepest level of trance you can then offer therapy in that particular scenario. By returning back through the other scenarios you can create an amnesia for the therapy. This is similar to the distraction principle, except that here you distract the patient several times as they come out of trance. Each time that they recall a different trance scenario they get further away from the memory of the deepest scenario used for the therapy.

For example if you first induce trance with a visualisation of walking along a beach you can then get them to shift from this scenario to a second scenario of walking through the countryside. You can follow this with a scenario of sitting by a log fire and then one of them relaxing by a swimming pool. After this they could experience being absorbed in a music concert at the theatre followed by enjoying paddling in a boat.

If the therapy occurs in the final scenario and the therapist then retraces the steps back out of trance through the various different scenarios the patient may experience amnesia for the boat scenario and all of the therapy that took place there at that time.

If the therapy occurs in the final scenario and the therapist then retraces the steps back out of trance through the various different scenarios the patient may experience amnesia for the boat scenario and all of the therapy that took place there at that time.

When our senses fall below the line however our focus of attention shifts to internal or imagined experiences inside our head. Even if we still have our eyes open our mind switches off the input from outside and watches the internal imagery instead. I am sure that you have had the experience of daydreaming with your eyes open and seeing images related to your daydream more clearly than what is actually in front of your eyes at the time. Daydreaming occurs in each of the senses also. This is because daydreaming and hypnotic trance are essentially the same thing.

Even experienced hypnotherapists are surprised to hear that amnesia can be experienced selectively in each sense. Amnesia is usually thought of as happening in all the senses simultaneously which often happens. However, each sense also works independently.

Patients can often have amnesia for the therapy or hypnotic phenomena experience in trance. For example with automatic writing a fairly deep trance level is induced and there is often a corresponding amnesia for the process. The amnesia is caused not only by the depth of trance but often because the material communicated by the automatic writing is traumatic. The patient's non-conscious mechanism has spent time in the past repressing traumatic experiences and wishes to continue this until the patient is ready to accept the information that was previously repressed.

Hypnotic Anaesthesia

Pain is usually experienced for a purpose. It is usually a signal or a message saying, "please look after me". When someone hurts themselves they have pain and this pain is a way of reminding them to take care of that particular part of the body. Even psychosomatic pain is a message – this will be discussed later. As therapists we should not attempt to take away pain as it has a function. Patients should be taught to re-interpret their pain and to

develop an attitude of indifference to the discomfort rather than developing total anaesthesia for what is an important signalling system. The only time when pain should be removed altogether is when the patient has a terminal illness or when hypnotically - induced anaesthesia is being used for surgery.

develop an attitude of indifference to the discomfort rather than developing total anaesthesia for what is an important signalling system. The only time when pain should be removed altogether is when the patient has a terminal illness or when hypnotically - induced anaesthesia is being used for surgery.

Acute pain is the term used when a patient experiences pain through injury. Acute pain has a beginning, middle and end. The patient can see an end to the pain after the healing process has occurred. Acute pain also occurs after surgery - again there is an expectation that the suffering will cease in the near future. Chronic pain is the term used for pain experienced in terminal illness. Chronic pain is an ongoing experience. Patients experience the pain of yesterday, the pain of today and the pain of tomorrow. Chronic pain is also the term used to describe the pain in disorders of an organic nature. Again the therapist should decide whether the patient experiences chronic or acute pain before opting for a particular treatment .

Sometimes patients experience a pain in one part of the body from a cause elsewhere. It is important for therapists to identify the source of the pain. Some pain is psychosomatic in origin. In this case there is no physiological cause for the problem although the pain is felt in a very real way by the patient. Often patients who come to psychotherapy for help with psychosomatic pain have already been through the hospital system and been told that it is 'all in their mind". When you meet such patients you should not reinforce this brush-off approach. You should attempt to be sympathetic because your patient does experience real hurt even though the pain is psychosomatic in origin. The psychosomatic pain is a message or a cry for help. It can be viewed as a hysterical response to some life issue or problem in the patient's past.

Abreactions are sometimes helpful in eliciting the cause of psychosomatic pain. Sometimes the pain occurs in a certain organ or limb and the therapist may be able to interpret the symptom as a form of metaphor. However, often the symptoms that do occur are chosen purely because of their ease of access. For example, a child who developed aching feet at school (as a way of avoiding sports) might suffer walking-related symptoms as an adult should he ever have the non-conscious need to have a psychosomatic problem as a cry for help.

Summary The Structure of Pain

Summary The Structure of Pain
Pain is a signal.
-Pain is a psycho-physiological experience.
-Acute pain is different from chronic pain.
-Pain can he referred or psychosomatic
-Pain can be treated with hypnotic phenomena.
Pain Control

There are many hypnotic techniques for pain control and here I have presented the most useful.

Hypnotic suggestion.

The therapist can suggest, either directly or indirectly, that the patient experiences anaesthesia of the hand. This is known as a glove anaesthesia and is a technique often used by dentists. The patient can then place the numb anaesthetised hand onto whatever part of the body is in pain. If the therapist is using indirect suggestion it is useful to prime the patient by suggesting many kinds of naturally - occurring anaesthesia that occur in the patient's everyday life. This is a similar approach to using metaphors and analogies. I will cover this area a little later in this unit.

Time Distortion.

As stated earlier in this chapter, time distortion can be used for pain control by expanding the duration of each pain free interval and contracting the moments of discomfort.

Glove Anaesthesia.

Glove anaesthesia can be induced directly or it can be induced via imagery. Images of the patient plunging his hand into snow help create numbness of the hand for use in glove anaesthesia.

Dissociation.

Dissociation.
hypnotically
into the everyday life of the person they have a profound sense
of being separate from their own reality. Whilst this is a technique that can be applied to hospitalised patients or those with terminal illness it is a technique not appropriate for patients needing to function normally in everyday life.

Metaphors and analogies.

Therapists can tell stories about times when the patient would naturally have had an anaesthetised hand - for example the experience of waking in the night and discovering that the arm is numb from having been slept on or the experience of playing in snow.

Another approach might be to describe the process of becoming hardened or insensitive to pain. The therapist can tell stories about his own experience of developing blisters on his feet whilst running and how these blisters hardened so that he no longer felt any discomfort or pain. The therapist is actually suggesting to the patient that he develop a resistance to the pain by being exposed to it.

This re-framing is actually including the pain as an educational tool for the purpose of pain relief. Likewise the therapist can tell stories about other patients who have been successful with pain control. A patient who wishes to learn self - hypnosis for pain-free child birth can be told the ease with which an earlier patient achieved the same results. If the actual induction and hypnotic phenomena are described in detail then the patient may well develop the same phenomena spontaneously as they respond to this indirect form of suggestion.

Visualisation.

Here the patient can be asked to visualise both the pain and some way of fighting it. For example they may say that the pain is a stabbing pain. They can be asked to see themselves cushioning the stabs with pillows. By numbing the pain and deadening it with their visualised pillows they can bring about a change in their perception of the pain.

Distraction.

Distraction.

Re-framing.

Another approach would be to use the reframing of parts technique taught earlier in this book. Since pain is a signal or a message the therapist can ask the patient to develop creative abilities to generate alternatives to pain as a way of meeting the needs of the signal. I suggest you refer to the re-framing parts model taught earlier.

Self suggestions and dissociation

A person is more likely to carry out a behaviour if they are self motivated. Some people say that all hypnosis is self-hypnosis. This may be true in a sense, in that "the self" has to allow the therapist to apply hypnosis. The self-suggestion induction requires the patient to repeat everything that the therapist says. So for example; if the therapist says "you can experience trance", then the patient says to himself "I can experience trance". The patient is involved in converting all the therapist's suggestions from the second person to the first person - something which is itself hypnotic and requires a certain amount of concentration.

However once the simple conversion process is underway it becomes automatic and the patient just finds themselves listening to the suggestions like an observer. As the suggestions are given and then repeated by the patient they become more and more absorbed in the sounds of both the therapist's and their own voice. This in itself is trance- inducing. Because the suggestions are self-directed they are highly self - motivating. However the patient does not have to think how to construct therapeutic suggestions. The therapist does this while the patient repeats the suggestions, having trusted that the therapist can create appropriate therapeutic suggestions.

When patients practice self-hypnosis they often experience difficulty because they have the conscious task of creating therapeutic suggestions whilst simultaneously remaining at a depth of trance suitable for absorbing the suggestions. With this self-suggestion induction technique the patient can

relax into trance and allow their own voice to give the suggestions repeatedly without conscious effort.

relax into trance and allow their own voice to give the suggestions repeatedly without conscious effort.

Next the therapist asks the patient to close their eyes and to imagine what it would feel like to sit in this second chair. Then the therapist asks the patient to imagine, as they feel as if they are sitting in the second chair, to look at themselves sitting in the therapy chair. We are in effect asking the patient to dissociate. The therapist then asks the patient to repeat the suggestions the patient hears. Because the patient repeats the suggestions in the first person he experiences a simultaneous association and dissociation. The patient experiences sitting in a second chair and so is kinaesthetically dissociated. The patient also experiences seeing their self from this second position and is now visually dissociated. In addition to this, as the patient repeats the words they remain in auditory association. As difficult as it may seem patients are able to accomplish this complex task, however the process is somewhat confusing to the patient.

If the patient is unable to dissociate and see and feel their body elsewhere in the therapy room then the therapist can suggest that the patient imagine transporting their self to other contexts. For example, lying on a beach whilst simultaneously seeing their self lying in bed. Any number of combinations are possible and the therapist should adapt the technique according to the patient's needs.

The task of trying to accomplish this simultaneous association and dissociation in all three major representational systems creates confusion. Confusion is itself trance inducing. As the patient attempts to tackle these tasks simultaneously they find that they have no room left consciously to attend to other information or stimuli. Their total attention is taken up with the task of simultaneously experiencing different experiences in their sense systems whilst feeling associated and dissociated at the same time.

They also have the auditory task of remembering to say certain suggestions. Because the therapist ties up the visual and kinaesthetic sense with other experiences or challenges, the patient starts to repeat the suggestions of the therapist automatically. The process is similar to learning to drive a car where the easiest task, for example the amount of acceleration, is handed over slowly to the non-conscious part of the person. With this particular induction the easiest task is just to repeat the words heard previously which decreases any resistance to suggestion.

When a patient becomes confused they want to understand and so find a way out of the confusion. If there seems to be no way out then they give up. They stop trying to understand and allow the confusion to wash over them. It would be a similar experience to attending a lecture and finding that the content was too advanced for the student. The student pays great attention and then becomes confused.

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When the patient's confusion is caused by the difficulty of attempting simultaneous tasks then the search for further information is internally orientated because the patient knows there is not enough information externally. By trying to make sense of the tasks i.e. to recall times when they were able to feel as if they were sitting in a second chair or times when they were able to see themselves, the patient goes internally into memory and previous experience deepening the trance state.

