Australian Journal of Clinical and Experimental Hypnosis

MAY 2010 VOLUME 38 NUMBER 1

Published by

Australian Society of Hypnosis

All submissions to the *AJCEH* are subject to a (blind) peer refereed review process; this includes expanded research-based analytical reviews of books, but does not include film reviews or short book reviews, unless otherwise noted. The rejection rate for first submissions of research-based articles currently runs at about 25%.

Submissions will generally be acknowledged within two weeks of receipt, and feedback on reviews within four months. The time span for publication of articles can take up to 12 months from date of first receipt, depending on the amount of changes required in the article and the timing of the submission of the final draft.

The opinions and views expressed in the materials presented in this journal are not necessarily those of the Editor, Editorial Board and Consultants, or of the Australian Society of Hypnosis. Each author is responsible for ensuring the authenticity, accuracy, and legality of their submitted works and to ensure that case studies are written in a way that protects the subjects' privacy. Where necessary, permission should be obtained for unusual case studies that could identify a client or research participant. In particular, we ask you to verify your sources and to ensure that your facts are correct, and that your submissions in no way contain any material that could be interpreted as libel, defamation, or slander. The *AJCEH* cannot be responsible for any complaints arising from the publication of such case studies or articles.

Annual subscription rate:	Australia:	Individuals	$A44.00
		Institutions and Libraries	$A55.00
	Overseas:	Individuals	$A44.00
		Institutions and Libraries	$A55.00
Price per single copy:		Individuals	$A30.00
(including back copies)		Institutions and Libraries	$A30.00
Subscription inquiries to the Australian Society of Hypnosis	*Australian subscriptions include GST*		

Australian Journal of Clinical and Experimental Hypnosis

May 2010 **Volume 38 Number 1**

Editorial iii

The Integration of Classical Music Composition Theory with Mind–Body Hypnotherapy
Bruce Gregory 1

A New Approach to the Genesis of Hypnosis: A Gift of Love and Security
Eugen Hlywa and Lynda Dolan 25

Use of Hypnosis in Psychotherapy With Major Depressive Disorders
Elliott H. Schreiber 44

Treating Physical Pain and Low Self–Esteem with Hypnosis: A Case Study
Catherine Suey 52

Metaphors to Reawaken Resiliency in Patients
Consuelo Casula 62

Sleep Script
James Auld 72

AUSTRALIAN JOURNAL OF CLINICAL AND EXPERIMENTAL HYPNOSIS

Copyright © The Australian Society of Hypnosis Limited 2010

EDITORIAL BOARD

Editor

Kathryn M. Gow, PhD, Queensland University of Technology

Associate Editors

James M. Auld, MSc, Dental surgeon in private practice, Inverell
Norm Barling, PhD, Bond University
Amanda Barnier, PhD, University of New South Wales
Greg J. Coman, PhD, University of Melbourne
Allan M. Cyna, MB, Women's and Children's Hospital, Adelaide
June Henry, PhD, Clinical psychologist, Toowoomba
Graham A. Jamieson, PhD, University of New England

Editorial Consultants

Joseph Barber, PhD, University of Washington School of Medicine
Graham Burrows, AO, KCSJ, MD, FRANZCP, FRCPsych, University of Melbourne
Peter B. Bloom, MD, Pennsylvania Hospital and University of Pennsylvania
Harold B. Crasilneck, PhD, PC, University of Texas
Barry Evans, PhD, Melbourne
Kevin M. McConkey, PhD, University of Newcastle
Michael Nash, PhD, University of Tennessee
David Oakley, PhD, University College, London
Peter W. Sheehan, PhD, Australian Catholic University, Sydney
David Spiegel, MD, Stanford University
Wendy-Louise Walker, PhD, Sydney
Graham R. Wicks, MBBS, DobstR COG, FRACGP,
Women's and Children's Hospital, Adelaide
Jeffrey K. Zeig, PhD, The Milton Erickson Foundation

FEDERAL EXECUTIVE OF
THE AUSTRALIAN SOCIETY OF HYPNOSIS LIMITED

President: Brian Allen, MAPS
President-Elect: Kathryn M. Gow, PhD
Past President: Kevin M. McConkey, PhD
Federal Treasurer: Di McGreal, MAPS
Federal Secretary: Greg Coman, PhD
Chairperson — Publications: Kathryn M. Gow, PhD
Chairperson — Board of Education: James Auld, MSc

Manuscripts and editorial matter should be addressed to the
Australian Society of Hypnosis, PO Box 3009, Willoughby North, NSW 2068.
Business communications and subscriptions should be addressed to Ann Wilson,
Australian Society of Hypnosis, PO Box 3009, Willoughby North, NSW 2068.

Editorial

This is the first issue of the *Australian Journal of Clinical and Experimental Hypnosis* to go online and, as such, we see it very much as a trial edition. For this reason, we have kept the number of articles smaller than in the average edition. This edition is focused on the practice of hypnosis.

International contributor Bruce Gregory reminds us that music is something that we need to appreciate again in hypnosis settings and Elliott Schreiber, with his wealth of experience in the field, gives us his views on utilising hypnosis with major depressive disorders, an area that used to be contested.

Our own Eugen Hlywa, who was recently awarded the Doctor of Psychology by the Institute of Psychology within the Academy of Pedagogical Sciences of Ukraine, teams up with Lynda Dolan and they put their case for the valuing of hypnosis practice experience and the healing and spiritual events that take place in the treatment setting.

Catherine Suey outlines a case study about the links between treating pain in combination with understanding the role of the patient's self-esteem in the healing process.

Another international contributor, Consuelo Casula, writes of how, through metaphors, therapists can send messages which are the fruit of a combination of scientific reasoning and therapeutic intuition to strengthen resiliency in patients.

Last, James Auld supplies a script to assist clients overcome many of the "blocks" they have to experiencing sound sleep.

We expect that the web-based journal will facilitate communication from both practitioners and researchers between Australia and other countries, and disseminate both research and innovative hypnosis practice within Australia more widely.

Kathryn M. Gow

Australian Journal of Clinical and Experimental Hypnosis
Vol. 38, No. 1, 2010, 1–24

The Integration Of Classical Music Composition Theory With Mind-Body Hypnotherapy

Bruce Gregory
Ryokan College, Los Angeles

The integration of principles of classical music composition theory with mind–body hypnotherapy can facilitate deeper levels of safety and new forms of comfort in the treatment of trauma and abuse. This integration is facilitated by the utilisation of creativity, expanded trust, the implied directive, the principle of equivalence set forth by Einstein, and by the principle of correspondence utilised in the set theory of Cantor.[1] The main areas, in which trust is expanded, are the trust of containing complexity, the trust of creativity, and the trust of containment[2] of the depth of safety. The levels of fear and the accompanying needs for safety are related to the four basic polarities involved in the treatment of trauma and abuse. The appreciation of basic principles of symmetry that are utilised creatively in classical music composition is a core factor in integrating principles of classical music composition theory with mind–body hypnotherapy.

The movement toward integration has been proceeding concurrently within, and between, a variety of disciplines for many decades. Since the early twentieth century, physics has been struggling to integrate the gravitational force represented by Einstein's field equations with quantum mechanics

[1] Georg Cantor was a German mathematician who was recognised as the creator of set theory, to which he applied the principle of correspondence to develop the theorems relating to transfinite numbers. A detailed description of his work can be found in Dunham (1955, chaps 11–12).

[2] Containment is a term used in psychodynamic therapy that is utilised in the treatment of affect states and acting out behaviours. A detailed discussion of containment can be found in Masterson (1976). In a hypnotherapeutic context, containment refers to interventions involving the conscious mind and unconscious defences. Detailed examples can be found in Erickson and Rossi (1979).

Correspondence regarding this paper should be sent to Bruce Gregory at bgregoryphd@earthlink.net.

(Greene,[3] 1999, 2004). The emergence of superstring theory in the 1980s and the discovery of the gravitron[4] showed promise of providing a unified theory that integrated all four forces; gravity, the electromagnetic force, and the strong and weak nuclear forces (Greene, 1999, 2004).

Within mainstream psychology, efforts toward integration of different theoretical orientations have argued for the inclusion of different perspectives which include theoretical integration, the inclusion of a spiritual dimension, and the inclusion of experiential, existential, and systemic orientations (Anchin, 2008; Magnavita, 2008; Norcross & Newman, 1992; Wilber, 2008; Wolfe, 2008).

In the domain of clinical hypnotherapy, Erickson integrated the active and passive approaches originated by Charcot and Janet in the nineteenth century in France with his naturalistic conversational approach (Erickson, 1958/1980; Erickson & Rossi, 1979). Rossi (1986, 1996, 2002) and Rossi and Nimmons (1991) continued and expanded Erickson's work by integrating mind–body hypnotherapy with molecular biology, chronobiology, and chaos theory with other therapeutic modalities that included cognitive behavioural therapy, psychodynamic therapy, and Jungian therapy. The bridge to molecular biology was clarified through the function of the hypothalamus as a relay centre, and by the vast array of physiological resources with varying capacities for facilitating containment, comfort, and transformation. The bridge to chronobiology was established by the appreciation of the overlap between Erickson's 90-minute therapy sessions with Kleitman's work identifying the ultradian rhythm (Erickson, 1958/1980; Kleitman, 1969; Rossi, 1986, 1996; Rossi and Nimmons, 1991). The bridges to other therapeutic modalities were made by applying the implied directive to Jung's transcendent function (Jung, 1916), Beck's work with cognition, and psychodynamic therapy's utilisation of containment (Beck, 1976; Gregory, 2005/2007; Jung, 1916; Masterson, 1976, 198l; Rossi, 1996, 2002).

By implication, Rossi was challenging therapists to reorient and expand their thinking about the healing process, and to consider and utilise the resources of molecular biology, chronobiology and chaos theory, which are subsets and aspects of the unconscious. Within this challenge was the implication that both

---

[3] Brian Greene is a physicist who has been recognised for his discoveries that support the development of superstring theory. Greene (1999, 2004) provides detailed discussion of the evolution of physics and its struggle to discover a unified theory that integrates the four fundamental forces.

[4] The gravitron is a theoretical particle in physics that underlies the force of gravity in quantum field theory.

the therapist and patient could learn to trust these resources. Further, since the accessing of these resources could facilitate neurogenesis, the creation of new nerve cells, Rossi was developing Erickson's assertion that hypnotherapy facilitates a patient's creative reorganisation of his experience and creative problem solving. Rossi's integration of molecular biology with mind–body hypnotherapy validated patients' capacity to be creative, and implied that this capacity could be nurtured and trusted.

The implied directive, a primary mechanism of the integration process, was originally used by Erickson (see Erickson & Rossi, 1976; Rossi and Nimmons, 1991) in the context of indirect contingency suggestions. It had three components; a time binding introduction, a suggestion that takes place within the patient, and a behavioural response that indicates when the suggestion has been internalised (Erickson & Rossi, 1976). A few examples are:

- Would you like to go into a trance now or later?
- Would you like to go into a mind–body state lying down or sitting up?
- Would you like your mind–body experience to be a familiar form of comfort or a new experience that contains a measure of fascination?

The concept had wider applications which were expanded by Erickson and Rossi (1976) through the following statement:

> An understanding of how Erickson uses implication will provide us with the clearest model of his indirect approach to hypnotic suggestion. Since his use of "implication" may involve something more than the typical dictionary definition of the term, we will assume that he may be developing a special form of "psychological implication" in his work. For Erickson, psychological implication is a key that automatically turns the tumblers of a patient's associative processes into predictable patterns without awareness of how it happened. The implied thought or response seems to come up autonomously within patients, as if it were their own inner response rather than a suggestion initiated by the therapist. Psychological implication is thus a way of structuring and directing patients' associative processes when they cannot do it for themselves. The therapeutic use of this approach is obvious. If patients have problems because of the limitations of their ability to utilise their own resources, then implications are a way of bypassing these limitations. (Erickson & Rossi, 1976, pp. 59–60)

The essence of this is that the implied directive is an effective way of communicating directly with the unconscious, while bypassing the potential interferences of the conscious mind and unconscious defences. In addition, the utilisation of the implied directive is a process for affirming, validating, and

nurturing the multiple issues involving a patient's relationship with his capacity. Some of these issues include; fears that's one's capacity is inadequate/defective; curiosity about one's capacity; nurturing of one's capacity; exploration of one's capacity; trust of one's capacity; appreciation of one's capacity; and issues of abandonment related to capacity.

Efforts toward integration of mind–body hypnotherapy with other branches of science and other therapeutic modalities also incorporate the utilisation of the principle of correspondence from set theory (Cantor, 1955; Dunham, 1991) and the equivalence principle from Einstein's work with gravity and accelerated motion (Greene, 2004; Isaacson, 2007). Cantor and Einstein employed creative thinking to develop the principles of correspondence and equivalence, which discoveries had significant impact on the way the world is now understood. A consequence of these discoveries was the implication contained in the recognition that equivalences and correspondences were themselves also sets, and thus contained subsets. Rossi's efforts toward the integration of mind–body hypnotherapy with other branches of science are also supported by the implementation of the implied directive, metaphor, and the interspersal technique (Erickson, 1958/1980; Erickson & Rossi, 1979).

TREATMENT OF TRAUMA AND ABUSE

The origins of the treatment of trauma and abuse can be traced to the work of Janet (1907), who was responsible for the use of the term "dissociation." Dissociation was a description of the separation of thoughts, feelings, and perceptions connected with a traumatic event. Janet was a pioneer in the development of techniques for retrieval, processing, and integrating of experiences coming from traumatic events.

Hypnotherapy has treated trauma, abuse, and the symptoms resulting thereof with both direct and indirect perspectives (Erickson, 1958/1980; Erickson & Kubie, 1939; Erickson & Rossi, 1989; Hammond, 1990; Phillips & Frederick, 1995). Symptoms from trauma and abuse have been associated with state dependent memory (Hilgard, 1977; Phillips, 1997; Rossi, 1986/1993) and ego states (Phillips, 1997; Watkins & Watkins, 1997). Ego states are equivalent to Rossi's utilisation of parts in his polarity approach (Rossi, 1996, 2002). Phillips and Frederick's four-stage SARI model (Phillips & Frederick, 1995) has identified stage 1 as the phase in treatment wherein the appreciation and facilitation of safety is most paramount. This safety is facilitated by the use of both direct and indirect suggestion.

Almost all patients' symptoms in cases of trauma and abuse reflect an imbalance with space.[5] This imbalance involves a violation of boundaries resulting in major damage to feelings of safety and underlying needs for containment. In addition, the patient has a sense of being frozen in time. An abused patient's space has been violated, and as a result, the patient feels unsafe and unprotected at very deep, core levels. The patient's internal space is further compromised by the anxiety associated with the feelings associated with the abuse, or traumatic experience, and the anxiety associated with the projections of future trauma and/or abuse. In addition, as a result of the experience, the patient is also left with feelings of helplessness, hopelessness, terror, and self-hate. It is this overlap between the experience of trauma and/or abuse with powerful affects and complex defence mechanisms that necessitates the need for deeper containment.

The feelings of helplessness, hopelessness, terror, and self-hate can be organised into four sets of polarities that can be utilised in the treatment process. Polarities[6] have been utilised in a number of treatment modalities that include; Gestalt (Perls, 1970), Jungian (Jung, 1916), and mind–body hypnotherapy (Rossi, 1996, 2002). Rossi (1996, 2002) applied Jung's approach to establish a template for creating polarities between symptoms of the patient, and the internal resources of the patient capable of operating in empowered ways. Polarities processes utilise the transcendent function, internalisation transmutation resources[7] (Kohut, 1971, 1977), and the network of physiological resources supporting the work of the hippocampus in facilitating neurogenesis (Loewenstein, 1999; Rossi, 1996, 2002; Squire & Kandel, 1998). A major component of this healing process is accomplished through the creative replay of experiences carried out by the hippocampus and the cortex, facilitating the reorganisation of fear memories and neurogenesis (Nader, Schafe, & Le Doux, 2000; Rossi, 2002, 2004). These polarities are reflected by Figures 1 through 4.

---

5 Merell-Wolff (1993) and Tulku (1977, chaps 1–5) address the value of space perspectives of considerations, thought, and logic from both Buddhist and Western frameworks. Loewenstein (1999, chaps 6, 9) and Squire and Kandel (1998, chap. 7) both address the value and appreciation of space. Greene (2004, chaps 1–4) and Isaacson (2006, chaps 6, 9) address the need for space and its role as a container. An application of Erickson's interspersal approach found in Erickson and Rossi (1979, chap. 5) evaluates a patient's receptivity for exploring his relationship with space, and utilising space as a source for comfort.

6 Polarities were introduced as a psychological dynamic by Jung (1916) in his identification of the transcendent function as the mechanism that integrated the conscious and unconscious minds. Jung later expanded the concept to include all types of opposites, some of which included light and dark, masculine and feminine, and active and passive.

7 In self-psychology, as postulated by Kohut (1971, 1977), internalisation transmutation resources are the unconscious resources within the patient that allow and facilitate receiving support from the therapist in order to build a new psychic structure.

Figure 1: Polarity 1. (Copyright © 2009 by Bruce Gregory)

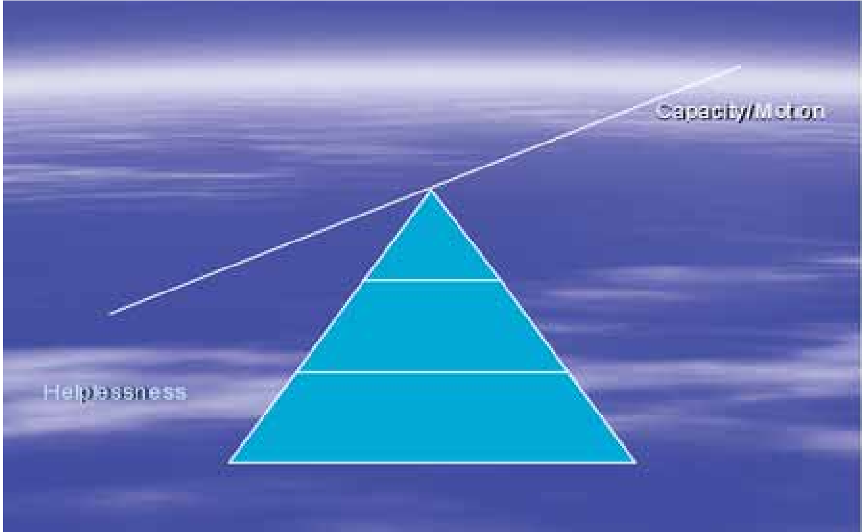


Figure 2: Polarity 2. (Copyright © 2009 by Bruce Gregory)

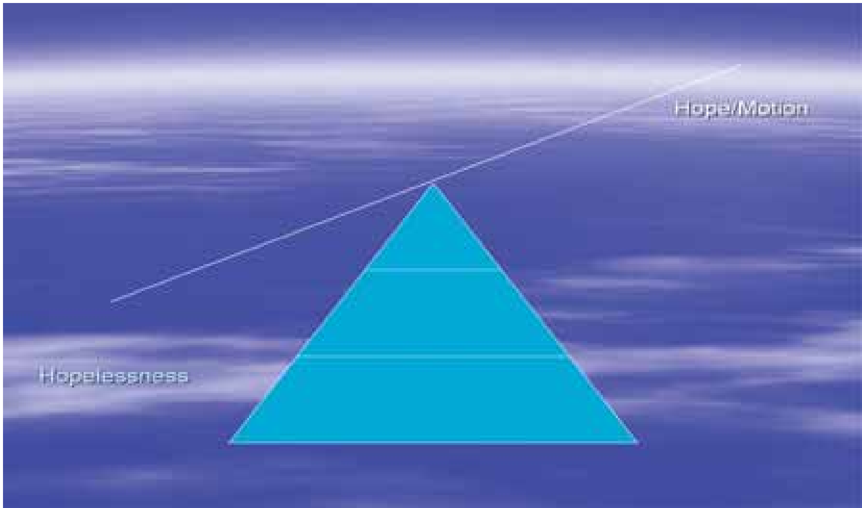


Figure 3: Polarity 3. (Copyright © 2009 by Bruce Gregory)

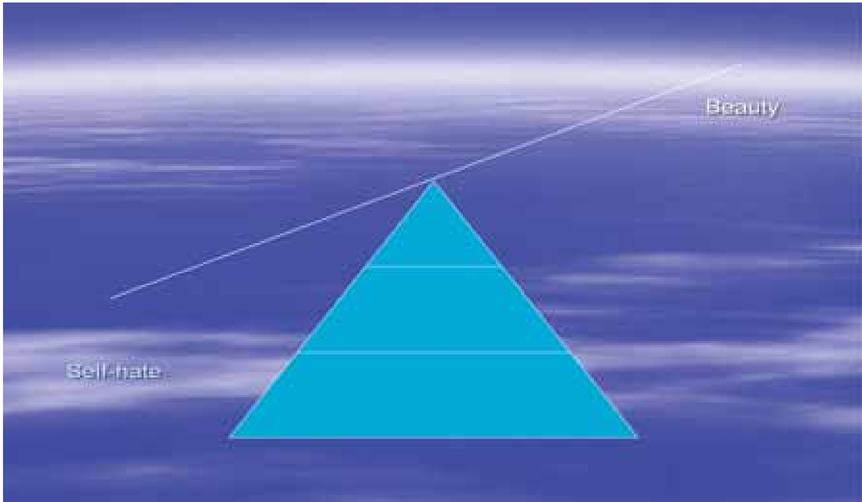
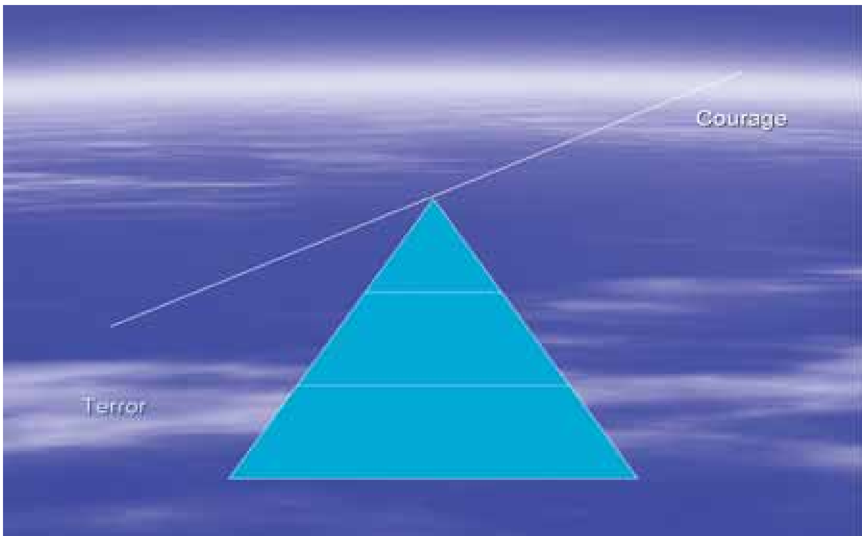


Figure 4: Polarity 4. (Copyright © 2009 by Bruce Gregory)



The treatment of trauma and abuse has incorporated principles of mind–body hypnotherapy from additional direct and indirect perspectives. Grove (1989) emphasised the importance of "clean language" in order to facilitate safety and unconscious processes to address the temporal, spatial and comfort needs in the treatment of trauma. Levine (1997) indirectly

referenced the implied directive by identifying the role of the reptilian[8] brain to facilitate the transformation of safety, motion, temporal, and position aspects of trauma and abuse treatment.

Underlying Rossi's integration of mind–body hypnotherapy with branches of science and other therapeutic modalities was the implied need for expanded trust, both on the part of the therapist and that of the patient. This need for expanded trust was a natural expression of the understanding of the need and value of trust that had been evolving since the beginning of the twentieth century.

EVOLUTION OF THE NEED FOR EXPANDED TRUST

The need and value of trust has been explored for many decades from a variety of perspectives.

Within mainstream psychotherapy, this discussion has included Roger's (1961) identification of the need for unconditional positive regard, Winnicott's (1965,1971) identification of the need for "good enough" mothering, Kohut's (1971,1977) appreciation of the needs for empathy, Klein's (1950) implication of the need for containment of affect, and Laing's (1965, 1971) identification of the need for validation. In addition, Masterson (1976, 1981) stressed the need for a development of a "therapeutic alliance" to contain the false self. Jung (1916, 1923) advocated the trusting of the unconscious in order to support the transformative, healing powers of the transcendent function operating within the domain of the unconscious. Also from a Jungian perspective, Hillman (1964) outlined the archetypal process for the evolution of self-trust in the context of interpersonal betrayals, and Edinger (1984) identified aspects of a template for the maturation of trust from a spiritual dimension.