Summary Self Suggestions

-
Self suggestions are self - motivating.
-
Self suggestions involve all the sense Systems.
-
Self suggestions create "trance inducing confusion".
-
Patients usually enter trance when confused because they give up trying to understand or they seek clarification internally.
So to clarify here is a summary of the technique:

-
The therapist asks the patient to close his eyes and see himself sitting in the chair.
-
Then the patient is asked to feel as if he is sitting in another chair.
-
Then the patient is asked to repeat out loud everything the therapist says, translating it from the second person to the first person.

PART TWO

Introduction

Despite the advances that have been made in the field of clinical hypnosis over recent years many people are still unaware of the vast array of therapeutic skills that lie behind the process of indirect hypnotic induction. This transcript makes specific the innovative, and often complex, techniques of its author Steve Brooks. The transcript of the hypnosis session is interspersed with a commentary by the author.

The commentary throws light on many of the complex hypnotic language patterns used and expands on the techniques and principles introduced in this book. To avoid repetition, the author has deliberately avoided commenting on what has already been written in the main text of this book, preferring to comment of the more subtle dynamics of the session and what at first seems to be a magical form of therapy but when explained, is seen as the result of many years of perfecting the art of Indirect Hypnosis.

Not only does the author demonstrate the induction of Indirect Hypnosis he also evokes many of the classical hypnotic phenomena in an indirect and informal manner. Phenomena include arm elevation, arm catalepsy, anaesthesia, age regression, dissociation, hallucination, eye catalepsy and post hypnotic suggestion. For a full list see below.

The indirect hypnotic suggestion is so informal in nature that the reader may, at first, not realise everything that is happening. However subsequent reviewing of the transcript and its commentary will reveal many new ideas and indirect hypnotic interventions.

For any student of Indirect Hypnosis this transcript represents a unique record of a spontaneous hypnotic therapy session. The author works intuitively calling upon his many resources gained through experience of Indirect Hypnosis. The approach is conversational in nature as is the commentary. Wherever possible the author has attempted to avoid the use of jargon preferring to describe the techniques and language skills in everyday terms. It is hoped that this transcript will be the source of inspiration for many people wishing to develop their skills in the field of Indirect Hypnosis and covert influence.

In the past, traditional hypnosis has been authoritarian in nature with the hypnotist giving commands or orders to the person. This approach limited its application in many contexts and often created resistance to trance and limited success with people. Indirect Hypnosis is entirely different and this new form of hypnosis whereby the hypnotist applies indirect suggestion covertly and in a very conversation manner allows the hypnotist to by-pass

the normal conscious resistance to hypnotic commands often experienced by the person.

the normal conscious resistance to hypnotic commands often experienced by the person.

The subject of this hypnosis demonstration is Avril. She has no experience or knowledge of hypnosis and has volunteered out of curiosity. The session was held in the TV studios of the University of Sussex in England in 1990 and the transcript made from the original video recordings. As the session progresses Brooks teaches Avril to experience hypnotic trance and hypnotic phenomena. At the same time he also instructs the reader in the art of Indirect Hypnosis. His running commentary on what he is doing follows his personal teaching style whereby he comments to his audience while demonstrating covert hypnotic skills with volunteers possibly one of the most powerful and enriching ways of learning Indirect Hypnosis.

Hypnotic Phenomena evoked indirectly during this session

One of the author s main aims during this session was to demonstrate how Indirect Hypnosis can be used to evoke all of the classic hypnotic phenomena in an indirect and conversational manner. The advantages of such an indirect approach being that the subject does not realise how and when they are being hypnotised and so do not consciously resist or overtly monitor what they are experiencing or what the hypnotist is doing. In other words, as long as there is rapport, they just go along with what the hypnotist is saying and doing and to their astonishment, are able to experience all kinds of hypnotic phenomena without knowing how they are doing it.

The following is a list of some of the classic hypnotic phenomena evoked indirectly by implication during this session:

1. Accessing Emotions.
2. Accessing Relaxed State.

3.3.
4. Age Regression.
5. Inducing Confusion with Ambiguity.
6. Creating Amnesia.
7. Anchoring States.
8. Arm Anaesthesia.
9. Arm Catalepsy.
10. Arm Levitation.
11. Associating Psychological Change with Trance.
12. Auditory Hallucinations.
13. Conscious Unconscious Dissociation.
14. Conscious - Unconscious Left Arm Levitation.
15. Deepening Processes.
16. Time Distortion.
17. Hypnotic Metaphors.
18. Dissociated Visual Experiences.
19. Visual Hallucinations.
20. Double Dissociated Visual Hallucinations.
21. Early Learning Set with Age Progression.
22. Everyday Association.
23. Eye Catalepsy.
24. Finger Catalepsy.
25. Frustrating Trance Techniques.
26. Inability to Lift an Arm.
27. Kinaesthetic Hallucinations.
28. Evoking Minimal Cues.
29. Setting up Post Hypnotic Cues.
30. Double Dissociation / Conscious & Unconscious Double Binds.
31. Post-Hypnotic Suggestions.
32. Prescribing a Relapse.
33. Pseudo Orientation in Time.
34. Re-entry into Trance with Post Hypnotic Cues.
35. Rehearsing Visual Hallucinations.
36. Teaching the person Self Hypnosis.
37. Time Distortion.
38. Pain Transfer.
39. Pain Reduction.
40. Utilization of Tension.
41. Visual Illusion of Dissociated Hand.

Students of human interaction of any kind and within any context will gain considerable benefits from repeated study of this eBook and are encouraged to return time and time again to discover new insights, ideas and previously hidden gems of wisdom surfacing through the work as experience develops. This text continues to be a major teaching resource for students of hypnosis with an almost legendary status as a classic in the field.

To purchase the double DVD training set based on this therapy session, with a running commentary plus interviews, please go to the BHR online shop:
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Training In Indirect Hypnosis

BROOKS:
Hi there AvriI.

SUBJECT: Hello.

BROOKS:
Well now, we met briefly the other evening and one thing I do know about you is that you are very curious about hypnosis.

I always start using indirect suggestion as soon as possible when working with people. Hypnotic time is valuable and there is no point in idle chatter unless it's hypnotic. By saying that there is only 'one thing' that I know about her I am suggesting that she should tell me more. I am also reinforcing her curiosity about hypnosis by pointing it out. The subject has no previous experience of hypnosis but is curious about it. But she does not know that my intention is to hypnotise here indirectly, but she will soon discover that her reality starts to change inexplicably.

BROOKS:
...about the experience of hypnosis and about how people go

into a nice comfortable hypnotic state and how this often just

happens all by itself.

In addition to suggesting that hypnosis is comfortable and 'just happens all by itself' I am emphasising these suggestions by altering the pitch and tonality of my voice so that they stand out from the rest of the communication. I also use my eyes and expressions to place additional emphasis on these secondary messages.

BROOKS:
First of all, before you start to, really learn something new for

yourself. I wonder can you just tell me how you feel at this

moment.

Here I am suggesting that she can learn something new when she has finished talking about how she feels - the act of talking about her feelings brings her closer to the new learnings. By asking her to describe her feelings at 'this moment' I am also suggesting that the feelings will change. A moment only lasts for moment. I did this because I could see that she was nervous.

SUBJECT: Slightly nervous.

BROOKS:
Slightly, only slightly nervous?

SUBJECT: Yes actually.

BROOKS:
You don't feel incredibly nervous?

SUBJECT: No, no.

BROOKS:
Only slightly nervous.

Now this is quite complex. When she says that she is only slightly nervous it gives me the chance to introduce humour. The humour helps her relax. By suggesting that I expected her to feel more nervous I am indirectly praising her on her ability to relax and implying that I am possibly more nervous than her. This is my way of matching her feelings about the experience. It brings us closer together because we share the same feelings. After all, we are both in a TV Studio, live on camera in front of film crew.

I also want her to feel positively motivated about the session so I want her to agree with everything I say. So every question has a positive answer. Even when she answers 'no, no' she is still agreeing with me.

SUBJECT:
I'm a fairly relaxed person.

BROOKS:
Oh well that's good. But I can tell you now it's important to have a little bit of nervousness somewhere. Because you can only do good work if you have some good materials to work with so a little bit of nervousness is rather a nice asset.

Here I am focusing her attention on the 'little bit of nervousness somewhere'. By doing this I am limiting her nervousness even more. I am also praising her for having a little bit of nervousness in the same way that I praised her for being relaxed. She feels both nervous and relaxed. I want to match both of her experiences so that she feels that I understand her and that it's ok to feel this way.

SUBJECT:
There is a bit there, don't worry

BROOKS:
Where about is it?

I want to limit her nervousness even more so I ask her to tell me where it is. By identifying exactly where it is she will know when it has disappeared. I am also directing her attention inwards as she tries to identify the feeling. This is one of the first stages of hypnotic trance.

SUBJECT:
I don't know, around here sort of...

BROOKS: In the chest here?
SUBJECT: Mmm.

BROOKS: In the chest here?
SUBJECT: Mmm.

BROOKS: Yeah, anywhere else?
SUBJECT: The hands I suppose are a bit tense but... no it's alright.
BROOKS: Ok.

(Subject takes a deep breath)

I had noticed her holding onto the chair but before I could say anything she took a deep breath. I time my breathing to match her exhalation so that she starts to feel that I am more and more a part of her experience, simply because I am breathing in the same way. It also makes her aware of how much attention I am giving her.

BROOKS: Feel a bit better?
SUBJECT: Yes.

Here I am praising her again for being able to relax.

BROOKS:
Isn't it interesting when you take a breath like that, you didn't have to think about it?

SUBJECT: No

Here again, I am giving her the chance to say no but still agree with me. This is
important, because people want to feel that they have some independence and if
they find themselves saying yes all of the time they start to feel manipulated.

BROOKS:
Somehow your body knew that it had to take a breath in order for you to relax and how are those hands, feel now?

SUBJECT: Mmm not too bad.

I am now placing more emphasis on the ability of her unconscious mind to help her achieve trance. I normally use the term unconscious mind when teaching hypnosis but will call it the subconscious mind if I think

that the person feels more comfortable with this term. I am also implying that because she has taken the breath her hands will feel different.
There is no actual cause and effect relationship here at present but I am suggesting that her breathing and the feelings in her hands are somehow related. I am doing this because I want her to start noticing how one physiological change can initiate another.
By doing this we can make the trance self-generating. For example later I tell her that as she breathes out she can go deeper into trance. This makes her on-going breathing a trance deepening process. All I have to do is watch and comment on the process.
I also deliberately offer her a grammatically ill-formed question; 'how are those hands, feel now?' This is another way of emphasising certain suggestions, deliberately miss-pronouncing words is another, as is deliberately missing words out. Each time I deliberately make a mistake she corrects it inside her head. She completes the statement, puts in the missing words or re-pronounces them correctly and so emphasises them to herself.