Overlapping these efforts was Erickson's efforts at shifting the focus of trust from between the therapist and patient to between the patient and his unconscious (Erickson & Rossi, 1979, 1980; Rosen, 1982). This shift in focus asserted that the unconscious could be trusted to:

- Be safe,
- Access the source of problems,
- Be sensitive to rhythms,

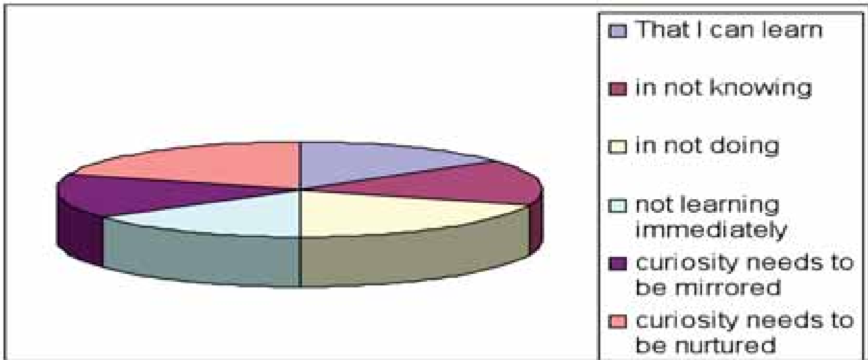
---

[8] Levine (1997) identifies the reptilian brain as the instinctual part of the brain, one of the brain's three parts, the other two being the mammalian or limbic brain (emotional) and the neo-cortex (rational). Levine advocates the activation of the resources of the reptilian brain to address the spatial and temporal components of being frozen as a consequence of trauma.

- Reorganise experience, and
- Provide comfort, creative problem solving, and healing.

Concurrently the patient was also learning to trust other aspects of his intrapersonal experience. These learnings are summarised in Figure 5.

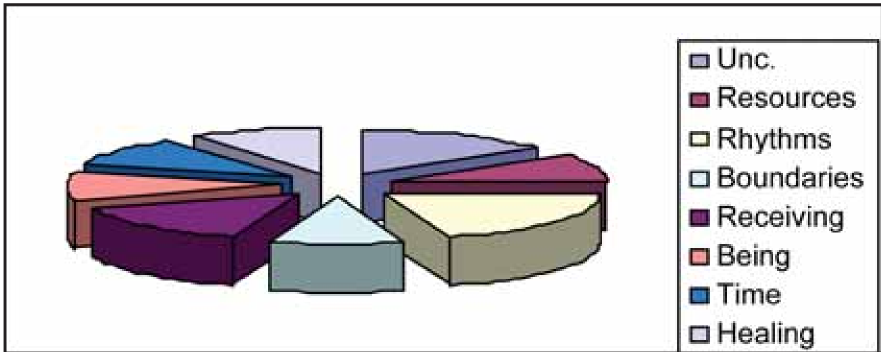
Figure 5: Development of Trust. (Copyright © 2005 by Bruce Gregory)



Rossi (1986, 1996, 2002) and Rossi and Nimmons (1991) extended the work of Erickson, integrating it with the areas of molecular biology, chronobiology, and chaos theory. By utilising the implied directive, the need for trust expanded, as evidenced by Figure 6.

By illustrating the connections between the mind and the body, and how external stimuli are processed by vast networks of unconscious physiological resources, Rossi was implying that the *subsets* of the unconscious (Cantor, 1955) needed to be explored, trusted and appreciated. The implication was that patients had the capacity to connect and have dialogues with these subsets that are identified in Figure 6 on unconscious levels. The need for a relationship with, and a trust of, time was implied by the processes of the ultradian rhythm (Kleitman, 1969) and the four-stage creative cycle identified by Poincaré (Rossi, 1996). The need for a relationship with, and trust of, rhythms had also been implied by Erickson and Rossi's five-stage hypnotic process (Erickson & Rossi, 1979) and Rossi's identification of the different time frames for gene activation and expression (Rossi, 2002). Erickson and Rossi (1976, 1979) had previously provided the templates for evaluating and facilitating these experiences through the utilisation of yes sets, truisms, metaphors, and the interspersal technique.

Figure 6: Re-Orientation of Trust. (Copyright © 2005 by Bruce Gregory)



Drawing on the work of Kandel and others (Kandel, 1998; Squire & Kandel, 1999), Rossi (2002, 2004) outlined the psychobiology of gene expression, identifying the "novelty, numinosum, neourogenesis effect," which is driven by the hippocampus and vast array of resources operating within its domain. The processes of the hippocampus, aided by the dialogue between the hippocampus and cortex during sleep (Lisman, & Morris, 2001; Rossi, 2002, 2004) validated the following list:

- The capacities for creativity and depth,
- The needs for creativity and depth,
- The need to trust the resources that support "receiving," and
- The need to trust complexity.

Rossi deepened Erickson's utilisation of the validation and reinforcement of "receiving" by highlighting a variety of resources that play significant roles in receiving, facilitating comfort, learning, and neurogenesis (Loewenstein, 1999; Rossi, 2002, 2004; Siegel, 2006). These resources included:

- Mirror neurons,
- Cell membrane, and
- Creb protein.

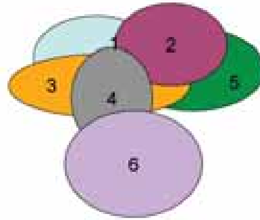
In addition, consistent with principles of the implied directive, the deepening of the need, utilisation, and valuing of trust is congruent with advances in astronomy, astrophysics, and molecular biology. In 1934, Hubbell made a discovery that galaxies were flying away from each other at extremely high speeds, indicating that the universe was expanding (Greene, 2004; Overbye, 1991). This discovery was verified mathematically by Friedman and

Lemaitre (Greene, 2004). In the area of molecular biology, research has shown that there is a direct correlation between the size of the hippocampus and depression. Studies indicate that the size of a depressed person's hippocampus is 15% smaller than a person who is not depressed (Sheline, Wang, Gado, Csernansky, & Vannier, 1996).

When examined in the light of the need for harmony that is consistently employed in classical music, the need for expanded trust is simply a logical corollary to the expanding universe. A molecular representation of expanded trust is shown in Figure 7.

Figure 7: Expanded Trust Molecule. (Copyright © 2009 by Bruce Gregory)

1. Physiological Resources
2. Creativity
3. Containing Complexity
4. Facilitating Deeper Safety
5. Motion
6. Position



THE INTEGRATION OF CLASSICAL MUSIC IN PSYCHOLOGICAL TREATMENT

Music has long been recognised to express deep human emotion, the struggles and triumph of the human spirit, and to facilitate healing (Campbell, 1997; du Sautoy, 2007; Scott, 1958). Plato wrote: "Musical training is a more potent instrument than any other, because rhythm and harmony find their way into the inward places of the soul, on which they mightily fasten, imparting grace, and making the soul of him who is rightly educated, graceful" (Scott, 1958, pp. 43, 44). Jung (Warming, 1992), Sullivan (1927), and Rossi and Rossi (2008) recognised that the sonata form utilised in symphonic composition corresponds to, and metaphorically expresses, the four-stage creative cycle. Jung commented, "music is dealing with such deep archetypal material" and

felt that it should be included in the treatment process because it facilitated access to very deep material (Campbell, 1997, p. 169). Rossi has noted that the composers Hayden, Mozart, and Beethoven all utilised the sonata form to express human conflict, crisis and resolution (Rossi & Rossi, 2008).

Campbell (1997) summarised many examples of the positive effect that classical music can have on learning, improving the immune system's functioning, and healing trauma and abuse in a variety of contexts. Rauscher, Shaw, and Ky (1993) showed that learning and listening to classical music could significantly improve performance on spatial and temporal tasks. Skille (1991) found that music could be utilised to lower blood pressure. Bartlett et al. (1993) demonstrated that listening to music could raise levels of interleukin. Tomatis' (1991) work on the functioning of the ear demonstrated that the network of resources/receptors contained therein functioned as enzymes facilitating learning and healing. He made a number of contributions that deepened the validation of capacities for containment, and the facilitation of comfort, learning and healing. Tomatis: (a) identified the distinction between listening and hearing; (b) developed techniques to improve functioning of the right ear, enhancing speech and musicality; and (c) recognised that the foetus hears sounds in the womb.

Bonny and Savary (1983) identified how different pieces of music, predominantly classical, could be used to facilitate of variety of transformative experiences, including peak experiences, in the treatment of alcoholics. Houston and Masters (1973) incorporated the utilisation of music with guided imagery to facilitate unconscious healing processes. In other research, Achterberg and others found that the combination of music and imagery helped to enhance the immune system (Achterberg & Lawlis, 1984; Tsao et al., 1991).

Some of the key components provided by music were depth and the natural flow of images, which are two significant variables in the treatment of trauma and abuse in the context of the patient's need for safety to achieve the level of depth necessary to address his wounds, and the patient's need for safety to relinquish sufficient control to allow the flow of images that often accompany creative reorganisation and healing processes.

Walker (1979, 1990, 1992) incorporated music with hypnotherapy in order to facilitate safety, depth, images, and the flow of the experience. Walker identified music as a pathway, incorporating various types of music which included baroque chamber music, Renaissance dance music, and music from the synthesiser. She recognised the need and value for the capacities

of receptivity and absorption, in order to increase the effectiveness of the integration of music with hypnotherapy. Walker also recognised how music supported the focus of attention, and that positive, sensitive suggestions further enhanced the therapeutic experience.

Walker's recognition and appreciation of music as a pathway has been further validated by more recent research from a variety of perspectives. The brain utilises a series of pathways when a person listens to music, as the brain is a parallel processing centre.[9] These pathways access and coordinate various centres of the brain which include the cochlear nuclei, the brain stem, the cerebellum, the hippocampus, the inferior frontal cortex, the language centres, the Broca and Wernicke areas, the cerebellar vermis, and the amygdale (Koetsch et al., 2004; Levitin, 2006; McClelland, Rumelhart, & Hinton, 2002; Patel, 2003). Each of these areas performs a specific function that supports the listener's experience. These areas operate without a core centre as a fluid integrated network, enhancing, by virtue of the implied directive, a patient's capacity for managing complexity in order to facilitate comfort, learning, and healing. In addition, at the same time research is finding that music and language utilise the same processing centres (Koetsch et al., 2004; Levitin & Menon, 2003; McClelland et al., 2002; Patel, 2003).

Healing responses to classical music reflect a number of relevant aspects of the mind–body healing process. These include:

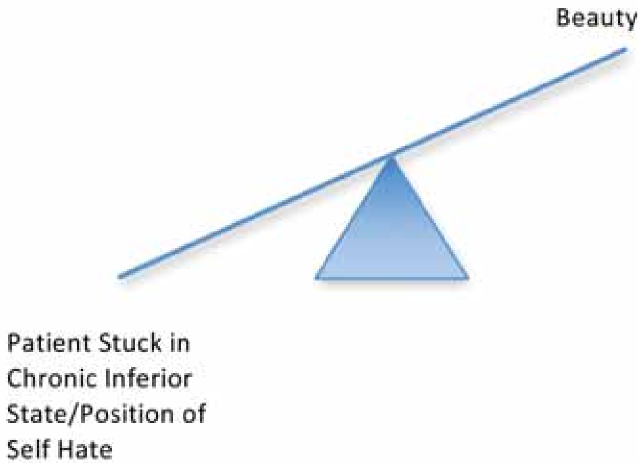
- The capacity to receive comfort from unconscious resource networks.
- The role of creativity in facilitating safety, comfort, learning, and healing.
- The mirroring of processes of tension and release can facilitate motion, and shifting of traumatic positions.
- The utilisation of the sonata and other forms mirrors the needs of patients in relation to complexity, safety, and timing.

The primary ways classical music can be integrated with mind–body hypnotherapy are through creativity, harmony, and beauty. Classical music often expresses beauty in relation to being, nature, and the human spirit, and can, through the implied directive, be used as a polarity in the containment of the debilitating affect states of self-hate, and unworthiness. See Figure 8.

---

[9] Dan Levitin, cognitive psychologist and neuroscientist, discusses in detail the centres of the brain involved in the parallel processing of music in Levitin (2006).

Figure 8: Polarity of Self-Hate/Beauty. (Copyright © 2009 by Bruce Gregory)



Classical music compositions are sustained, developed, enjoyed and appreciated as a function of their adherence to the principles of harmony. Traumatised or abused patients, or patients who are struggling with devastating addiction issues, are often in a deeply fragmented state of disharmony. A therapist's trust, in the *need and capacity*, for facilitating the gene expression of the resources that promote more harmony, the primary resource for promoting harmony being *creativity*, is a prerequisite to creatively facilitating polarity exercises that support this goal. This follows the utilisation of *creativity* to facilitate more safety and containment of the complexities of the defences and fears surrounding the wounds of abuse, trauma, and addiction. The section below addresses this issue.

One major component of the learning and healing process that involves reorganisation, brain plasticity, and gene expression is the *creative* replay between the hippocampus and cortex during sleep (Ribiero, Simoes, & Nicolelis, 2008; Rossi, 1996, 2002; Squire & Kandel, 1998). This creative replay of the unconscious is a significant example of an equivalence between unconscious healing processes and classical music composition theory since classical music compositions use *creative replay* to develop themes. This is achieved through various forms (i.e., strophic, binary, ternary, arch and rondo), modulation of rhythm, pitch, melody and harmony. Some examples of this are Mozart's Symphony No. 40 in G Minor, Handel's Piano Sonata No. 41, Bach's *Goldberg Variations* and *Musical Offering*, and the work of Schoenberg.

The classical music forms that utilise creative replay are listed below:

- Strophic AAA,
- Binary AB,
- Ternary ABA (sonata),
- Arch ABCBA, and
- Rondo ABACADA.

Creative replay in classical music utilises the principles of symmetry. The types of symmetries include mirror or reflectional symmetry, translation, rotation, and glide symmetry (du Sautoy, 2007; Livio, 2005). Creative replay in classical music is also utilised in the modulation of keys, harmony, and processes involving tension and release.

For the purposes of learning, neurogenesis and healing, classical music provides metaphors that are equivalent to processes for containing complex, overlapping defences that imply the need for deeper safety through its utilisation of creativity. In addition, creativity in the context of classical music composition theory is expressed in the modulation of melody, in harmony with principles of symmetry to engage and compel the interest of the listener. Thus, creativity, in a mathematical and physiological sense, "functions" as a container. An abused/traumatised patient or a patient struggling with addiction is by definition deeply wounded on a number of complex levels that fall within the set and subsets of safety, stemming from the degree and magnitude of the force and violation against the self.

Continuing the evolution of the valuing of creativity, Rossi (1996, 2002) applied and integrated the four-stage creative and healing process identified outlined by the French mathematician Henri Poincaré. The four stages are listed below.

- Preparation,
- Incubation,
- Illumination, and
- Verification.

I propose that the factors the composer must engage to integrate and hold the listener's attention creatively in classical music compositions, and the needs of patients needing deep levels of safety in order to contain their fear sufficiently, are functionally equivalent in terms of containment, implying that creativity needs to be more thoroughly integrated into the treatment process. In addition, in mathematical terms, they correspond to Einstein's equivalence of gravity and acceleration.

This means that when dealing with the complex factors operating in the treatment of abuse, trauma, and addiction, the therapist's trust that the client has resources, and that the client's resources—the unconscious resources of the client (which are vast, interlocking networks of physiological resources that operate on the cellular, molecular, and genetic levels)—actually do the healing and need to be complemented by trust, valuing of utilisation of creativity in the following areas:

- Focusing the patient's attention,
- Preparing the treatment by facilitating deeper levels of safety by creatively seeding the aspects of the patient's experience relative to time, space, motion and position, and
- Creatively organising and sequencing questions that imply polarities around motion.

This corresponds to the composer's creative utilisation of symmetrical forms to hold the attention of listeners, and the composer creatively modulating keys, rhythm, and harmonies.

It is this preparation—the ways in which the therapist creatively reorganises the complex network of wounds, the emotional affects (terror, hopelessness, self-hate, shame, rage, pain and grief) and the effects (being frozen in space and time, low self-esteem) associated with them—that creates the container for the healing to proceed. The *utilisation of creativity*, in Rossi's words, *"incubates" the healing process.* The creativity complements and enhances the already active resources of the therapist; sensitivity, empathy, mirroring, and validating.

APPLICATION OF PRINCIPLES OF CLASSICAL MUSIC COMPOSITION THEORY

The application of classical music composition theory to mind–body hypnotherapy has three basic sections. It can be understood as a variation of stage 1 of Rossi's four-stage creative cycle (Rossi, 1996, 2002). It utilises the thought process of set theory (Cantor, 1955; Dunham, 1991). The variables (factors) utilised in the healing process correspond to the set of numbers.[10] The set of numbers is divided into subsets that consist of whole, rational, irrational, complex, etcetera. The subsets specifically utilised in this application are time, space, position, and motion.

---

[10] Background information on Cantor's development of set theory regarding numbers can be found at http://en.wikipedia.org/wiki/Georg_Cantor.

Stage 1 of Rossi's four-stage healing process is one of preparation. Basic accessing questions are utilised creatively to explore and validate the patient's experience in order to activate the novelty, numinosum, and neurogenesis effect (Rossi, 1996, 2002). The questions are open-ended, and designed to facilitate a mobilisation and activation of unconscious resources, which include the resources of the parasympathetic nervous system, the resources supporting the operation of the hippocampus, and the resources within the cell nucleus supporting gene expression.

In this application, while the questions remain open-ended, the focus of the questions is concentrated on the patient's experience in terms of *time, space, motion, and position*. In stage A of the preparation stage, the questions are focused on the patient's experience in terms of position and motion before, during, and after the experience. In stage B of the preparation stage, questions are asked about the patient's experience regarding the temporal and spatial components of the experience before, during, and after the experience. The purpose of this is to allow the patient's unconscious to begin reorienting in different time frames, as opposed to being "frozen in time" as a result of the trauma.

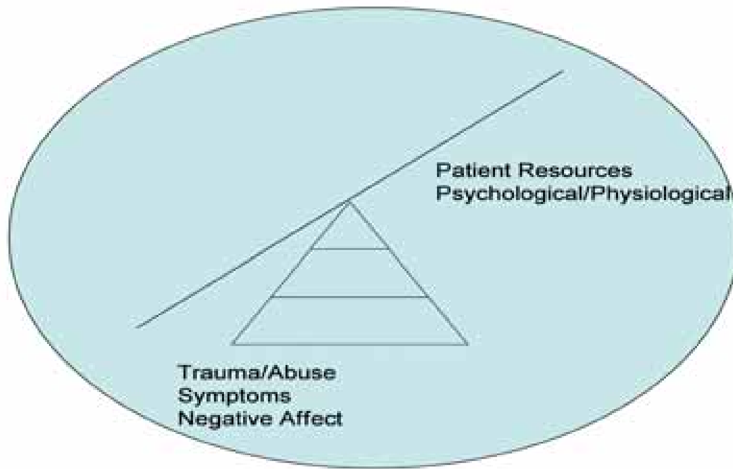
The therapist does more than simply validate the experience of being frozen, stuck, spinning, or rotating. By creatively highlighting the experiences of motion, time, space, and position, a deeper sense of safety is facilitated. The creative rearrangement of questions and perspectives corresponds to the creativity used in classical music compositions to modulate keys, rhythm and melody that facilitate harmony.

It is the questions from stages A and B of the preparation stage that activate the stochastic resonance components of the process. These questions asked casually, function as non-sequiturs to interrupt fixed/rigid patterns within the patient's unconscious.

The mindset of the therapist needs to be *trusting and playful*. It is this combination that communicates to the patient's unconscious the needed support to neutralise sufficient aspects of the negative affect to align the patient with deeper sources of comfort and to facilitate the safety necessary for the neurogenesis and healing to take place.

Figure 9 represents how the therapist's expanded trust functions as a container.

Figure 9: Expanded Trust of Therapist Functioning as Container. (Copyright © 2009 by Bruce Gregory)



In stage C, the creativity utilised in classical music compositions is applied within the context of different musical forms (strophic, rondo, etc.) to facilitate a critical phase transition within the patient, around the issues of safety and containment, that is sufficient to activate stage 2 of Rossi's four-stage cycle. It is the creativity that is utilised, in accordance with principles of symmetry, that accomplishes this transformation within the patient. The basic symmetries utilised are translation, rotation, glide, and reflection.

The shifts in orientation of the questions relate to perspectives of position, timing, space, and motion, and are balanced with themes including those of validation, mirroring, and compassion, depending on the needs of the patient. For example, the therapist decides on a form (e.g., ternary) and establishes subsets of A in a rondo form (ABACADA). This type of form contains layers of symmetry. Then the therapist, like the composer, chooses the themes that are going to be repeated: the validation of the experience, the suffering of the experience, the duration of the experience, the positions of various persons in the experiences, the magnitude of the forces in the experience, and so on. Following this, the therapist creatively modulates the order of the themes, the pace of the delivery, the angles of viewing, et cetera.

CASE EXAMPLE

The patient was a 43-year-old African-American male, who worked on a patrol boat when he was serving in Vietnam. Since returning from Vietnam, he reported being unable to be close to large bodies of water. Exploration of his experiences provided two sets of events that were major sources of his trauma. During his childhood in North Carolina, he lived near a river with a strong current in which he almost drowned. Also, during many of his patrols in Vietnam he observed numerous dead bodies floating in the water.

The patient was asked a series of questions that explored his experience, and validated his experience from different perspectives, positions, and time frames, and his experiences in relation to large bodies of water subsequent to his experience.

The patient spontaneously entered a hypnotic state after about 10 minutes of questions, and went into a medium state which lasted approximately 20 minutes. The patient reported feeling very safe throughout the experience, during which he surprisingly found himself back in the river in North Carolina, in the middle of the river, swimming against the current, feeling no fear while attempting to help someone who was in distress.

One week later, the patient reported that three nights after the hypnosis session, he found himself driving to the beach, where he parked his car in the lot, walked calmly to the edge of the ocean, took off his shoes and socks, and then proceeded to walk into the ocean to about waist high level. He couldn't explain cognitively how or why he did this, but reported that he had not felt any fear.

Examples of some of the questions that were utilised as part of the deepening process were:

- Can you remember what time one of the events occurred when you saw the dead bodies in the water?
- Do you remember what position you were in on the boat, or what you were thinking just before you saw the bodies in the water?
- Have you ever imagined what the scene would have looked like from 50 feet above the water?
- Have you ever dreamed of swimming backwards in time in the river in North Carolina?
- Have you ever wondered what happened in your body after seeing dead bodies in the water three times?

- Have you ever wondered when the trauma of seeing dead bodies in the water was set in place?
- What gives you more comfort, taking a bath, or drinking a glass of cold water?
- Can you imagine the patrol boat going faster, or the visibility being unclear, and not seeing the dead bodies?
- Have you ever explored where in your body the trauma may be located?
- Have you ever imagined what the trauma in your body looks like?
- Have you ever imagined whispering what you wanted to say to the dead bodies?
- Do you remember dreaming about the dead bodies talking to you?
- Have you ever seen a picture of someone “frozen in time”?
- Can you imagine the patrol boat on the water passing the bodies seeing yourself on the other side of the boat where you couldn’t see the bodies?
- Can you remember a time in childhood when you felt safe in the water?
- Would you imagine yourself six months in the future looking back on the past six months, remembering three times you felt safe in the water?

The questions utilised in this case creatively explored and seeded the patient’s experience in terms of time, space, motion, and position. The patient demonstrated response attentiveness by his nonverbal responses to the questions supporting the activation of unconscious processes. The form of the questions approximated the rondo form of classical music composition theory, addressing the validation of the experience, the suffering endured in the experience, the duration of the experience, the positions of various persons in the experience, and the magnitude of forces that were a part of the experience.

CONCLUSION

The integration of principles of classical music composition theory with mind–body hypnotherapy in the treatment of trauma and abuse is achieved through the utilisation of creativity, expanded trust, and the implied directive. The utilisation of the implied directive incorporates both the equivalence principle developed by Einstein, and the correspondence principle from set theory. Deeper levels of safety and new forms of comfort can be facilitated by the integration of the principles of classical music composition theory and mind–body hypnotherapy. Therapists need to expand their trust to include:

- Trust of creativity,
- Trust in their capacity to contain complexity, and
- Trust in their ability to facilitate deeper levels of safety.

The deeper levels of safety required in the treatment of trauma and abuse are then facilitated by the creative application of basic accessing questions with the principles of symmetry utilised in classical music composition theory. These principles are applied to the variables of time, space, motion, and position within the framework of the four basic polarities operating within the experience of traumatised and abused patients. These levels of safety are facilitated within the context of stage 1 of Rossi's four-stage creative cycle.

REFERENCES

Acterberg, J., & Lawlis, G. F. (1984). *Imagery and disease.* Champaign, IL: Institute for Personality and Ability Testing.

Anchin, J. C. (2008), Pursuing a unified paradigm of psychotherapy: Tasks, dialectical considerations, and biopsychosocial systems metatheory. *Journal of Psychotherapy Integration, 18*, 259–263.

Bartlett, D., Kaufman, D., & Smeltekop, R. (1993). The effects of music listening and perceived sensory experiences on the immune system as measured by interleukin-1 and cortisol, *Journal of Music Therapy*, *30*, 194–209.

Beck, A. (1976). *Cognition therapy and the emotional disorder.* New York: International University Press.

Bonny, H., & Savary, L. (1983). *Music and your mind: Listening with a new consciousness.* Port Townsend, WA: ICM Press.

Campbell, D. (1997). *The Mozart effect.* New York: Avon Books.

Cantor, G. (1955). *Contributions to the founding of the theory of transfinite numbers* (P. E. B. Jourdain, Trans.). New York: Dover (reprint).

du Sautoy, M. (2007). *Symmetry*. New York: HarperCollins.