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:
Which hand do you think feels the most tense at this moment?

SUBJECT: That one I think. (Indicating her right hand)

It is impossible for both hands to feel the same. Some people may not be able to tell the difference at this stage however usually they can be persuaded that one hand feels different from the other. By asking "which hand" I am suggesting that one hand feels less tense. I am slowly relaxing her more and more by a process of elimination.

BROOKS:
You're right.... (pause) hand feels more tense than your left, so

your left hand is left there feeling more relaxed than your right

which is tense here. Is that right?

SUBJECT: Mmm.

BROOKS:
Ok. So you'd be surprised if this right hand was left feeling more relaxed than your left.

SUBJECT: Mmm (laughs)

Here I use confusion to disorientate her from her present reality and to get her to start doubting her organised conscious understanding of the situation. When a person is confused they want to get out of the confusion. If they can't resolve the confusion with the information at a conscious level they search for it at an unconscious level.
There are two kinds of confusion techniques here. The first utilises a pause to imply one meaning and then offers a secondary meaning when the statement is completed. The second uses ambiguity by mixing up the

meaning of left and right. This also primes her for the multiple communications that follows.

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:
Mmm... nice to just smile when it's unexpected, have a little laugh or a smile. Do you enjoy humour?

SUBJECT: Yes.

Once again I introduce the idea that her unconscious mind can give her something positive without her consciously deciding to make it happen. By drawing her attention to the spontaneous smile I am also suggesting that other things can happen spontaneously. By asking her if she enjoys humour, I am getting her to agree with me and acknowledge that she enjoys her present situation. I know she enjoys humour, because she has just smiled, so I use this as a way of ratifying the positive aspect of her experience at this time. Notice that I am not taking any risks, I am just utilising what she gives me and feeding it back covertly to persuade her to take the next step.

BROOKS:
Mmm so do I, now I think humour is very important in therapy and in hypnosis. A lot of people think hypnosis is something quite serious, I find that that it's something you can utilize humour with, I like the idea of utilising the natural resources to laugh and, enjoy this experience. I find that very important.

I am telling her that laughing is a natural part of the hypnotic induction and therefore she must be going into a trance. I also give her an ambiguous suggestion which is at the same time an observation and a command: "I like the idea of utilising the natural resources to laugh and, enjoy this experience".

BROOKS:
Now people often ask me what happens when you, go into a trance, and I say to them well when you, go into a nice comfortable hypnotic state, all kinds of changes happen to your body... to the muscles in your body, in your face, breathing changes, blink reflex changes.... and a little smile comes all by itself.

SUBJECT: (laughs)

BROOKS: It's almost like there is a part of you that knows what I'm talking about.

Here is another grammatically ill formed statement, which is also emphasised with a voice tonality change. I also point out all the physiological changes that I can see developing in her at this time. It is rather charming how her unconscious mind picks up my two-level communication and gives her a smile, which I immediately include on

my list of physiological changes that accompany trance.

my list of physiological changes that accompany trance.

BROOKS:
Now, you know people communicate on many, many levels. People communicate with language and also with non-verbal communication. I'd like to include as part of the non-verbal communication changes in tonality, changes in the tempo of a voice, pitch of a voice. You know you can say things in so many different ways. I can say to you; "I wonder what it feels like to, go into a trance?" and you can take that in many different ways.

SUBJECT: Mmm.

A number of things are happening here. Firstly I am giving her a truism, and this helps develop an acceptance for what follows. Secondly I am actually telling her about the very technique I'm using. I thought this would be a fun thing to do because I love playing with words. As I explain the principle behind the two-level communication I am actually communicating on two levels. She doesn't know whether I am giving an example of the technique or whether I'm actually using it on her. Thirdly, if she chooses to pay attention to my explanation she will possibly spend the rest of the session listening for the two-level communications thereby emphasising them for herself. If she remains unaware of them they will influence her behaviour anyway at an unconscious level without her conscious awareness. She is in a nonverbal double bind – which means that she has no choice to be affected by what I am doing, but does not know that she has no choice and does not know that the affects are the result of her not having a choice.

BROOKS:
You can think of it as a question. You can think of it as something else that you can respond to...

It appears as if I'm giving her a choice here but whichever way she thinks about it I am really only suggesting one thing - that she responds.

.... but you don't have to think that you're thinking about it because that change in tonality that occurs as I say that statement can in fact register at a different level.

Are you aware that you pick things up consciously and also subconsciously as you go through life?

SUBJECT:
Yes I think so.

Here I am telling her not to think about thinking because she can pick up my communication at an unconscious level. I am reinforcing the double bind by telling her not to do something I have just told her to do. If she takes me literally and doesn't bother thinking about what I have said, then it will influence her unconsciously, if she makes an effort to try not to think about it, the more she tries not to think about it, the more she will have to think about it in order to not think about it.

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:
Mmm... it's a bit like you can walk down the street, you see a smile on a face of a stranger and you register that smile but you don't think about it consciously, it just happens to pass you by, it may be another time, another day, in another place you remember that smile on that face. Maybe you see somebody that looks like that person and you're reminded of that person that smiled to you, because you picked that information up without even considering that you were picking it up consciously.

Here I decided to give her some serial suggestions embedded within an analogy overlapping descriptions of a universal experience. It is a truism that describes a naturally occurring unconscious learning process common to everyone; the shifting between external stimuli (smile on a face) and storage of information at an unconscious level and how a similar external trigger or anchor can evoke previous associations. I want to encourage this shifting between external and internal awareness. It is this transition from outside sensory experience to inside sensory experience that is the essence of hypnotic trance. I am simultaneously describing this shifting experience and evoking it. In order to make sense of the analogy she has to shift her awareness from my words (external auditory stimulus) to her memory of the same or similar learning recognition situations (internal experience) thinking in pictures, sounds and feelings. I am also telling her that she doesn't have to pay attention to me consciously - she will receive my communication regardless.

BROOKS:
Now with hypnosis what I do is talk to both parts of you, that is, your conscious mind and your sub-conscious mind. And you know that the interesting thing is that you don't even have to listen.

SUBJECT: Mmm.

I am now overtly commenting on the process I am using. I can do this now because I have primed her. Again she can choose to pay attention to the process or just let it happen. I also reinforce the suggestion that she need not pay attention. In fact I suggest that she become absorbed in thinking about how 'interesting' it is, not having to listen. You should never tell a person to 'not listen'. That's a command, and they will either

resist and listen to you or they will try to obey and by trying to not listen find it impossible simply because they first have to listen so that they know what not to listen to.

resist and listen to you or they will try to obey and by trying to not listen find it impossible simply because they first have to listen so that they know what not to listen to.

BROOKS:
You know at school you're taught to concentrate and you mustn't daydream. You're told that you should have your attention focused all the time on the teacher. Well here I'd like to encourage you to let your mind wander.

SUBJECT: All right.

I gave her another analogy (external) to evoke possible memories (internal) and I give her permission to daydream. I say permission because the analogy is framed within the context of school. I am suggesting that she can break the rules of learning. It's also a new concept that can disassociate her from her normal frame of reference related to learning.

BROOKS:
Mmm.... do you ever let your mind wander sometimes?

SUBJECT: Yes.

BROOKS:
Yes. What do you wonder about when you wander?

Here I want to associate the experience of wondering with the process of mind wandering. I want to make wondering contingent upon wandering. The nominalization 'wonder' has no boundaries. It implies discovery, awe, magic, exploration and a whole chain of open-ended associations. These kind of nominalizations break through conscious barriers and rigid learning sets. The more she wonders the better. Wondering can only be done internally.

SUBJECT: Well I lead quite a hectic life so I don't have too long to sort of

think. When I do relax.... I don't know. I like to read books or I

think of things I suppose.... and books

BROOKS: Mmm.

SUBJECT: as I watch television in the afternoons, that's when we're closed.

BROOKS: Mmm.
SUBJECT: And... I don't know... far away places. I would like to travel.
BROOKS: Do you ever travel in your mind?

Here she gives a brief list of trigger-response cues that trigger wondering; books, television, travel. All are trance inducing and involve a shifting from external to internal reality and I latch onto one and expand upon it - focusing on her internal experience with the question 'do you ever travel in your mind?' Of course, at this point in time I know that she must travel in her mind because she has just made a future orientated statement based on her wish to travel, and as I discover this as based on a past memory of travel. This is why I latched on to this particular trance inducing leisure activity.

SUBJECT: Mmm sometimes.
BROOKS: Where do you like to go?
SUBJECT: Well I think back to holidays we've had...

�We� being her and her husband.

BROOKS: Mmm.
SUBJECT: Do you mean a specific place?
BROOKS: Do you have somewhere in mind?

I keep her internal by asking �somewhere in mind?�

SUBJECT: Um, I think Turkey was my favourite place.
BROOKS: Mmm.

A simple mmm will suffice here to reinforce her internal absorption. I don't want to distract her with words. The tonality of the mmm is meant to evoke wondering. I use mmm a lot as it implies understanding, curiosity, agreement, interest, a question ? depending on the tonality you use when saying it.

SUBJECT:
I think about that because we're thinking of going back there this year so...

BROOKS:
Yes, what stands out in your mind about Turkey... what's the memory that comes to mind most easily.

I keep emphasising the "mind" aspect of her on-going experience and

suggest ﷽most easily﷽ implying that all memories will be easy to recall but that one will be easier than others. This is much better than saying ﷽Try remembering something﷽ or ﷽Can you remember﷽, as these imply doubt.

suggest ﷽most easily﷽ implying that all memories will be easy to recall but that one will be easier than others. This is much better than saying ﷽Try remembering something﷽ or ﷽Can you remember﷽, as these imply doubt.
:
Umm, lying by the swimming pool. (Laughs)

BROOKS: Yeah!

She laughs as she remembers something and I match her with the tonality of my "yeah" It's important to pace your subject as closely as possible during the induction. Stay with her at all times until she develops her own totally subjective experiences. Even then pace her as closely as possible. If she comes out of trance for a second you come out too - just long enough to guide her back in again. When I am using hypnosis I go into an altered state too. But my state is one of heightened concentration.

SUBJECT:
What everybody does on holiday I suppose.

BROOKS:
And what is it you like about lying by the swimming pool?

I want her to get into the experience.

SUBJECT: That there was nobody else around, except the person I was with obviously.

BROOKS: Umm.

SUBJECT:
It was absolutely deserted.

BROOKS:
And so you felt.... (pause) ?

I still want to get her more into the experience.

SUBJECT:
It was lovely.

BROOKS:
Yeah. It's nice to have that feeling, yet there was one person there you could communicate to whenever you wanted to and they could communicate to you but you could just be in your own little world.

SUBJECT:
Well yes. We go on holiday really not to have to talk to anyone because we do it all year round.

Here I attempt to parallel the current hypnotic situation with her scenario. Her and her partner on holiday and her and I in the hypnotic situation, equals, no one else around, deserted, lovely (her

communication) two people communicating, ‘be in your own little world’ (my suggestion). I want to blur the distinction between her memory and her current experience. This way she can more easily associate with the holiday experience and it's associated feelings. She doesn't recognise I'm doing this. In fact she takes me literally and answers on a conscious level. Hypnosis is matter of negotiation between the hypnotist and the conscious and unconscious mind of the subject.

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:
Yes. How nice to have that peace and comfort and relaxation.

SUBJECT:
We really like to be on our own but it is rare in a holiday resort so it was lovely to find this part where there was nobody there

BROOKS:
And how do you feel, what does your body feel like when you're in a place like that?

SUBJECT:
Totally relaxed.

Good we’re getting there now. Next I want to draw her attention to how her body is responding to the holiday memories.

BROOKS:
Have you noticed how your breathing has changed as you have been talking about this?

SUBJECT: Has it?

BROOKS:
Mmm, how has your breathing changed, slowed down?

She hasn't noticed how her breathing has slowed down so I give here some hints by asking her ‘how has your breathing slowed down’ ‘ the important word here is ‘how’ as she will now have to think about the ‘how’ rather than the ‘has’. It would have been more compounding had she noticed on her own without my hints. She does notice the nervousness though. This is her anticipation of going into a deeper trance. I say deeper because she has already been in and out of a light trance several times as we have been talking and without being aware of it.

It's good to have some nervousness in a subject. It makes them believe something will happen. The worse kind of subject is the totally relaxed 'now do your stuff on me' kind of subject. They are relaxed because they believe nothing will happen. It doesn't mean they can't be hypnotised it means you have to be more indirect or call it something other than hypnosis. This is quite ethical if your outcome is to help the person. A

chiropractor manipulates bones so why not manipulate concepts, it doesn't hurt so much either. So if possible, discover any anticipation and utilize the tension.

BROOKS: Notice you keep a little bit of nervousness there still a little bit? And you're probably quite.... yes?

BROOKS: Notice you keep a little bit of nervousness there still a little bit? And you're probably quite.... yes?
:
My hands are still gripping I think.

BROOKS:
Yeah. Well, keep a real firm hold of that chair.

SUBJECT: (Laughs)

Here I utilise the tension. Never tell a subject to try and relax. The effort of trying to relax causes anxiety. Tell them to try to become even more tense they will then either tire themselves out or make the process so conscious that they shift the tension from unconsciously initiated tension to consciously chosen tension. They might then be in a position to also decide to let go of the tension. The humour also helps her relax by making her laugh. I like people to laugh themselves into hypnosis. It's also more fun for me.

BROOKS:
And whatever you do don't let go until your sub-conscious mind knows that you can, go all the way into a nice deep comfortable hypnotic state. Don't let go....

SUBJECT:
(laughs)

BROOKS: …until, you find that happening all by itself.

This is a dependent suggestion where letting go is contingent upon the conscious mind 'knowing' that she can enter a deep comfortable state. This places more emphasis on her unconscious processes. It also gives her a way of knowing when to expect to go deeper. Here, letting go of tension equals a deeper state. If she is making an effort to hold onto the tension sooner or later she will have to let go. She is in a double bind again and doesn't know it.

Somebody asked me the other day. "Ok so these changes occur to you when you go into trance; changes in muscle tension in your face, alteration in your respiration, blinking....

SUBJECT: Mmm.

BROOKS:
"What actually happens"?

I said, "you know I don't really know quite what happens when, you go into a trance, but something I've noticed is that, your awareness or your attention seems to shift from external things to internal things".

I want to point out the physiological changes characteristic of going into trance. One of the best ways of doing this is Erickson's 'My Friend John Technique' where the hypnotist describes an imaginary friend and what happened to them as they went into trance. Here I am recounting a question session with one of my students. It allows me to place emphasis on certain suggestions and give suggestions to shift her attention from external to internal reality while telling her a story. She thinks I am just telling her a story, but really I am hypnotising her.

I want to point out the physiological changes characteristic of going into trance. One of the best ways of doing this is Erickson's 'My Friend John Technique' where the hypnotist describes an imaginary friend and what happened to them as they went into trance. Here I am recounting a question session with one of my students. It allows me to place emphasis on certain suggestions and give suggestions to shift her attention from external to internal reality while telling her a story. She thinks I am just telling her a story, but really I am hypnotising her.

Now I'm very curious about those feelings you are having in your eyes right at this moment.

The shifting from external to internal reality and overloading of indirect suggestions has triggered acceleration in the blink response. By pointing this out I indirectly suggest an association between blinking and going into a trance. This can result in one of two responses in the subject. Either the blinking will increase or it will stop altogether. Increased blink reflex is unconsciously generated or indirectly consciously generated through consciously trying to stop it. The increase compounds the ensuing trance. Consciously controlled termination of the blinking usually demonstrates a temporary unwillingness to enter trance at this stage if this is the case the hypnotist has two choices here, either he can retrace his steps and hold off until the subject feels ready or he can utilize the lack of blink reflex suggesting that the subject blink less and less. The subject can resist and yield simultaneously. Either way the blink response compounds the ensuing trance as long as the hypnotist implies an association between the two.

SUBJECT: Yes. (Blinking)

BROOKS:
You notice how you're blinking?

SUBJECT: Yes. (Laughs)

BROOKS:
And that's not something you do everyday, blinking in that special way.

I reinforce the association between blinking and the ensuing trance.

But don't close your eyes and go into a deep trance until your subconscious mind knows that it can happen all by itself. You

understand that?

understand that?

BROOKS:
Mmm. OK you just wait and hold on. Ok. You don't want too much of a good thing all at once.

SUBJECT: No.

When you see a desirable response in a subject, frustrate it, it then makes it more compelling. The harder she tries to delay an on-going unconscious response the more difficult it will be to prevent it from occurring. She can choose to take my suggestion to resist going into trance thereby making it more compelling or she can choose to resist my suggestion to resist and so go into trance.

Because of her apprehension I decided to use an authoritarian approach. I am overtly provoking her and hoping to evoke resistance to my suggestion to resist, yet I am doing it in a humorous way to blur the congruity between my verbal and non-verbal communication. It can create 'therapeutic confusion' as she's relying on me for her frames of reference. In order to maintain the frames of reference she has to narrow her attention even further - she's relying on me totally for direction as I juggle with her sense of logic.

BROOKS:
You know the best kind of presents, I think, you can give to someone are the one's with a lot of wrapping paper. Because you have to unwrap them nice and slowly, and as you unwrap them so the excitement builds, you become more and more interested and curious about what's inside that present.

I think of myself as someone who gives presents to people an awful lot, often they don't know they're getting it.... Mmm, every now and then have a little glimpse or some idea of what the present might be.

Here I am giving a metaphor that parallels her on-going experience. It paces her present reality (sic) and suggests what is to follow. Present reality = something new being discovered a bit at a time. What follows = excitement and curiosity about ensuing trance experience. The word present implies a pleasant surprise. It can also mean 'present moment.'

SUBJECT:
I can close my eyes if I want to?

BROOKS:
But not until it happens by itself.

You notice however how the harder you try to keep them open the more difficult it becomes. They almost want to close.

I continue to frustrate her response despite her wanting permission to close her eyes.

I continue to frustrate her response despite her wanting permission to close her eyes.

You can take the word like now, and there is an N, there is an 0, and there is a W and of course there is a W in the word NOW. The word backwards means WON. Now won, won now.

There is a W in the word now. There can be a won in the word now and a W in the word now.

Now this is really complex because not only am I inducing confusion to get her into a trance. I am also setting up a number of things for later. I am also again reinforcing her ability to listen to me on different levels (unconsciously) with a truism. I chose the word 'now' because I intend using this as a trigger word to evoke trance in the future. I break it down into individual letters because I want to suggest a 'W' (double you), as I want her to hallucinate seeing her self later. So I am suggesting that there can be two of her - a double you, yet at the same time only one of her.

This is why I emphasise that associated with the word ~now' can be the word 'won' (one of her) and a 'W' (two of her). When setting up hypnotic phenomena like hallucinations it's best to spend time in priming and indirectly suggesting that it will happen.

How do you make sense of something like that?

SUBJECT: I've really never thought about it.

BROOKS:
You've really never thought about that in the same way that you've never paid attention to the individual words in a sentence yet the subconscious mind listens for every word, every syllable, every letter but you don't have to pay any attention to those details, you can just enjoy being in Turkey.

SUBJECT: Mmm.

She's never thought about it, of course she hasn't - she has to go on an internal search to answer the question I then use her response to compound the suggestion with repetition. You should always use every opportunity to use repetition - in enforces the suggestion, however don't do it directly.

BROOKS:
Yes, you noticed how you keep going there every moment; you just close your eyes you go back to Turkey. That's it. A nice feeling. That's it. Now that's right.

Now.... Now those alterations in your body can develop in their own way in their own time. I'd like you to carry on holding on to the chair with those hands. Just holding on to the chair with those hands, keeping that grip on that chair.

I pick up on her blink reflex and I encourage it by suggesting going back to Turkey. Having frustrated the response to close the eyes and dissociate her with confusion she can't resist eye closure any longer. As she's still holding on to the chair I decide to capitalise on the previous association between holding on and not going into trance until her unconscious decides. I am frustrating the response still further.

Now I can tell you that the muscles in your face have smoothed out really very well. The respiration has changed, breathing, pulse is slowing down, I can see the alteration in your pulse in your neck and this alteration in your physiology parallels the experience of going into a nice hypnotic state but you don't have to try to do anything. You really don't have to try to do anything Avril because your subconscious mind can let that happen.

Here I point out the physiological changes that I can see and make trance contingent upon the continuation of these changes.

Now how do you feel at this moment? I'd like you to share that with me. How do you feel right now?

SUBJECT: Warm.

BROOKS:
Warm. Mmm, do you feel warm more on one side of your body than the other or maybe the top half compared to the bottom half, or all over.

SUBJECT: All over.

BROOKS: All over and is that how you feel if you re in Turkey? Nice and warm?

SUBJECT: Yes.

BROOKS:
Mmm... yes. Nice place to be. That smile tells me an awful lot about your experience. You find this a little bit humorous as well?

SUBJECT: Mmm

BROOKS: Mmm what do you find humorous about it? Please tell me.

BROOKS: Mmm what do you find humorous about it? Please tell me.

BROOKS: Just comfortable.

SUBJECT: Very comfortable.

BROOKS: Very comfortable. Now I wonder where you can be even more comfortable.

Trainees often ask me; "Why do you ask a subject to share her experience just as she is going into trance - surely this brings her out?" Well firstly I don't mind if she comes out because I like to frustrate the response and secondly she will give me information about her subjective experience. So far I have been utilizing only what I have been able to see. Now I'm getting inside information. Also to share her experience she has to go on an internal search once again, especially when I ask her to identify where she feels warm.