Dunham, W. (1991). *Journey through genius.* London: Penguin.

Edinger, E. (1984). *The creation of consciousness.* Toronto: Inner City Books.

Erickson, M. (1958/1980). Naturalistic techniques of hypnosis. In E. Rossi (Ed.), *The collected papers of Milton H. Erickson on hypnosis: Vol 1. The nature of hypnosis and suggestion* (pp. 168–176). New York: Irvington.

Erickson, M., & Kubie, L. (1939). The permanent relief of an obsessional phobia by means of communication with an unsuspected dual personality. *Psychoanalytic Quarterly*, *8*, 471–509.

Erickson M., & Rossi, E. (1976). Two-level communications and the microdynamics of trance and suggestion. *American Journal of Clinical Hypnosis*, *18*, 153–171.

Erickson, M., & Rossi, E. (1979). *Hypnotherapy: An exploratory casebook*. New York: Irvington.

Erickson, M., & Rossi, E., (1989). *The February man: Evolving consciousness and identity in hypnotherapy*. New York: Brunner Mazel.

Federn, P. (1952). *Ego psychology and the psychoses*. New York: Basic Books.

Greene, B. (1999). *The elegant universe: Superstrings, hidden dimensions, and the quest for the ultimate theory*. New York: W. W. Norton.

Greene, B. (2004). *The fabric of the cosmos*. New York: Alfred A. Knopf.

Gregory, B. (2005/2007). *Integration of Rossi's mind–body hypnotherapy with other therapeutic modalities*. Workshop presentation at Ericksonian Foundation Conference, Phoenix, AZ.

Grove, D., & Panzer, B. (1989). *Resolving traumatic memories: Metaphors and symbols in psychotherapy*. New York: Irvington.

Hammond, D. C. (1990). *Handbook of hypnotic suggestions and metaphors*. New York: W. W. Norton.

Hilgard, E. (1977). *Divided consciousness: Multiple controls in human thought and action*. New York: Wiley.

Hillman, J. (1964). *Betrayal*. Guild Lecture No. 128. London: The Guild of Pastoral Psychology.

Houston, J., & Masters, R. (1973). *Listening to the body*. New York: Dell.

Isaacson, W. (2007). *Einstein: His life and universe*. New York: Simon & Schuster.

Janet, P. (1907). *The major symptoms of hysteria*. New York: Macmillan.

Jung, C. (1916). The transcendent function. In *The collected works of C. G. Jung: Vol. 8. The structure and dynamics of the psyche* (pp. 67–91). Princeton, NJ: Princeton University Press.

Jung, C. (1923). *Psychological types or the psychology of individuation*. New York: Pantheon.

Kandel, E. (1998). A new intellectual framework for psychiatry? *American Journal of Psychiatry*, *155*, 457–469.

Klein, M. (1950). *Contributions to psychoanalysis*. London: The Hogarth Press.

Kleitman, N. (1969). Basic rest-activity cycle in relation to sleep and wakefulness. In A. Kales (Ed.), *Sleep: Physiology and pathology* (pp. 33–38). Philadelphia: Lippincott.

Koelsch, S., Kasper, E., Sammler, D., Schulze, K., Gunter, T., & Friederici, A. D. (2004). Music, language, and meaning: Brain signatures of semantic processing. *Nature Neuroscience*, *7*, 302–307.

Kohut, H. (1971). *The analysis of the self*. New York: International University Press.

Kohut, H. (1977). *The restoration of the self*. New York: International University Press.

Laing, R. D. (1965). *The divided self*. New York: Penguin Books.

Laing, R. D. (1971). *The self and others*. New York: Pelican Books.

Levine, P. (1997). *Waking the tiger*. Berkeley: North Atlantic Books.

Levitin, D. J. (2006). *This is your brain on music*. New York: Dutton / Penguin.

Levitin, D. J., & Menon, V. (2003). Musical structure is processed in "language" areas of the brain: A possible role for Brodmann area 47 in temporal coherence. *NeuroImage*, *20*, 2142–2152.

Lisman, J., & Morris, G. (2001). Why is the cortex a slow learner? *Nature*, *411*, 248–249.

Livio, M. (2005). *The equation that couldn't be solved*. New York: Simon & Schuster.

Loewenstein, W. (1999). *The touchstone of life: Molecular information, cell communication and the foundations of life*. New York: Oxford University Press.

Magnavita, J. J. (2008). Toward unification of clinical science: The next wave in the evolution of psychotherapy? *Journal of Psychotherapy Integration*, *18*, 259–263.

Masterson., J. (1976). *Psychotherapy of the borderline adult*. New York: Brunner Mazel.

Masterson, J. (1981). *The narcissistic and borderline disorders*. New York: Brunner Mazel.

McClelland, J. L., Rumelhart, D. E., & Hinton, G. E. (2002). The appeal of parallel distributed processing. In D. J. Levitin (Ed.), *Foundations of cognitive psychology: Core readings* (pp. 3–44). Cambridge: MIT Press.

Merrell-Wolff, F. (1973). *Pathways through to space*. New York: Julian Press.

Nader, K., Schafe, G., & Le Doux, J. (2000). Fear memories require protein synthesis in the amygdala for reconsolidation after retrieval. *Nature*, *406*, 722–726.

Norcross, J. C., & Newman, C. F. (1992). Psychotherapy integration: Setting the context. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 3–45). New York: Basic Books.

Overbye, D. (1991). *Lonely hearts of the cosmos*. New York: HarperCollins.

Patel, A. D. (2003). Language, music, syntax, and the brain. *Nature Neuroscience*, *6*, 674–681.

Perls, F. S. (1973). *Gestalt therapy verbatim*. Moab, UT: Real People Press.

Phillips, M. (1997). Spinning straw into gold: Utilization of transferential resources to strengthen the hypnotic relationship. *American Journal of Clinical Hypnosis, 40*, 118–129.

Phillips, M., & Frederick, C. (1995). *Healing the divided self: Clinical and Ericksonian hypnotherapy for post-traumatic and dissociative conditions*. New York: W. W. Norton.

Rainville, P. (1999). Cerebral mechanisms of hypnotic induction and suggestion. *Journal of Cognitive Neuroscience*, *11*, 110-125.

Rauscher, F. H. Shaw, G. L., & Ky, K. N., (1993). Music and spatial task performance. *Nature*, *365*, 611.

Ribiero, S., Simoes, C., & Nicolelis, M. (2008) Genes, sleep and dreams. In D. Lloyd & E. Rossi (Eds.), *Ultradian rhythms from molecules to mind: A new vision of lif*e. New York: Springer.

Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.

Rosen, S. (1982). *My voice will go with you: The teaching tales of Milton H. Erickson*. New York: Norton.

Rossi, E. (1986/1993). *The psychobiology of mind–body healing* (rev. ed.). New York: Norton.

Rossi, E. (1996). *The symptom path to enlightenment: The new dynamics of self-organization in hypnotherapy*. New York: Zeig, Tucker & Theisen.

Rossi, E. (2002). *The psychobiology of gene expression: Neuroscience and eurogenesis in therapeutic hypnosis and the healing arts*. New York: W. W. Norton Professional Books.

Rossi, E. (2004). Art, beauty and truth: The psychosocial genomics of consciousness, dreams, and brain growth in psychotherapy and mind–body healing. *Annals of the American Psychotherapy Association, 7*, 10–17.

Rossi, E., & Nimmons, D. (1991). *The twenty minute break: The ultradian healing response*. New York: Zeig, Tucker & Theisen.

Rossi, E., & Rossi, K. (2008) *The new neuroscience of psychotherapy, therapeutic hypnosis and creative rehabilitation: A creative dialogue with our genes*. Los Osos, CA: Author..

Scott, C. (1958). *Music: Its secret influence throughout the ages*: Philadelphia: The David McKay Company.

Sheline, Y., Wang, P., Gado, M., Csernansky, J., & Vannier, M. (1996). Hippocampal atrophy in recurrent major depression. *Proceedings of the National Academy of Sciences, 93*, 3908–3913.

Siegel, D. (2006). *The mindful brain in psychotherapy: How neural plasticity and mirror neurons contribute to emotional well-being*. New York: W. W. Norton.

Skille, O. (1991). Vibroactive Research 1980–1991. In R. Sprintge & R. Droh (Eds.), *Medicine-Music* (p. 249). St Louis: MMB Music.

Squire, L., & Kandel, E. (1999). *Memory: From mind to molecule*. New York: Scientific American Press.

Sullivan, W. (1927). *Beethoven: His spiritual development*. New York: Alfred A. Knopf.

Tomatis, A. (1991). *The conscious ear: My life of transformation through listening*. Barrytown, NY: Station Hill Press.

Tsao, C. C., Gordon, T. F., Maranto, C. D., Lerman, C., & Murasko, D. (1991). The effects of music and directed biological imagery on immune response (S-G1). In C. Maranto (Ed.), *Applications of music in medicine* (pp. 85–121). Washington, DC: National Association for Music Therapy.

Tulku, T. (1977). *Time, space and knowledge*. Berkeley: Dharma Publishing.

Walker, W.-L. (1979). Music as a deepening technique, *Australian Journal of Clinical and Experimental Hypnosis, 7*, 35–36.

Walker, W.-L. (1990). Music as a pathway for self-hypnosis, *Australian Journal of Clinical and Experimental Hypnosis, 18*, 57–59.

Walker, W.-L. (1992). Combining music and words as a pathway through hypnosis: Practical guidelines. *Australian Journal of Clinical and Experimental Hypnosis, 20*, 117–132.

Warming, P. (1992). The use of music in Jungian analysis. In D. Campbell (Ed.), *Music and miracles* (pp. 231–234). Wheaton, IL: Quest Books.

Watkins, J., & Watkins, H. (1997). *Ego states: Theory and practice*. New York: W. W. Norton.

Winnicott, D. W. (1965). *The maturation and the facilitating environment*. New York: International Universities Press.

Winnicott, D. W. (1971). *Playing and reality*. London: Tavistock.

Wilber, K. (2008). Unification beyond eclecticism and integration: Integral psychotherapy. *Journal of Psychotherapy Integration, 18*, 259–263.

Wolfe, B. E. (2008). Towards a unified framework of psychotherapy. *Journal of Psychotherapy Integration, 18*, 259–263.

Australian Journal of Clinical and Experimental Hypnosis
Vol. 38, No. 1, 2010, 25–43

A New Approach to the Genesis of Hypnosis: A Gift of Love and Security

Eugen Hlywa and Lynda Dolan
Clinical psychologists in private practice, Sydney

Hypnotic phenomena have been harvested by human beings for millennia and utilised for curative and other purposes for the benefit of the human race. It is proposed that hypnosis as a spiritual entity, emanating from within the self, reaching genesis in utero and manifesting itself thereafter throughout the human life, is an extremely powerful force, promoting both positive and negative achievements. An abridged review of the literature on the essence of hypnosis is offered, including consideration of some of the limitations imposed by the experimental approach to the investigation of hypnosis. This is followed by a discussion of the principles underlying the core concepts of the proposed theory, with reference to historical observations and real life experiences in the form of case studies. The authors conclude that hypnosis, as a naturally occurring phenomenon, can provide all the capacities to help human beings in their endeavour to create and maintain happiness in the universe.

The article commences with a personal experience of the first author and two case notes to set the context for the following analysis.

- **Personal Experience of Spontaneous Trance and Self-hypnosis (E.H.)**

  My experience with hypnotic phenomena goes back to 1942. When undergoing training for an intelligence officer service, I was instructed how to use self–hypnosis and thus defend myself from torture. I was told that with hypnosis one can control experiences including pain, fear, despair, extortions, brainwashing and bleeding. All of this sounded very romantic, until I found myself a prisoner of the German Nazi regime in Mantelupich prison of Krakow, where I was an inmate in 1943.

  I was brought in to the "room of torture" for interrogation, where a close friend of mine, a very brave senior member of the underground

Correspondence concerning this paper should be sent to Eugen Hlywa at ehlywa@tpg.com.au or Lynda Dolan at lyndolan@bigpond.com.

anti–Nazi organisation (OUN), stood naked in the room, and a barking dog was clawing and tearing his skin. To me, he looked and behaved like a sculpted statue (not a living person), without *moving, crying and no sign of bleeding*. He used self–hypnosis to eliminate pain, fear and bleeding, a skill which some of the intelligence officers learned during the training. Brutalities and hardship of the Nazi prisons and camps produced many examples of the inmates "defending" themselves with *spontaneous trance*.

- **Professional Encounters of Spontaneous Trance and Self-Hypnosis**

Case Study 1 (an account by the first author): After World War II, a professor of anthropological psychology, Victor Petriv at the UFU in Munich, continued to stimulate my interest in the hypnotic phenomena. However, my first *professional* encounter with the effects of spontaneous trance occurred in the mid-1950s, here in Australia.