I can talk to you. As I talk to you I can also talk to "you," only when I talk to "you" is there any need for you to listen.

Because when I'm talking to you, you don't need to pay any attention. Just let your mind wander, become absorbed in your own thoughts.

Here I am separating my communication to the conscious and the unconscious more directly with a change of voice loci. When I lean to my left I am talking to her unconscious and when I am leaning to my right I am talking to her conscious mind. As long as I am consistent she will be able to unconsciously respond to the separate communications. I'm actually telling her to not listen consciously. I want her conscious mind to be in Turkey while I have a private chat with her unconscious. I don't want 'her' (conscious mind) interfering with her autonomous processes

You're breathing out, each time you breathe out so you can go nice and comfortably deeper into this hypnotic state without any effort on your part.

This makes trance depth contingent upon her breathing. Dependent suggestions should always utilize an on-going behaviour that is important for the subject. Breathing is pretty important so we use it. Also breathing out is more conducive to going deeper than breathing in.

Now, those hands can experience something very special for themselves. Now you are nice and upright in this chair. Upright

in this chair. A nice comfortable position.

in this chair. A nice comfortable position.

Do you like to have movement in your life?

SUBJECT: Yes.

Here I am priming her for the experience of an arm levitation and catalepsy with a metaphor. The metaphor isn't relevant at the present moment, she will have to wait in unconscious anticipation to discover its relevance.

BROOKS: Yes and isn't it interesting in just attempting, and trying to respond to a question like "do you have a little movement in your life"? It's difficult to actually answer. Difficult to put a little movement in your life at this moment. That stillness, do you notice that?

Yes but you can nod your head can you not? That's right. You can nod your head.

I capitalize on the difficulty in responding to my question whilst limiting her movement to head nods. By saying 'but you can nod your head can you not? (Nod) I am implying that she can't move anything else. I am also using repetition (not/nod) and giving her a difficult to resist negative tag suggestion (can you 'not') By putting in the 'not' for her it reduces any temptation she had to say no. However she's in a double bind because even if she shakes her head she's agreeing that her movements are limited to head movements.

Tell me, as you breathe, notice how your hands feel different from each other. Which hand feels maybe the heaviest, the lightest, warmest, maybe one hand feels it's holding on and the other hand feel more relaxed. Tell me at this moment. How does your left hand feel compared to your right hand?

SUBJECT: It's lighter.

I'm making her response to the double bind presupposition about her hands contingent upon her breathing. I give her very open-ended suggestions which imply there must be a difference between her hands. It also gives her the chance to explore her unconscious potential. If a hand wants to feel light, it can. If it wants to be heavy it will be.

BROOKS:
Your left hand feels lighter than your right. Mmm... so you are left there with a light feeling. Mmm.. and isn't that interesting. Notice those feelings in that hand and this moment now. In that left hand. Notice what's happening to that left hand. It happens all by itself and you're not even thinking about the heaviness in your right hand as that movement in your left hand occurs all by itself. Now I wonder whether that left hand will lift at the wrist or the elbow. You can wonder how that will happen.

Will it be the fingers that lift up before the wrist or will it be the wrist that lifts before the elbow or will it be at the shoulders that, that arm lifts up into the air.

Mmm... do you feel that? That's it just let it relax. Now you're going to have difficulty keeping it down. Almost as if there is a nice relaxing blast of air pushing it up just letting it hover nicely and as that starts to happen more and more now AvriI, just allow yourself to go deeper and deeper into hypnosis but you don't have to do anything with that arm, that can just happen all by Itself.

Mmm... that's right, now normally you can open your eyes whenever you wish.

As soon as she says that her left hand is lighter I decide to go for an arm elevation. This wasn't a good idea because earlier I had suggested a lack of movement apart from the head. However as her light left arm had presented itself spontaneously I decided to encourage it with open-ended suggestions. As soon as I saw that she seemed to be trying to respond consciously. I changed course and distracted her away from any possible failure at arm levitation and quickly suggested eye catalepsy.

Maybe you'd like to learn something now as you try to open your eyes, you can try to open your eyes. That's it that's interesting, the harder you try, the tighter shut they become and the tighter shut they become the deeper and deeper and deeper you can go into nice hypnotic state. That's right just deeper and deeper that's it. Mmm... that's it, that's it, that's it.

I tell her to learn something interesting as she tries to open her eyes. Normally she can open her eyes so what can she possibly learn this time? I then compound the suggestion with a group of stacked dependent suggestions trying = learning = trying harder = tighter shut = deeper trance.

Now you can enjoy being in Turkey and your subconscious

mind can understand everything I say without you having to listen.

mind can understand everything I say without you having to listen.

Here I re-cap by saying her multiple experience of hypnotic phenomena proves her unconscious is more able to control her subconscious functions than she is.

Mmm.... and as I talk to you so, you can just allow yourself to go deeper and deeper and you can be in this special place. You can be by the swimming pool, how does If feel to be by the swimming pool? Letting your mind wander, you can have a dream, you can have a dream and in your dreams you can go anywhere you choose and my voice can become part of that dream. The sound of my voice be part of that experience of dreaming. Become part of the sound, the wind, part of the sound of your own breathing sound. This becomes part of your experience as you go deeper and deeper comfortably into a nice hypnotic state. You don't have to do anything, you don't even have to think about it, you don't have to pay any attention to how you're going deeper. That's right, that's right.

Notice how I hitchhike her going deeper onto my continuing to talk to her. I am going to do a lot of talking and she's going to go deeper. I find it useful to use a lot of presupposition when inducing trance. The subject gets her confidence from the hypnotist. If the hypnotist presupposes trance will occur he is demonstrating confidence in his ability as a hypnotist and hers as a subject.

Even the phrase "just allow yourself to go deeper and deeper" is a presupposition that she can go deeper subject to her giving herself permission. I re-evoke the swimming pool because she has already suggested that this is her favourite place. I want to associate deeper trance with her favourite place.

I give her a dream analogy about mind wandering and the analogy parallels her current experiences. The analogy and reality don't have to match exactly, in fact the analogy is there to parallel the basic elements of the current experience yet lead her towards including more and more of the trance elements inherent within the analogy as part of her present reality.

I want her to include external elements of dreaming in her present reality. Inherent with the dreaming experience is amnesia, distorted perception, time distortion and all of the various classic hypnotic phenomena. What better way of training her in these experiences than reminding her that she does it in her sleep every night.

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Firstly I tell her not to think about how she's going deeper. I don't say "if" she's going deeper I say "how" again a presupposition. It also conserves psychological energy for the work to come and stops her trying consciously to do something she's better experienced at doing unconsciously.

Mmmmm.... Mmm, and you know you can experience a change, an alteration in time. You could be enjoying yourself watching a good film and time seems to pass so quickly. You are not even aware that the time has flown by.

It seems like just a few moments have passed and you feel so comfortable watching the film yet also you could be doing something you don't like and time seems to really drag. You know those kinds of experiences? Mmm... How do you do that? How do you alter time? How do you make a long time happen in just a few seconds? You know you can dream, you can dream of a whole series of events that spans over hours and you put all of those moments into just a fraction of a second of dream time. In real world time I could give you just ten, twenty seconds, yet in hypnotic time you can experience a whole lifetimes experience of doing things, achieving things for yourself and that just happens automatically.

Here I give her another analogy to induce time distortion. Time distortion is a natural everyday occurrence.

By asking her how she does it I am evoking the psychological processes involved. She can't answer consciously so she has to search and thereby evoke the processes.

The question "how do you make a long time happen in just a few seconds" is a double entendre. The words "in just a few seconds" can have a different meaning depending on context. When the contextual framework is loose the meaning can become blurred. At the conscious

level the subject interprets the words within the framework of the time distortion analogy. At an unconscious level the unconscious will not interpret but save the information for future reference. If the context were to change or expand to include other contexts then the unconscious would apply these stored learnings appropriately. For example within the current framework the question will probably be taken literally i.e. "How do you contract a long duration of time into a short period of time."

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By embedding this analogy in to the dream analogy I can expand the possibilities, and because the dream analogy refers to her current experience I am implying that almost anything is possible.

Also in a hypnotic state you can bring about alterations and sensations in different parts of your body. In your hands, your arms, your legs, your face, you know a hand can easily lose sensations and you don't have to even know how it's happening.

I am now extending the possibilities to include alterations in her kinaesthetic and tactile experience. I remind her of the other experiences with her hands to compound the suggestion.

You may have had the experience of lying in bed and realising that you have been sleeping on an arm and that arm is numb and heavy sort of a wooden-like feeling almost as if it doesn't belong to you. You know what I'm talking about do you not? You notice a little of this at this moment?

SUBJECT: Yes.

I'm attempting to induce three kinds of phenomena here; anaesthesia, disassociation and an illusion of heaviness. They can exist simultaneously or independently. By attempting all three I increase my chance of achieving at least one. Notice that I say, "attempting", you can't guarantee hypnotic phenomena you can only hope to evoke it. By using a combination of suggestions you can get close to guaranteeing it but it's never predictable. When I ask her whether she experiences some of the anaesthesia "at this moment" I am not making a random guess. I

check it out first. Earlier she had stated that her left arm felt lighter than her right. This of course also means that her right arm feels heavier than her left. So I know she has some heaviness in the right arm. Secondly she has had the experience of an induced heaviness and catalepsy in the eyelids. So these sensations are familiar to her. She has also responded well to all of my suggestions so far so we both have expectations of success. I also check it out with the question "you know what I'm talking about do you not?' To answer the question she has to have had the experience, so again it is familiar.

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BROOKS:
Yes and which arm is that in? That arm, yes. Mmmm... almost a temptation to move it to get rid of that numbness yet the harder you try to get rid of that numbness the more numb it becomes. I don't know whether that numb sensation can spread down from the shoulder all the way down to the tips of the fingers or from the fingers upwards. You can be curious about how that numbness develops in its own way, maybe a tingling, maybe a pins and needles type feeling or just total lack of sensation in that arm as if it doesn't belong to you.

SUBJECT:
My neck is aching.

BROOKS:
Your neck is aching. Mmmm... now which side of your neck aches? The left side of your neck aches and the right side of your neck feels comfortable.

SUBJECT: Mmm...

BROOKS:
I'd like your subconscious mind to make the right side of your neck ache. Will it ache more towards the front or to the back I wonder? Just wait and discover how your subconscious mind makes the right side of your neck ache. Let me know when you notice that ache in the right side of your neck. Meanwhile that arm can get heavy in its own way. Now normally you could lift that arm could you not?

SUBJECT: Mmm..

Some people think that I am blessed with good subjects. Maybe it's

because I recognise problems as a blessing in disguise. Her neck hurts. I remember a time when I would have though to myself "oh no another difficult subject'. There really is no such thing as a difficult subject, there are only opportunities for learning. As soon as she announces that her neck aches I immediately limit the ache to one side of her neck with a presupposition. This reduces the potential problem by 50%. I start reframing the problem by telling her that if one side of her neck aches then the other must be comfortable. She has to agree and this helps build acceptance for my other suggestions. I then shock her with a direct suggestion for the right side of her neck to ache. This shocks her because it's the last thing she expects to hear. On the conscious level I am actually asking her problem to get worse. I am also not addressing her at all, I am talking directly to her unconscious. By cutting across her in this way I am telling her that she has no choice in the matter - her neck is going to ache on the right hand side. Her only participation in this is to let me know when she feels it aching. I then immediately change back to the numb arm. I do this for two reasons. Firstly, because I want her to have amnesia at the conscious level for the preceding suggestions regarding her neck so that she doesn't sabotage the process by trying consciously, and secondly, because I believe that people perform hypnotic tasks better if they have a number to do simultaneously.

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I finish with the question" now normally you could lift that arm could you not?' Of course this implies that now she can't.

BROOKS:
Notice that heaviness now maybe almost as if it's tied down to the arm of the chair as if it's stuck down to the arm of the chair. The harder you try to lift it the heavier it becomes. You can really try and move the muscles in your shoulders, try hard to lift that arm. That's it. You were not trying hard enough. Really try hard. That's it. It's so difficult and isn't that a strange sensation to have? And you can wonder what else you can achieve in this special hypnotic state. You are doing very, very well Avril, learning on many levels.

Hypnotic induction is a matter of negotiation however there comes a time when you can become more direct. I will use a combination of indirect and direct suggestion with subjects. I tend to use direct suggestions only if I have a good trance and a responsive subject. Here

I'm actually challenging her in what appears to be a very direct way. The indirect aspect is my 100% confidence in her not being able to lift her arm and the utilization of the law of reversed effort (the harder you try the more difficult it is). I use her success here to compound future hypnotic experiences and congratulate her. Everyone likes acknowledgment for their efforts so congratulate your subjects both in and out of trance. I'm congratulating her on her ability to trust her unconscious and her willingness to learn that she can't do things that she would normally be able to do.

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SUBJECT: I don't know.

BROOKS:
You don't know? Have you got an ache on the right side yet?

SUBJECT: A bit.

BROOKS:
It's starting to happen. And what's happening to the left side?

SUBJECT:
Feels a bit better.

BROOKS:
Feels a bit better. How interesting that as we shift the ache from the left to the right so the left feels a little bit better, you are left with that comfortable feeling and right here I have control over that ache. You know I can make that ache, ache on the right side or I can take it away because I made it happen. And so I can help you feel even more comfortable but not until all of the ache has shifted from the left to the right.

That can just happen in it's own time.

If you want to take away pain don't try and remove it. Firstly it's there for a reason and secondly it will respond better to negotiation. By asking her ache to appear in the right side of her neck I am actually asking it to move from the left to the right. As soon as the subject realizes that the pain can move she also realizes that it can disappear. She has the experience of comfort developing in the left side of her neck where the ache used to be. She also believes that I created the ache on the right so she can believe that it will go if I tell it to. Because I haven't the right to remove the pain I leave it up to her unconscious. If her unconscious wants me to remove it, it will shift it all to the right. If it wants her to keep the pain then she will and if it wants to remove it itself then it will do it without telling anyone. I prefer the unconscious to do the work because I'm lazy.

I also include a little confusion regarding left and right just to reduce any conscious involvement.

Now how does your right arm feel now?

Now how does your right arm feel now?

BROOKS: All right?

SUBJECT: Mmm...

BROOKS:
What do you think you can or cannot do with it?

SUBJECT: I can't lift it.

Now we're back to the arm. Remember to keep bouncing your subjects around; it loosens up their frames of reference.

I ask her what she can or cannot do with her arm because I'm not sure whether the heaviness is still there. If I had asked her "what can you do?" She would look for all the positives. If I had asked her "what can't you do?" She would look for the negatives. Sol ask her what she can and cannot do, this way she has to consider both. As I said earlier, hypnotic phenomena can be unpredictable unless conditioned through repetition. But then it wouldn't be spontaneous and so much fun to evoke.

BROOKS:
You can't lift it. You not only cannot lift it, you can't release that grip you have on the chair. Notice how those fingers are just stuck in that position, that rigidity in those fingers on the right hand.

I quickly utilize the success with the arm to evoke catalepsy in the fingers. I did this because I recognised the rigidity earlier related to my suggestions to grip onto the chair. I don't like to take too many risks so I prefer to hitchhike suggestions and then imply that I created them.

Now in a few moments I'm going to ask you to open your eyes and look at that right hand, so just move your head so that you are in a position to look at that right hand. That's it,

To further compound her success I want her to have a visual representation of anaesthesia. What better way than to see the hand as if it were someone else's. By asking her to prepare herself by repositioning her head, I am implying that she is about to do something special. To be able to reposition her head to so that it is in the correct position she has to hallucinate seeing her right hand with her eyes closed in order to gauge the best position for her head. She is mentally rehearsing the task before I give it to her. This will increase its success.

Now you can try to open your eyes and look at that right hand.

I asked her to "try" and look at her hand because I thought that there was a chance that she might not be able to open her eyes. If she had been unable to open her eyes then I would have pretended that this was the response I wanted to evoke.
That's it.

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That's it.

SUBJECT: It looks strange.

By asking her to be curious I'm not telling her that it's not her hand but I'm implying that she will not know. I want her to have doubts - so I give her a complicated suggestion requesting disassociation. This could be classed as a form of Double Disassociation Double Bind (Rossi/Erickson).

BROOKS:
It looks strange. You know it can look even stranger and in a moment I'm going to lift that arm in a certain way and whatever you do, don't take your eyes off that hand.

You're going to find it difficult and as I lift that arm, I'd like you to notice something happening now.

You may remember that earlier I was priming her for a right arm catalepsy by telling her about being upright in the chair. Well here I evoke the catalepsy and one response after another which rapidly moves from phenomena to phenomena. By telling her not to take her eyes off her hand I am compounding her belief that something important is going to happen. I tell her that she will find it difficult but because I don't specify what will be difficult she has to wait with anticipation thus increasing her responsiveness. I make noticing something happening to her contingent upon me lifting her hand in a certain way. I am actually lifting her arm in a rigid way and slowly giving responsibility for maintaining the rigidity to the subject. By alternately releasing and then holding her arm I can feel her catalepsy developing. Once it has developed enough to support the arm by itself I give the wrist a number of conflicting pushes in opposing directions This seems to confuse the conscious mind and 'fix' the arm in a cataleptic position. Because I am giving the arm conflicting messages it gives up trying to respond and becomes immobile

Notice that rigidity in that arm now. Now that hand feels almost

as if there is a sort of iron bar inserted down the middle of that arm. Just that staying there in that position. But that hand can be limp or be just stuck there in that position. That's it, that's it. Now how interesting to have that rigidity in your arm yet that limp feeling in your hand now you can move your hand.

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BROOKS:
But then as you move your hand, notice a certain rigidity developing in your fingers.

SUBJECT: Mmm.

BROOKS:
And how does that happen all by itself?

Now there isn't anything particularly subtle about this. It's very direct but effective in this case. It may not be as effective with another subject or at another time. I decided to use the iron bar as visual conceptual reinforcement but as I was giving the suggestion I noticed that she was moving her hand so I immediately used it to reinforce the rigidity in the arm. As her attention shifted from the hand to the arm I used the opportunity to encourage the catalepsy I saw developing in the fingers.

You can be curious about what it feels to bend those fingers but not able to demonstrate it to yourself and then notice what happens to your eyelids now. That's right, and you really can't put that arm down.

This is such an exciting part of the session because so many phenomena are happening at once. As she tries to bend her fingers I noticed a drooping of the eyelids so I utilized the opportunity to trigger an eye closure with the word 'now'. I then went straight back to reinforcing the catalepsy in the arms.

You can't move the left arm, you can't move the right arm. You can really try hard to lower that right arm. The harder you try the more difficult it becomes, almost as if there are strings just holding it up here, holding it up, lifting it up, that's it, lifting.

Once again I give her a couple of examples of what her unconscious has achieved - just to compound future phenomena and maintain positive expectation. I also use the law of reversed effort. I decided to give her some hallucinated strings to hold up the arm because I thought that the iron bar might have been a little heavy. It also meant that the strings could pull the arm up into that 'upright' position.

And as you are upright get that feeling, that's it and that hand can slowly move towards your face very slowly but don't go all

the way back Into the past until that hand touches your face.

the way back Into the past until that hand touches your face.

This achieves three things. Firstly it gives her the choice of how far back and at what speed to regress and secondly it makes regression contingent upon an on-going behaviour (movement of the hand towards her face). Lastly it frustrates an exciting possibility (regression) and so makes it more compelling. The frustration compels the arm to continue to levitate and the levitation makes the regression more inevitable.

That's it. That's it all the way back through time. A calendar's pages changing, turning back, going back through time very quickly all the way back to some early memory when you were a little child and a little child first learns to touch her face and explore her face. Explore the feelings in that face now. Just learn what it feels like to have a face. Mmm.. really learn something from exploring that face and you can feel that hand touching your face, you may even not be aware that it's your hand.

I included the calendar's pages turning back as a visual component (her kinaesthetic was tied up with the hand moving and her auditory with the sound of my voice). By telling her that she may not be aware that it's her hand touching her face I am merely capitalising on the earlier hand disassociation (associated with anaesthesia) and reminding her of a universal learning experience that young children have, that of discovering their face and hands.

She regresses and I utilise the hand touching the face as part of the regressed experience. You should never hesitate to use whatever is happening.

Interesting sensation to have. How does it feel as a little girl to have that hand just gently touching your face? Is it a nice feeling? Do you know whose hand it is? You don't know, you can think you know but you really don't know. That's right, well, it's nice to feel that safe, comfortable, secure feeling as a child just exploring and learning something about yourself.

I told her that she was safe and secure in case that she found that a dissociated hand touching her face was disconcerting.

Tell me where do you think that you are as a child now?

SUBJECT: In the cot.

I ask her where do think that you are 'as a child' now because I didn't want her to respond as an adult. When subjects are in trance they often respond literally to questions. By framing the question in the tense of the child (past yet present) I reduce the risk of her answering as an adult and possibly slipping out of the regressed state. When she answered that she was in the cot I though that she might feel trapped so I suggested the possibility of being out of the cot. However she preferred being in the cot. The sense of freedom being out of the cot was something I felt, yet was not part of her reality. I shouldn't have projected my own assumption into the situation.

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:
In the cot. And you can look out of the cot and wonder what it's like to have the freedom to be outside this cot. Mmm... you like to get out and play or do you want to stay in the cot?

SUBJECT: Stay here.

BROOKS:
Stay in the cot. What are you wearing?

SUBJECT: Blue.

BROOKS:
You are wearing blue.