At 12 noon on one Saturday, a GP asked me to see "a very upset bunch of new Australians." Three middle-aged women and one man who was very upset and crying, and another young woman, with a *joyful* expression who could speak English, answered that everything is "OK; nobody died, nobody injured or hurt, nobody ill—I am quite happy."

The upset man identified himself as the father of the young woman, and on questioning him I found out that his daughter, being in love and enjoying a long courtship with the groom to be, "*only hours before going to church, suddenly became insane and refuses to wed him—she is out of her mind, she is mad*." He also told me that the natural mother of the "bride to be" left the family for another man, which created extreme sadness and embarrassment to him and his daughter.

When paying closer attention to the young woman who refused to wed her lifelong sweetheart, I noticed that *in that situation, her pleasing happy facial expression was not appropriate and her eye movements were too static. When I asked her whether she was in love with the groom to be she vehemently repeated that she loved him very much. The question put to her as to why she would not marry the man she loved was dismissed by her as something very irrelevant (trance logic)*. I realised that I was dealing with a person who was carrying out a post-hypnotic suggestion.

> Without describing here the hypnoanalytical process used, I discovered that this young lady was carrying out a post-hypnotic suggestion unwittingly acquired from her fortune teller. She was "extremely hurt" by her mother "dumping her and her father"; she was terrified by the prospect of her marriage collapsing in the way that her "family nest collapsed" and she found (for good fees) a "sympathetic listener and adviser" in a fortune teller. The fortune teller assured her that she would "*not marry* this man she loves," and hence her strange behaviour.
>
> ***Case Study 2 (an account by the second author):*** A young woman referred to me entered my consulting room looking pale, emaciated, uttering a few words of greeting and handed me her GP's referral letter, which requested assistance for the patient to receive some "coping mechanisms for her condition of A.N. [anorexia nervosa]." During the initial few sessions the patient hardly spoke a word and felt much more comfortable quietly retreating into protracted hypnotic rest (Hlywa, 2008). I soon realised that this patient was in a dissociative and spontaneous trance state.
>
> An acute and sensitive approach to establishing the psychotherapeutic relationship made me remain cautious, thus not asking any questions, but rather allowing the patient to feel relaxed and comfortable. I quickly realised that she had experienced a lifelong history of invasive medical interventions which later, during spontaneous revivification, she recalled as intrusive.
>
> After several initial sessions of protracted hypnotic rest, the patient was able to establish a trusting therapeutic relationship. Subsequently, further sessions of similar protracted hypnotic rest integrated into the psychotherapy enabled her to abreact past traumas of violent rape both at 15 years of age and then 22 years, six months prior to entering therapy. She was able to resolve her traumas, resume a healthy eating pattern and integrate the traumatic experiences into her personal matrix, thus resuming a much more healthy and integrated pattern of functioning in her life.

The essence of hypnosis must have amazed anyone who has experienced or used this powerful and wonderful phenomenon. In our case, it is the personal experience and constant professional use of hypnosis that has provided us with a fascination for the topic for several decades. For a long time, we have looked for a hypothesis, or some theory, that would throw sufficient light on

the genesis and the nature of the topic. There are many theories of hypnosis in the literature; however, to our knowledge there is no known theory which embraces and integrates the essence of hypnosis. Woody and Sadler (2008) emphasise the importance of hypnosis as lying at the "crossroads of some of the most challenging problems in comprehending the nature of the mind" (p. 105) and highlight the need for the development of "stronger theory" to fully understand the essence of hypnosis. They conclude that: "Understanding hypnosis involves tough issues such as, how does volition work, and what is the nature of awareness? It also touches on philosophical problems such as, how does one know what is real, and what is free will?" (p. 105).

Barabasz and Barabasz (2008) support Spiegel in their call for the recognition of "'multi-level' explanations in understanding human mind/brain/body phenomenon" (Spiegel, 2005, p. 32, in Barabasz & Barabasz, 2008, p. 359). In addition to the author's recommended constellation of mind/brain/body, we add the *spirit*. The spirit, being homogenous, intangible and immutable, is recognisable only by its power, influence and action, thereby eluding the constraints of laboratory researchers.

Many researchers and theorists have called for a multi-level understanding of hypnosis, which unfortunately has not yet occurred. We therefore feel bound to share our hypotheses with the practitioners of hypnosis. We have tried to establish some answers from existing theories, and believe that most of them explain some of the phenomena. However, so far none point to *(a) the emanation, (b) the development of hypnosis and (c) the fading of hypnosis as it naturally occurs.*

In the current article we present our theory of emanation as the essence of hypnosis and the axle of psychotherapy. We propose that:

- The process of spontaneous auto-hypnosis occurs much more universally than is appreciated in everyday life.
- The hypnotic experience in human beings has its genesis in the prenatal developmental state. The quality of a human being's capacity for experiencing trance depends on the security provided by a mother's *love* and her presence during the individual's early infancy.
- Hypnosis (like intelligence or will) reveals its presence through its deeds, and is homogenous, immutable and thus spiritual.

Abridged Review of Recent Research on the Essence of Hypnosis

In their review of the research, Barnier and Nash (2008, p. 2) note that "hypnosis has been considered not only difficult to study, but *not quite scientific.*" They refer to several researchers in their efforts to clarify the nature of hypnosis, including Kihlstrom (1992, in Barnier & Nash, 2008) who suggests that "hypnosis has matured as both a fascinating topic for scientific research and an effective technique for clinical application" (p. 1). They also refer to Clark Hull, who commented that investigators of hypnosis must have "the courage to brave the semi–superstitious fears of the general public and the uneasy suspicions of their 'orthodox scientific brethren'" (Hammer, 1961, p. 9, in Barnier & Nash, 2008, p. 2).

Barnier and Nash (2008, p. 3) further note that "hypnosis *is* challenging because, at its heart, hypnosis is a *private* experience," thus escaping rigorous scientific control and opening itself to multiple considerations, manipulations and suggestions. They also state, however, that "the most important and interesting aspect of hypnosis ... is the individual's private experience of hypnotic suggestions." These authors declare that "the aim of [their] handbook is to cover the whole terrain of hypnosis in one integrated text" (p. 6). This is, if we may remark, extremely welcome, especially if it satisfies an intention expressed in the following sentence: "We believe that the study of hypnosis is worthwhile *only to the extent it reveals something truly interesting about human nature*" (p. 10).

In appreciating the above statements, we arrive at the essence of the problem, which Barnier and Nash (2008) address within the framework of *hypnosis as a phenomenon versus scientific constraining.* The crux of the researcher's difficulty with this framework is that the process of *constraining* is imposed by research conditions which are in themselves defined in order to facilitate proper scientific investigations and research.

As such, we are convinced that all researchers are very much conscious of the warnings so eloquently expressed by Laurence, Beaulieu-Prévost, and du Chéné (2008, p. 225), who point out a constant danger that "experimentation is most often *theoretically* driven" (p. 226). These authors quote the important and profound statement of Abbe de Faria (1819, in Laurence et al., 2008, p. 225), "*one must seek the truth where it is, not where one would like it to be*"; and the question as to whether it is "not paradoxical to say that *we influence our own actions and that we are not aware of our own influence?*" (Faria, p. 45, in Laurence et al., 2008, p. 228). We will address the influence of this important issue in our theory of the emanation of hypnosis later in this article.

Limitations Imposed by the Experimental Approach to the Investigation of Hypnosis

Barnier and Nash (2008) refer to several researchers including Tellegen who suggests that hypnosis involves the person's capacity to "represent suggested events and states imaginatively and enactively in such a manner that they are experienced as real" (Tellegen, 1979/1980, p. 220, in Barnier & Nash, 2008, p. 6). This valid statement about only one of the phenomena of hypnosis carries with it the crux of the investigation of hypnosis. But there are, as all researchers may be aware, many other implications that interfere with the investigative process, thus stripping the natural phenomenon of hypnosis from its *pristine state.*

Furthermore, Barnier and Nash (2008, p. 6), in accordance with the definitions they endorse, differentiate the "*administration*" of the hypnotic induction procedure from the "*state*" of hypnosis, thus, in our opinion, excluding the *spontaneous—the naturally occurring and age-old utilisation of the curative facilitation of the* phenomena of hypnosis. These authors then proceed to conclude their discussion on defining hypnosis by recognising the experiential dimension of hypnosis and summarising that "*hypnosis is not just what we, as researchers and clinicians, do to people. It is also much more importantly, what people experience*" (Barnier & Nash, 2008, p. 12).

We suggest that by using the *phenomenological* approach in trying to obtain deeper insight into the phenomenon of hypnosis as it naturally occurs, one should be prepared to remain open to forthcoming revelations such as: (a) do hypnotic phenomena exist without being *formally* or otherwise induced by another person (a "hypnotist")? (b) what constitutes induction? (c) is or are there a criterion/criteria—necessary ingredient/s—that facilitate/s hypnotic trance? (d) assuming that all criteria of induction have been fulfilled, are there noticeable chances that a person fails to enter hypnotic state, and, if so, what and why? (e) when one considers that hypnotic phenomena have existed and have fulfilled a positive and/or a negative role in human experience/behaviour for millennia, is it reasonable to assume that the human capacity for hypnosis is innate?

Most of the above and many more questions have been tackled and answered by the research scholars in properly controlled *experimental* situations, which inevitably carry with them a profoundly unavoidable and powerful influence. We believe further that any and all *formally induced* hypnotic trance, ipso facto, will bear an influence on a subject in a form of hypnotic suggestion. This, depending on multiple factors, will taint the pure—*the*

virgin phenomenon—resulting in the advancement of a whole pleonastic of hypotheses and theories.

Kihlstrom (2008) offers the following definition of hypnosis that enables and justifies scientific procedures, stating that:

> Hypnosis is a process in which one person designated the hypnotist, offers suggestions to another person designated the subject, for imaginative experiences entailing alterations in perception, memory and action. In the classic case these experiences are associated with a degree of subjective conviction bordering on delusion, and an experienced involuntariness bordering on compulsion. As such, the phenomena of hypnosis reflect alterations in consciousness that take place in the context of a social interaction. (p. 21)

McConkey (2008) notes that for several prominent researchers and psychologists such as White, Hammer and Sutcliffe, an understanding of hypnosis involves an understanding of:

> the *relationship* between the *hypnotist* and the *subject*; the subject's interpretation of the hypnotist's communications in that situation; the abilities, expectancies and strivings of the hypnotised person that influenced their response to those communications; and perhaps, most importantly, the mechanism by which "mere words" lead to convincing alterations in experience (p. 54).

The statements of Kihlstrom, of McConkey, and of many others, are universally appreciated and thoroughly accepted by the scientific community. Such hypnosis is being used by the therapeutic profession universally but, being constrained by the definition (where *"hypnotist" and the "subject" are the core of the definition*), it does not contain a provision for a *spontaneous auto–hypnosis, which, as general and some clinical observations suggest, is a phenomenon much more universal and popular than normally appreciated.*

Decades-long interest in hypnosis prompted us to search for the genesis and nature of hypnotic phenomena without neglecting the theories, hypotheses and deliberations which have greatly enriched our acquaintance with the subject matter. We have tried to peruse many hypotheses and theories, and much research on the topic, and admire the tenacity of the researchers while understanding the magnitude of their task. We must admit, however, that Wolberg's statement on the scientific knowledge of the essence of hypnosis, perhaps with very slight variation, is as valid today as at the time he wrote the words:

> We are no more certain about where hypnosis fits in the electronics or chemistry or neurophysiology of brain function, than we are about consciousness or sleep. We are no further advanced in divining hypnotic psychology or psychodynamics or

> sociology than we are in fathoming non-hypnotic cognitive affective and behavioral processes. (Wolberg, 1965, p. 259)

Our *additional concern with researchers in the field is* a limitation *of hypnosis to the one* "induced by the operator"—thus excluding the spontaneous, the naturally occurring hypnosis in human beings. The amount of naturally, spontaneous, pristine occurring hypnosis exceeds the process of formally induced hypnosis by many fold, especially in children when they face critical, startled and emotionally intense situations.

Nash (2008, p. 487) states that "hypnotisability" is unique to every person and depends on the individual's capacity. He describes a "pre–hypnosis interview" that provides (a) patients with some expectations and (b) the therapist's knowledge of the patient's expectations. He describes "open-ended questions" relating to the attitudes, fears, unrealistic expectations, passiveness or control, abreaction and religious values in hypnosis. In our opinion, if such information is not directly asked by the patient, such "questioning" should be omitted and the therapist would be more effective if they concentrated on establishing the psychotherapeutic relationship.