SUBJECT: Mmm.

BROOKS:
Mmm, seemed to surprise you. Mmm.

SUBJECT: Mmm.

BROOKS:
And you really didn't know you'd be wearing blue.

SUBJECT: Mmm.

It's nice that she sees herself wearing blue. It ratifies the experience because in reality she is wearing grey, and as she is a female she may have expected to see herself wearing pink.

BROOKS:
Now let's move ahead in time a little way maybe a few years being a slightly older child. Tell me as your hand lowers down, slowly as it lowers become that child at a slightly older age. What's happening now? Mmm.. what is this experience about?

Do you know how old you are at this moment?

SUBJECT: No.

BROOKS:
You really don't know. What's happening? You don't know.
Ok, let your subconscious mind give you some images, shapes,
colours, experiences. Mmm, there's some feelings there as well.

You notice those feelings? That's it just hold on to those feelings. Where do you feel those feelings Avril, where do you feel them?

You notice those feelings? That's it just hold on to those feelings. Where do you feel those feelings Avril, where do you feel them?
:
Music - my ears.

BROOKS:
Your ears, you can hear with your ears?

SUBJECT: Mmm.

BROOKS:
And you can hear with your ears here. And what's the music that you hear?

SUBJECT: It's a radio.

BROOKS: A radio?

SUBJECT: Mmm.

BROOKS:
Well just listen to this radio and tell me what happens next.

Here I use the hand lowering as an age regression technique. Whenever possible use an ongoing behaviour and hitchhike the behaviour you wish to occur onto the on-going behaviour. She had an experience that I misinterpreted as being a possibly bad experience; I was wrong. However I checked it out because it is important to utilize an abreaction if it occurs.

An abreaction is a reliving of past trauma often triggered by an association of memories. If you are doing therapy and you get an abreaction you should let your person go all the way through it even though it may be quite dramatic. To stop it halfway through may repress it further and make it harder to access later. In this case I didn't want an abreaction as I was demonstrating hypnosis not therapy, but I was prepared to utilize it if it had occurred.

Because she seems to be having difficulty holding onto the memory I suggest shapes, colours, experiences and feelings. I am suggesting some of the sub modalities of her sensory experience for her to pay attention to. Sometimes subjects need a little prompting. When she seemed to respond to feelings I told her to hold onto them - to locate them. Feelings are usually tied to sets of images and sounds. I really doesn't matter which comes first - feelings, sounds or images. Grab the first one, encourage it and usually the other senses will follow. In this case the feeling led to auditory and then visual.

I play around with the words hear, here and ear simply to repeat the word hear. Indirect repetition will usually increase the response. I say, "let's listen" so as to include myself as part of the experience. If I am a

disassociated voice outside of the experience she will not be so involved or associated with the memory.

disassociated voice outside of the experience she will not be so involved or associated with the memory.
.
BROOKS: You don't know. Mmm.. And where are you listening to the

radio?

SUBJECT:
Front room at home.

BROOKS:
In the front room at home.

SUBJECT: Mmm.

BROOKS:
Anybody with you?

SUBJECT: My father.

BROOKS: Your father.

SUBJECT: Mmm.

BROOKS:
And what are you doing in addition to listening to the radio, are

you are playing?

SUBJECT:
Sitting on the settee.

BROOKS:
Sitting on the settee. Are you feeling happy or sad? Are you

happy? Is it a nice feeling you have?
SUBJECT: Mmm.

I am still having to prompt her a little and I'm still checking out possible abreactions.

BROOKS:
And what's your father doing?

SUBJECT: Reading a newspaper.

BROOKS:
Reading a newspaper that's a nice thought to have. OK. Hmmm. Mmm.. Now throughout your life you've done a number of different things, you've had a number of different interests; activities you've enjoyed and you know those activities that you've enjoyed. It's sometimes as easy to forget things. You know you can be in conversation, and half way through the

conversation you forget what you were talking about. You've had that experience have you not? Or you go off at a tangent and you loose thread of the conversation and you really can't

remember what you were talking about.

remember what you were talking about.

Now, you know from your own experience that there are some times when you can't open your eyes and there are some times when you can and you can wonder what the difference is. How do your eyes feel at this moment?

SUBJECT:
They're not too tight.

I am checking out her eyes because in a moment I want to her to hallucinate herself at a younger age and with her eyes open.

BROOKS:
They're not too tight? Well that's wonderful. Now you can know what you look like. You know what you look like do you not?

SUBJECT: Mmm.

BROOKS:
And you know what a chair looks like. I'd like you to look at

yourself on that settee listening to that radio. Can you describe

what you look like now?

SUBJECT:
I had a jumper and skirt on.

BROOKS: Mmm.

SUBJECT: Straight hair.

BROOKS: Mmm.

SUBJECT: Brown.

First of all I have her rehearse the hallucination. This compounds it in her mind. Because she has the experience of seeing it with her eyes closed (which is often easier) She will expect to see it with her eyes open. Notice also how she is disassociated from the image because she describes it in the past tense. Earlier I talked of the "double you" in the word "now". I am now attempting to induce the "double you" experience. The experience of being two people simultaneously.

BROOKS:
Brown. OK in a moment, I'd like you to learn something of importance to yourself. At the moment, just as soon as your

subconscious mind is ready, I'd like you to discover that your eyes open all by themselves and when that happens, you look in front of you and you see yourself sitting there. I don't know whether you will see yourself as a child, as a teenager, as an adult.

subconscious mind is ready, I'd like you to discover that your eyes open all by themselves and when that happens, you look in front of you and you see yourself sitting there. I don't know whether you will see yourself as a child, as a teenager, as an adult.

I use repetition here and am quite emphatic about exactly what I want her to see and believe. I can do this directly because I have built up rapport based on truisms. Everything I have suggested has happened so she has a high expectancy.

How does it feel?

SUBJECT: I was a lot thinner.

BROOKS:
How old is she there? How old are you?

SUBJECT: Fourteen.

Now she has partly associated with the younger self. What is interesting is that she has not associated fully because her statement implies an awareness of the adult self which an associated 14 year old would not have. She is experiencing being two people simultaneously, which is exactly what I want.

BROOKS:
You are fourteen here, and there. Now I wonder what it's like for a fourteen year old to look at a woman like yourself. You can be the you here looking at the you there. Look from over here at the you there. What do you think that you think of her?

Now that I have both of her here I am suggesting that she step into her younger self and look into the future at her older self through the eyes of the younger self. This can be quite a dramatic learning experience for her because it requires a shift in her perspective. She may well learn things about herself that she has either never acknowledged or realised.

Of course she may not learn anything.

Of course she may not learn anything.
:
You know this here is how you are going to become. Is there

anything that you want to change about the you here in this

chair?

I am giving her the opportunity to do something therapeutic for herself. I am very careful about specifying which "her" I am talking to or about. Lack of precision on the part of the hypnotist as this point could result in a very confused subject, which although appropriate in some contexts would not be appropriate here.

SUBJECT:
I'd like to be thinner stay the same weight I think.

She makes two interesting statements here, as she looks at her older self. Her first statement about her being thinner seems to have a future orientation and requires an awareness of the belief systems of both older and younger self. Her second statement seems to be oriented to the ongoing present experience of maintaining the weight of the younger self and does not necessarily require awareness of the beliefs and criteria of the older self. The first statement is about loss of weight whilst the second is about the maintenance of lack of weight. Therapeutically the second approach may be more compelling for her than the first. However we should use both. She has given me both perspectives so I will feed them back to her therapeutically. I will have her discover how she can lose weight by going into the future. I will then have her look back at how she managed to maintain her success. Persons often establish their beliefs about themselves at different points in time and access to these beliefs, for the purpose of change can be hindered or helped by the degree of awareness (or disassociation) between the selves at different times.

BROOKS:
Like to be thinner?

SUBJECT: (Nods)

BROOKS:
Deeper. Mmm fine. Now your eyes can close, that's it as you go deeper and

As her eyes close so she re-orientates with her older self. You may remember that the disassociation between the younger and older self was made contingent upon her opening her eyes. Now she has closed her eyes she is ready for the first part of my therapeutic intervention with the older self. For this I ask her to go deeper into trance so that she has access to the resources required for the process. I do this by making going deeper contingent upon the ongoing experience of eye closure.

BROOKS:
And how can you find yourself feeling thinner? How is that

going to happen? It's not going to happen in a matter of seconds.
But let's do some travelling in time.

going to happen? It's not going to happen in a matter of seconds.
But let's do some travelling in time.

BROOKS:
In a few moments I'm going to give you a task but I am not going to tell you what it is until I give it to you.

This is a semantically confusing suggestion to make, however it is given in all seriousness. Obviously she will not know what the task is until I tell her. What I am suggesting here is that she frustrates what she may anticipate as the task until I give her a signal to carry it out.

But you know how you can change time you can experience 3, 4, 5, 6 months of time happening in just a few seconds of real world time.

And you're going to learn from this and I'm not going to tell you the task until it's time to do it.

You may remember that earlier I was priming her for this with suggestions about time distortion. Any hypnotic phenomena is more likely to occur if you prime it well in advance. I like to leave about twenty minutes between any priming and the more direct evocation of the phenomena, almost as if the priming suggestions were post hypnotic suggestions.

You may notice that I have already given her part of the task yet have just told her that I haven't given it to her. This is because I didn't want her to confuse the process of the task with the content of the task.

I'm going to give you twenty seconds of real world time, and I'm going to time that, twenty seconds of real world time and in that twenty seconds I want you to experience 6 months of future time.

Are you ready?

SUBJECT: Mmm.

I now give the second part of the process, which frustrates her even more.

I now give the second part of the process, which frustrates her even more.
:
OK now I want you to experience the next six months of your life and discover everything you needed to do, everything that you had to do and did successfully to lose weight - now. (Pause

-20 seconds)
I now give her the content of the task and I give it to her in a very direct emphatic way. By almost spelling out every word I am stressing the importance of the task. Because I have frustrated the task a number of times she should feel more compelled to carry it out.

BROOKS:
OK are you finished? OK now just look back over the last six months and look back at all of the steps you needed to take in order to lose that weight, that you wanted to lose the first time you saw me.

Notice how you broke those things down into easy to handle steps.

Here is the second part of the therapy. She's looking hack now instead of forward. She's developing a second perspective on how to lose weight. This perspective is based on the first yet presupposes that she has lost weight. To do this she has to disassociate from the present self and become the future self. I am helping her install a future belief about herself six months in the future. Because this belief is associated with a future date it will hopefully act as a motivator. It's her unconscious carrot on a string, compelling her towards success.

And how much weight have you lost over this six months since the time that we first met, how many pounds do you think you've lost?

SUBJECT: About a stone.

BROOKS:
About a stone? And that's some achievement.

SUBJECT: Mmm.

BROOKS:
And look back and notice how you did it in those easy to manage steps.