Nash (2008) concedes that "since imparting information to a subject is *de facto* delivering a suggestion, one must be careful not to 'overdo' the disabusing process" (p. 489). However, it is important to consider the fact that any and all imparting of information could be adopted by a patient as a post-hypnotic suggestion and be acted on accordingly. Furthermore, this imparting of information may not always suit every patient, and may easily destroy the patient's expectation and enthusiasm, as well as the psychotherapeutic relationship, thus causing the retardation or cessation of the therapeutic process. We strongly believe that in experimental conditions any such information or structuring would impregnate a subject with foreign ideas and eliminate the pristine "*authentic self*," thus creating an artefact.

Emanation as the Essence of Hypnosis and the Axle of Psychotherapy

Our proposed theory of emanation embraces the essence of hypnosis and *forms the axle of psychotherapeutic process.* We propose that all hypnosis *emanates* from deep within the person and, as such, is self-hypnosis. We embrace the view that one cannot impose anything onto another human being.

Historical and Other Observations in Support of our Emanation Theory of Hypnosis

The subject of the phenomenon of emanation is found in the early Vedas and in the Bible, in the writings of Plato, Plotinus, and the philosophy of Socrates but is almost completely absent in modern science of psychology and psychotherapy.

We align ourselves with prominent existential analysts including Paul Tillich (1954, 1962) who says:

> The other person cannot be controlled like a natural object. Every human being is an absolute limit, an unpierceable wall of resistance against any attempts to make him into an object. He who breaks this resistance by external force destroys his own humanity; he never can become a mature person. (Tillich, 1960, in Watkins & Barabasz, 2008, p. 310)

We further align our emanation theory with prominent psychotherapists such as Milton Erickson (1967) and Carl Rogers (1951, 1961) who reflect the view that a positive psychotherapeutic process is only being promulgated when the therapist creates a milieu where the patient reaches deep within themselves for their own "*authenticity*" (Hlywa, 2004, pp. 23, 181–182) and achieves the power to be "loyal to self" (Hlywa, 2004, pp. 17, 163, 184). Human beings innately possess their values through which subjective experience is filtered, created, interpreted and reacted upon. This we call *loyalty to oneself.*

Gunnison (2004, p. v) combines the therapies of Rogers and Erickson in his model of "hypno–counselling," where he suggests that the client is invariably at the *core* of the counselling process and the foundation of what occurs during subsequent sessions. He defines "hypno-counselling" as based on "(1) the facilitative and therapeutic climate and the growth principle of Rogers (1985) and (2) the hypno–suggestive language and utilisation approach of Erickson" (Gunnison, 1990B, in Gunnison, 2004, p. 6).

Erickson described the utilisation approach as "*patient–centred* and highly dependent on the momentary needs of the individual. [Such an approach] focuses on the person, utilising and activating unconscious resources and learning that already existed *within* rather than being imposed from *without*" (Erickson & Rossi, 1979, p. 14, in Gunnison, 2004, p. 4).

Rogers (1977, p. 185, in Gunnison, 2004, p. 7) noted that "there is one best school of therapy. It is the school of therapy you develop for yourself, based on a continuing critical examination of the effects of your way of being in the relationship." Rogers (1980, p. 115, in Gunnison, 2004, p. 8) also noted

that "individuals have within themselves vast resources for self-understanding and for altering their *self-concepts, basic attitudes and self-directed behaviour*; these resources can be tapped if a *definable climate of facilitative psychological attitudes* can be provided."

According to Rogers this therapeutic *climate* is characterised by (a) positive regard towards the patient, (b) empathy, (c) genuineness (congruence) and (d) specificity of expression; similarly referred to as "resonance" by Watkins and Barabasz (2008, p. 308). Such a therapeutic *climate* could be achieved, in the clinical process, during protracted therapeutic interaction on the conscious level; however, the hypnotic relationship creates such a climate within a relatively short time.

The principles of emanation theory are extended to the therapist, who can personalise their own approach and style. Gunnison (2004) supported Rogers and Erickson's encouragement to practical psychotherapists to develop their own theory of personality and a mode of treatment suitable for individual patients rather than trying to imitate other practitioners. Gunnison noted further that:

> As practitioners this requires *interacting* with our clients by encouraging them to become *their own authorities*, their own experts. Implicit in this may be found a revolutionary shift in direction of our values regarding our clients' trust, understanding, respect, confidence and belief in them and who is in power and control. (p. 4)

The *interpersonal relationship* is the *fundamental* variable in the healing process (Gunnison, 2004). Without a positive–therapeutic interpersonal relationship, any psychotherapeutic process lacks a firm foundation (Hlywa, 1977, 1998). Students of the psychotherapeutic process (albeit with reluctance because they want to contribute, to gear, to control and to be in charge of the process) are unwilling to admit that the human factor of *being responsible for ourselves is the dominant ingredient inevitable in a healthy positive therapeutic process*.

Along with other researchers of the psychotherapeutic process, John Watkins described the value of the phenomenon of emanation by an example when he psychoanalytically treated a patient suffering from depression. The patient understood the interpretation of his dreams by the analyst, but failed to recover from depression "until several weeks later … he [the patient] stood, wild-eyed and with a horror-struck expression, shouting, 'I really *do* hate my father'" (Watkins & Barabasz, 2008, p. 6), thus demonstrating the power of insight, which can only emanate from the person.

We have regard for, and use, the phenomenological methods advanced by Hryhorij Skovoroda (1972), Edmund Husserl (1962) and Martin Heidegger

(1996) to explicate (i.e., to unfold) the core of this state. We also take into consideration the view that, to a degree, all people have a capacity to enter into hypnosis (or a trance state), and believe that such a capacity is (a) *genetic*, and/or (b) acquired universally by *a process* formed in the earliest human experience. We believe that such a state occurs spontaneously without formal induction by a hypnotist.

Some enthusiastic novices who do not appreciate the nature of hypnosis, presuming that with hypnosis they can *"control" another human being*, may become bitterly disillusioned when a patient not only ignores a suggestion that clashes with their personal principles, but the positive psychotherapeutic relationship ceases—thus hurting themselves and the patient.

Core Concepts of the Theory of the Emanation of Hypnosis

- *Spontaneous/auto-hypnosis*

  In our clinical experience, subjects treat the question of the *origin of response* as something impertinent, irrelevant or even illogical. Somnambulists treat the question of response as something emanating from them, and mere questioning about the origin of response as offensive and lacking in decorum.

  We do not pretend this to be of any scientific value, but our experiences with bilingual patients indicates that while undergoing age regression to the time when they did not have a knowledge of English, yet communicating and answering questions in English, the patients dismiss the paradox as something not worthy of their consideration when confronted with this inconsistency. For example, a patient of German origin did not know English until the age of 24. In therapy, the patient regressed to the age of 11, where, according to information, there was no knowledge of English. However, at the time of the regression in therapy, the patient answered in English and, when confronted with this inconsistency, dismissed this as something irrelevant. This means that deeply hypnotised people act in interaction with reality, believing that their decision and behaviour emanate from themselves internally (not from external sources).

  The same applies to positive and/or negative hallucinations. The question of the origin of their behaviour and experience simply does not exist for patients and they treat it as something impertinent, thus *conveying the subjective notion, that they are the source of emanation.*

This is very clearly demonstrated in hypnotic suggestion, and even more clearly by *post-hypnotic suggestions*, and has been known for ages. Sigmund Freud (1943), while criticising hypnotic therapy, says that: "The hypnotic therapy endeavours to cover up and as it were to whitewash something going on in the mind" (p. 392)—and pointed out that:

> the solving of his [the patient's] conflicts and the overcoming of his [patient's] resistances succeeds only when what he is told to look for in himself corresponds with what actually does exist in him. (p. 393)

Erickson (1967) expressed a similar view when he said:

> I dislike authoritative techniques and much prefer the permissive techniques as a result of my own experience. What your patient does and what he learns must be learned from within himself. There is not anything you can force into that patient. (p. 536)

Finally, Barnier, Dienes, and Mitchell (2008, p. 145) pose the question of *emanation* which has interested us for a long time. They state that "the overall question we are grappling with asks: *what is the source of the hypnotised persons 'feelings of hypnosis'*?" They are looking for the "switch" or "induction" that leads to the exaggerated responses, and in so doing they confront "Dissociation" with "Interactionist" theories. Following elaborations on a new approach in the research methods, they acknowledge that "we need theories that seek explanations for the complicated and evolving relationship between what hypnotised people do and how they feel across the entire time course of a hypnotic session and hypnotic items" (p. 171).

Woody and Sadler (2008), when considering the multifaceted collection of phenomena involving a wide diversity of mental systems, point out the difficulties in the research work, but suggest that the "diverse matrix of hypnotic behaviour [has] an essential common denominator: in hypnosis all these behaviours are accompanied by the subjective experience that the *self is not the origin of the response*" (p. 89).

The hypnotic common denominator of "subjective experience that the *self is not* the origin of the response" *may* clash with Orne's (1959) phenomenon of "*trance logic*," and that of Hilgard's (1970) "*hidden observer*." However, it definitely opposes frequently expressed opinions of the subjects because they feel that *they* are the source of emanation of their experiences and behaviour.

- *The genesis of hypnotic experience in human beings reaches prenatal developmental state*

 We propose that *human beings acquire the capacity for hypnotic experience while in the mother's womb.* Assuming that sensory mechanisms of the foetus, in-utero, are adequately functioning, we suggest that the unborn infant would for the first time be orientated and acquainted with, and mesmerised by, the rhythmic sound of the mother's heartbeat. Advancing this proposition, we suggest that, at birth, the infant could be overwhelmed by entering this completely unknown, strange and probably threatening world. However, when the child lands onto their mother's breast and recognises and is welcomed by the *very familiar sound of her heartbeat*, the infant benefits from the capacity to *use this resonance for their own good.*

 On appropriate occasions, we have inquired of mothers, midwives and obstetricians the most desirable place for an infant immediately following their appearance in this world—and naturally and spontaneously, the answer is "mother's chest, or breast." We believe *that the genesis of hypnosis emanates from the mother's womb, which provides the foetus with amenities for life, growth, security and love.*

 We believe that the phenomenon of "pure hypnosis"—in its virgin (pristine) entity, capacity, experience and behaviour—evolves during prenatal development and that such "pure hypnosis" is positive, but also has the capacity for negative influence … and is in service of the subject. Hypnosis is *manifested* when the child emerges from the womb onto the mother's chest and recognises and experiences the heartbeat from in utero, thus gaining an anchor for security, love and care. It is obvious to everyone that the process of childbirth is a shocking experience for an infant, during which the child encounters everything strange, new, threatening and inhospitable. It is a process creating despair, which is not easy to resolve, as there is not known to the new-born a factor that would provide comfort and support life as in the mother's womb. Hope for security and comfort, with which the infant was familiar in mother's womb, is provided after birth by *"landing" on the mother's chest.* There the infant comes into contact with something *very comforting and familiar—the mother's heartbeat*, a sound to which the foetus is deeply accustomed!

 There is ample research evidence that children (in general) are better hypnotic subjects than are most adults (see, e.g., Hilgard, 1970). This would support (at least to a degree), a hypothesis in favour of trance *being acquired in the process of experience*, not only endowed genetically as is

being postulated by some neurologists. The question of "*what of experience would prompt an individual to enter a trance state, taking into consideration the whole population?*" would lead us to the earliest stages of life. In the case of humans, we suggest that one should focus on the *prenatal and the first five years of life.*

The earliest (known to the authors) recorded experiments, albeit with birds and animals, go back to 1646 when Jesuit priest Padre Kircher described his experiments with chickens in the famous article, "Experimentum mirabile de imaginatione gallinae Kircherei" (in Tinterow, 1970, pp. 149–159). These were followed by Pavlov (1951), Strilchuk (in Platonov, 1959), Völgyesi (1963), Tinterow (1970) and many others, and point to startling, threatening, sometimes dangerous or very pleasant situations that inevitably demand *the utmost focusing and attention and thus induce the state known as hypnosis.* These conditions demand narrowing or focusing attention onto *only one stimulus and being oblivious to any other internal and/or external stimuli.*

Human infants enjoy such thrilling experiences when being held by their mother or father, and kept close to the "ticking heart." This, to an infant, is a familiar, mysterious, calming, regular, rhythmic, gentle sound which, if combined with mothers' milk, conveys and creates an overwhelming pleasant and lasting experience in the infant's life.

David Spiegel (2008) made a statement that has attracted our attention for many decades: "the high prevalence of hypnotisability in childhood is an adaptive method of learning and relating to others during pre-adolescent development" (p. 179).

In addition to this, we propose further that infants obtain such learning in a spontaneous trance state when they focus attention on motherly heartbeat, and later, on several things and objects which naturally engulf, attract and focus their attention.