Notice how I put myself into the future with her. I am asking her to look back six months to the time when we first met when in reality we have only known each other for a few hours.

And just take a look at yourself now in the mirror and notice

how you look. Do you want to put a little bit more weight back on?

how you look. Do you want to put a little bit more weight back on?

BROOKS:
You're happy with this amount of weight loss.

SUBJECT:
It's a start.

BROOKS:
It's a start? One stone is a start? I'm going to suggest that with your success that you ought to have a little relapse. You know I don't know whether it'll be in a few weeks or a month that you could relapse and put on maybe half a pound or so before you get back on course again. And then maybe you have another little relapse a month or so after that before you get back on course again, and for your subconscious mind to give you as many relapses as are healthy for you. For you to lose weight successfully but to maintain your optimum health for your own well being.

Sometimes persons expect too much from themselves. In this case I felt that she might benefit from relapsing a few times because too much weight loss might be unhealthy for her.

Persons often relapse anyway so why not suggest that it can happen, then if they do relapse they see it as part of the success of therapy rather than as failure.

For you to lose weight successfully but to maintain your optimum health for your own well being.

OK now let's travel back through time to the present moment with me, back to the present moment with me. Mmm, have you got the feelings back in that arm yet?

It's always important to re-orientate your persons to the present time frame. The last thing any hypnotist wants is a disorientated person walking around the streets. I use repetition to reinforce this suggestion. There's a presupposition in my question about the feelings in the arm. You must always be very confident whenever you give any form of hypnotic suggestion. There should be no doubt in the person's mind that you believe, fully, that the feelings will return to the arm.

SUBJECT: Mmm.

BROOKS:
Wonderful and what about the right hand?

SUBJECT: Mmm.

BROOKS:
Does that feel fine? Yes

SUBJECT:
It still aches that one.

BROOKS:
That still aches? Maybe you could keep a little of that ache for a while after you come out of hypnosis as part of your education.

Some persons may show concern if the physiological changes that occur during trance continue after trance has been terminated. I always reassure my persons by either giving a post hypnotic suggestion for the continuation of a physiological change after trance has been terminated or by reframing the condition after the person has come out of trance. Of course, maintaining a physiological change that was initiated during trance is another way of ratifying the trance experience.

Now I can ask you to come out of hypnosis in any number of ways I can use all kinds of sound, I don't have to use my voice and you can find yourself going back into a trance very quickly in a way that is very surprising and humorous for you.

Here I am priming her. I am preparing her for the trigger that indicates the termination of trance. I eliminate the sound of my voice and I include in an open ended way other alternatives. I link this to a post hypnotic suggestion that she can find herself going back into trance very quickly. I add that the experience of re-entering trance can be surprising and humorous. This in itself is a second post hypnotic suggestion that I've hitch hiked on the first one. So here we see a pattern. Firstly she awaits the trigger or the signal that indicates that she can come out of trance, this signal not only triggers the termination of trance but then triggers a post hypnotic suggestion that she can re-enter trance. Re-entering trance is in itself a trigger for the experience of humour and surprise.

So prepare yourself for coming out of trance in a moment. One, two, three (clicks fingers)

Hi there. Well how are you?

SUBJECT: Fine.

BROOKS:
Feeling fine. What does it feel like to go into a trance now?

Here I carry out the post-hypnotic suggestions as promised. The trigger word to re-enter trance is the word "now". Very early in the session I had used the word now a number of times to induce hypnosis. It now acts as a post hypnotic cue.

You can try and open your eyes and this time the harder you try the more difficult it becomes. Just try to open those eyes now the more tightly shut they become. The harder you try, the more tighter shut they become. Really try, you're not trying hard enough

You can try and open your eyes and this time the harder you try the more difficult it becomes. Just try to open those eyes now the more tightly shut they become. The harder you try, the more tighter shut they become. Really try, you're not trying hard enough

that's it a real effort. Really put all of your effort into it and then when you don't expect it (clicks fingers)

SUBJECT:
(Laughs)

I want to put her into and take her out of trance a number of times, this not only reinforces the post hypnotic cue to re-enter trance it also ratifies the whole experience and is educational for the person.

BROOKS:
Hi there. Mmm, what do you like to do with yourself in your spare time Avril?

SUBJECT:
Well we usually sleep.

BROOKS: You sleep in your spare time.

SUBJECT:
Yes because the rest of the time we're working very hard so...

BROOKS:
So sometimes you need a...

SUBJECT:
I'm not at all energetic which I should be.

BROOKS:
You need time to relax and just let go sometimes. It's nice just to let yourself go now

Here I immediately change the subject and ask her an irrelevant

question about her spare time. Often students ask me why I do this. I find that by changing the topic of conversation after trance has been terminated it helps ensure some form of amnesia for at least part and sometimes all of the trance experience. In this case I wanted to use this strategy and also create a context in which the post hypnotic cue to reenter trance would come as a surprise once again.

That's right, that's right. Just deeper and deeper relaxed and you have the wonderful way of relaxing and altering your breathing and did you know that you can go into a trance, you can go into a nice comfortable relaxed state any time you wish. You know how to do that? All you have to do is to think of that word now,

As she's once again in a trance I can give her more post hypnotic suggestions. Here I give her a post-hypnotic suggestion to re-enter trance whenever she wishes. I am in fact teaching her self-hypnosis.

and that happens for just one person, that happens for you. It also happens for the double you, both of you, the double you can go back into a hypnotic state just by hearing the sound of my voice say that word... now.

To guarantee that she will be fully associated when she re-enters trance on her own at any time in the future I include the "double you" statement. The last thing I want is for her to practice self-hypnosis and discover that she disorientates and dissociates into two different people. It is very important to remember to undo any suggestions that you suggest during trance if they could perhaps be detrimental in the future. As I am teaching her self-hypnosis here it is important that when she reenters the trance on her own she doesn't experience a reoccurrence of hypnotic phenomena that could be disorientating or harmful in any way.

So any time whenever you want just a few moments to yourself just to relax yourself at work, just to take a little time to yourself all you have to do is hear my voice saying... now, and just by hearing my voice saying now so your eyes can just close and both of you can just go into a nice comfortable hypnotic state.

Here I use repetition to compound her ability to practice self-hypnosis.

The two you's that happen when you hear the word now. And to get yourself out of this nice comfortable hypnotic state all you have to do is to hear this (clicks fingers)

Hi there.

SUBJECT: (Laughs)

Here I'm asking her to hallucinate the sound of my fingers clicking. In future hypnotic contexts if she practices self-hypnosis on her own I won't actually be there to click my fingers. It's now important for her to learn to hallucinate the sound of my fingers clicking and in addition to this to hallucinate the sound of my voice saying the word "now".

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:
What keeps happening to you?

SUBJECT:
I don't know.

BROOKS:
How does it feel when that happens?

SUBJECT: It feels nice.

BROOKS:
It feels nice. I'm glad it feels nice.

SUBJECT: Mmm.

BROOKS:
Interesting how it seems to happen all by itself, it's not something that you make happen, it seems to just happen to you.

SUBJECT: Mmm.

Here I reinforce the fact that the response she is experiencing is occurring at an unconscious level. For her to practice self-hypnosis in the future it is important for her to trust her unconscious mind more and more.

BROOKS:
You know the feeling? Yes. I'd like you just to hear me saying the word.... now. That's right. Almost don't believe that it works. How nice to have that skill at your disposal any time that you want it. You know that's going to help you lose weight as well, but you don't even need to know how because your sub conscious mind knows for you. Just taking that little time for yourself is going to alter the way you eat so that you lose weight effectively.

Once again I induce trance with the word "now". I add that by going into trance she will be helping herself lose weight. It's important to realise that the experience of going into trance is not in itself a way to lose weight. However in this context, because losing weight is bound within the therapeutic framework of this session, the re-entry into trance at a later date should re-instate all of the therapeutic hypnotic suggestions and therapeutic processes that occurred.

I'm very keen to hear from you in the future about how

successful you are at losing weight and then to bring yourself out of this trance all you have to do is hear (clicks fingers).

Mmm how about that? I'd like you just to listen and hear that word. This time hear it to yourself. That's it. That's it. Shifting, shifting the experience from outside now so that it's...now inside of you, now inside of you.

Mmm how about that? I'd like you just to listen and hear that word. This time hear it to yourself. That's it. That's it. Shifting, shifting the experience from outside now so that it's...now inside of you, now inside of you.

I want to be one hundred percent certain that she's able to practice this technique so I get her to go in and out of trance a number of times. I am also shifting the trigger to enter and the trigger to come out of trance from her external reality to her internal reality. I want her to be able to hear those words and hear the sound of my fingers clicking inside her head without me being there.

Yes, yeah you did very well. Very very, well. What do you keep shaking your head for?

SUBJECT:
I don't understand it.

BROOKS:
You don't understand it?

SUBJECT: No.

BROOKS:
You know there are a lot of things in life that you won't need to understand because they're going to happen all by themselves. How nice to lose weight

SUBJECT: (Laughs)

to give yourself those few moments in time without knowing how you have to do it, it just happens all by itself. That's a nice thing to have.

Once again I reinforce her unconscious minds ability to control the situation.

Do you know what I mean by giving people presents now? I like to give people presents like that.

SUBJECT: Thank you.

BROOKS:
That's a present you're never going to lose, it's always going to be part of you.

SUBJECT: Mmm.

BROOKS:
Like tying a shoelace.

SUBJECT: Mmm.

BROOKS:
All those things you take for granted, it's just going to become part of your everyday life. Once more OK. Now hear the word....

She hallucinates the word "now".

" ah you're doing it already.

SUBJECT:
(Laughs)

BROOKS:
Hear the word.

SUBJECT:
I don't understand.

BROOKS:
I'd like you just to discover that you can try and open your eyes and find it difficult until you hear the sound of that click. Just try first. Notice that?

By having her experience the inability to open her eyes until she hallucinates the sound of my fingers clicking I am really ratifying the whole experience and her ability to utilise these learning for herself.

SUBJECT: Mmm.

BROOKS:
And you know how to bring yourself out? (Pause) That's it. Well you've done very well.

You know what I do for a living? I push snowballs down hills. What I do I get a handful of snow and I"

Here I finish with a metaphor. Taking a small handful of snow, rolling it down a hill, watching it get bigger, watching it grow. I aim to help every person that I see grow and develop in this way. This was one of Milton Erickson"s metaphors, and as a mark of respect to him I decided to finish the session with one of his metaphors. That brief moment in time when the person and hypnotist are together is such an important moment that the hypnotist should put their whole being into helping that person. The results of therapy are not just the immediate responses that occur. The results of therapy will be noticed throughout the person"s life and long, long after the person and hypnotist have parted company.

To purchase the double DVD training set based on this therapy session, with

a running commentary plus interviews, please go to the BHR online shop: a running commentary plus interviews, please go to the BHR online shop:
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THE END