- *Hypnosis (like intelligence or will) reveals its presence through its deeds and is homogenous, immutable—thus spiritual*

Barabasz and Barabasz (2008) point out that:

> The neurophysiological data extant are undeniably mountainous. It is no longer defensible to conceptualise hypnosis only on the basis of socio-psychological notions. It is perhaps time to consider the "debate" of the last century resolved … and move on as recommended by Spiegel (2005) to the recognition that "multi–level explanations are an absolute necessity in understanding human

> mind/brain/body phenomenon because we are both neurally-based and social creatures who experience the world in mental–phenomenal terms." (,p. 359).

We would add to this the constellation of mind/brain/body, the *spirit*, which being homogenous, intangible—and immutable—is recognisable only by its power, influence and act.

We are well aware that the mere word "*spiritual*" in many instances alone would repel scientists. Science deals with matter and justly claims huge success in understanding the material world, including man's physiology—but not the essence of man. The science of "human *behaviour*" has made valuable inroads, but it is less competent in the case of *experience*, and even less of motivations, emotions, and countless other human potentials.

We believe that the "tall poppies"[1] (the great achievers) obtain their seeds and energy from the genesis of hypnosis, dating to the mother's heartbeat, which in itself is but a "shell of a core" that contains the omnipotent, invisible, *spiritual entity*.

Spiegel's (2008) statement about neurobiological evidence for genetic capacity for hypnosis that human beings possess may be analogical to that of C.G. Jung's (1936, 1974) human capacity for *collective unconscious*. The neurological question must be left to the neuroscientists, who are properly equipped to deal with the subject.

According to Hegel, the nature of Spirit may be understood by contrasting it with its opposite, namely Matter. He says that:

> The essence of matter is gravity; the essence of Spirit is Freedom. Matter is outside itself, whereas Spirit has its centre in itself. Spirit is self–contained existence. But what is Spirit? It is the one immutably homogenous infinite—pure Identity—which in its second phase separates from itself and makes this second aspect its own polar opposite, namely as existence for and in itself as contrasted with the universal. (Hegel, in Russell, 1971, p. 707)

Webster's dictionary (Thatcher, 1980) extends the above definition, and we quote some of it:

> The intelligent, immaterial, and immortal part of man; the soul, as distinguished from the body which it occupies; a person considered with respect to his mental or moral characteristics; the human soul after it has quitted the body; an apparition; a specter; a ghost; a supernatural being; angel, fairy, elf, sprite, demon, or the like; vivacity, animation, ardor, enthusiasm, courage, or the like; emotional state; mood;

[1] "Tall poppies" is an Australian expression used to describe people who excel in achievements in their field of activity, interest or enterprise

> humor; the vital or the essential part of anything; inspiring or actuating principle; essence; real meaning; intent, as opposed to the letter or formal statement. (p. 808).

The essence of hypnosis is embraced in the spiritual dimension. Hypnosis, like other non–material entities, manifests itself only by its action, which fuels life, but has a capacity, like hurricanes, to bend iron and shake the oceans (Skovoroda, 1972).

Disregarding great achievements, as well as great crimes, on this planet performed by "ordinary, decent" people would be equal to being blind and/or deaf. Great inventors, having achieved profound insights, in just a few decades, are being regarded as "having fun." Highly reputable individuals on the highest levels of the socio-economic strata commit hideous, often ridiculous crimes, sometimes without the slightest reason to do so—and if confronted, they produce explanations, fit to be perfect "*trance logic.*"

Hypnoanalytic work suggests that most intra-psychic conflicts have their genesis in "*unstructured or self–hypnosis*," which, in turn *generates* the whole Pleiades of psychological and psychosomatic illness.

Spiritual entities of humans, thus far, have escaped ingenious scientific clamps, but the therapist's use of phenomenological methods provides a way for "explication—unfolding" the core of hypnosis. The phenomenological method does not pollute by questioning the patient with the therapist's ideas but unfolds the truth, insight or feeling of the patient.

While appreciating that we are breaking very valuable, elaborate and tested scientific "external standards," we do so only being convinced that the essence of hypnosis is homogenous (spiritual), and thus immutable; it exists for millennia; having spiritual qualities thus acts as *sub specie aeternitatis* (under the form of eternity), and the royal way to the core of it is ontological faith, appreciation and respect of its acts (Hlywa, 2006; Kant, 1958).

Conclusions

It is our thesis that hypnosis as a spiritual entity, emanating from within the self, reaching genesis in utero and manifesting itself thereafter throughout human life, is an extremely powerful force, promoting both positive and negative achievements. The person, by scattering their attention, is incapacitated, but due to hypnotic conditions, the person can concentrate and thus achieve positive or negative outcomes (depending on suggestion or attitude) much more quickly than on a conscious level.

In our decades-long psychotherapeutic practice (like most psychotherapists), we have encountered hundreds of cases where spontaneous self-hypnosis contributed to the geneses of psychopathological conditions. Furthermore, we have made numerous observations of "great achievers" who are exceptionally successful in life. Barabasz and Watkins (2005), Herbert and David Spiegel (2004), Watkins (1987), Wolberg (1948, 1964) and others point to the positive and negative potentiality of this phenomenon of spontaneous self-hypnosis, which for millennia served the human race as a healing medium.

We are enormously conscious of the gigantic efforts and dedications of the researchers in the field—Barnier and Nash (2008), Barabasz and Watkins (2005), Hilgard (1970), McConkey (2008), Orne (1959), Wolberg (1967) and countless others, including their self–criticisms, refinements and improvements of methods, such as Sheehan and Perry (1976).

We contest a view that "hypnosis," as defined by the APA Division 30 (2005), will ever suffice to explain the essence of the phenomenon referred to as hypnosis. This is because, by virtue of experimental constrictions/conditions (including pre–and hypnotic induction, where the experimenters "explain", "suggest using imagination," implicitly or verbally), the phenomenon is contaminated by the subject's capacity for enhanced suggestion, and thus the phenomenon under investigation is not the *pristine* phenomenon as it naturally occurs. *It is an artefact created by the subject with the experimenter, by means of which a certain capacity—but not the essence of the phenomenon—is being investigated.*

Being very conscious of the gigantic task facing scientists investigating the *essence of hypnosis*, we can only hope that they sift-off the by-products and the artefacts of hypnosis and concentrate on the task to reach for the "*core*" of the phenomenon, bearing in mind that *its existence, its power, its universality and usefulness withstood the test of millennia.*

Our experience and observation of the phenomena of hypnosis suggest to us that hypnosis is a naturally occurring phenomenon which bears all the capacities to help human beings in their endeavour to create and maintain happiness in the universe.

REFERENCES

American Psychologial Association. (2005). *Society of Psychological Hypnosis: Division 30—American Psychological Association.* Retrieved 12 May 2010, from http://www.apa.org/divisions/div30/define_hypnosis.html

Barabasz, A. F., & Barabasz, M. (2008). Hypnosis and the brain. In M. R. Nash & A. J. Barnier (Eds.), *The Oxford handbook of hypnosis: Theory, research and practice* (pp. 337–363). New York: Oxford University Press.

Barabasz, A. F., & Watkins, J. G. (2005). *Hypnotherapeutic techniques* (2nd ed.). New York: Brunner-Routledge.

Barnier, A. J., Dienes, Z., & Mitchell, C. J. (2008). How hypnosis happens: New cognitive theories of hypnotic responding. In M. R. Nash & A. J. Barnier (Eds.), *The Oxford handbook of hypnosis: Theory, research and practice* (pp. 141–177). New York: Oxford University Press.

Barnier, A. J., & Nash, M. N. (2008). Introduction: A roadmap for explanation, a working definition. In M. R. Nash & A. J. Barnier (Eds.), *The Oxford handbook of hypnosis: Theory, research and practice* (pp. 1–18). New York: Oxford University Press.

Erickson, M. H. (1967). *Advanced techniques of hypnosis and therapy*. New York: Grune & Stratton.

Freud, S. (1943). *A general introduction to psychoanalysis*. New York: Garden City Publishing Company.

Gunnison, H. (2004). *Hypnocounseling: An eclectic bridge between Milton Erickson and Carl Rogers*. Williston, VT: Crown House.

Heidegger, M. (1996). *Basic writings*. London: Routledge & Kegan Paul.

Hilgard, J. R. (1970). *Personality and hypnosis: A study of imaginative involvement*. Chicago: University of Chicago Press.

Hlywa, E. (1977, 24 September). *Hypnosis and client–centred therapy*. Unpublished paper presented at the 7th Annual Congress of the Australian Society for Clinical and Experimental Hypnosis.

Hlywa, E. (1998). *Pryncypy psychotherapii i hypnotherapii* [Principles of psychotherapy and hypnotherapy]. Sydney: Lev, Star Printery.

Hlywa, E. (2004). *Vstup do psychotherapii* [Introduction to psychotherapy]. Kyiv: National University, Ostroh Akademie.

Hlywa, E. (2006). *Ontolohichnyj obras ludyny v tvorchosti Hryhorij Skovoroda*. [Ontological theory of personality based on the writings of Hryhorii Skovoroda]. Kyiv, Ukraine: KMM, Ukranian Akademie of Pedagogical Sciences.

Hlywa, E. (2008). Protracted hypnotic rest. *Australian Journal of Clinical and Experimental Hypnosis*, *35*, 50–63.

Husserl, E. (1962). *Ideas*. New York: Collier Books.

Jung, C. G. (1936). *Modern man in search of a soul*. New York: Harcourt.

Jung, C. G. (1974). *Psychological reflections*. London: Routledge & Kegan Paul.

Kant, I. (1958). *Critique of pure reason*. New York: The Modern Library.

Kihlstrom, J. F. (2008). The domain of hypnosis, revisited. In M. R. Nash & A. J. Barnier (Eds.), *The Oxford handbook of hypnosis: Theory, research and practice* (pp. 22–52). New York: Oxford University Press.

Laurence, J-R., Beaulieu-Prévost, D., & du Chéné, T. (2008). Measuring and understanding individual differences in hypnotisability. In M. R. Nash & A. J. Barnier (Eds.), *The Oxford handbook of hypnosis: Theory, research and practice* (pp. 225–253). New York: Oxford University Press.

McConkey, K. M. (2008). Generations and landscapes of hypnosis: Questions we've asked, questions we should ask. In M. R. Nash & A. J. Barnier (Eds.), *The Oxford handbook of hypnosis: Theory, research and practice* (pp. 53–77). New York: Oxford University Press.

Nash, M. R. (2008). Foundations of clinical hypnosis. In M. R. Nash & A. J. Barnier (Eds.), *The Oxford handbook of hypnosis: Theory, research and practice* (pp. 487–502). New York: Oxford University Press.

Orne, M. T. (1959). The nature of hypnosis: Artefact and essence. *Journal of Abnormal Psychology*, *58*, 277–299.

Pavlov, I. P. (undated translation from Pavlov, 1951). *Psychopathology and psychiatry*. Moscow: Foreign Languages Publishing House.

Pavlov, I. P. (1951). *Complete Works*. (2nd ed.) Moscow: Academy of Medical Sciences Publishing House.

Platonov, K. I. (1959). *The word as a physiological and therapeutic factor*. Moscow: Foreign Languages Publishing House.

Rogers, C. R. (1951). *Client-centred therapy: Its current practice, implications and theory*. Boston: Houghton Mifflin.

Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.

Russell, B. (1971). *History of western philosophy*. London: George Allen & Unwin.

Sheehan, P. W., & Perry, C. W. (1976). *Methodologies of hypnosis: A critical appraisal of contemporary paradigms of hypnosis*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Skovoroda, H. S. (1972). *Basic writings in two volumes*. Kyiv: Naukova Dumka.

Spiegel, D. (2008). Intelligent design or designed intelligence? Hypnotisability as neurobiological adaptation. In M. R. Nash & A. J. Barnier (Eds.), *The Oxford handbook of hypnosis: Theory, research and practice* (pp. 179–199). New York: Oxford University Press.

Spiegel, H., & Spiegel, D. (2004). *Trance and treatment: Clinical uses of hypnosis*. Washington, DC: American Psychiatric Publishing.

Thatcher, V. S. (1980). *The new Webster encyclopedic dictionary*. Chicago: Consolidated Book Publishers.

Tillich, P. (1954). *Love, power and justice*. New York: Oxford University Press.

Tillich, P. (1962). Existentialism and psychotherapy. In H.M. Ruitenbeek (Ed.), *Psychoanalysis and existential philosophy*. New York: E. P. Dutton & Co.

Tinterow, M. M. (1970). *Foundations of hypnosis*. Springfield, IL: Charles C. Thomas.

Völgyesi, F. A. (1963). *Menschen und Tierhypnose* [human and animal hypnosis]. Zürich: Orell Füssli Verlag.

Watkins, J. G. (1987). *Hypnotherapeutic techniques*. New York: Irvington.

Watkins, J. G., & Barabasz, A. (2008). *Advanced hypnotherapy*. New York: Routledge, Taylor & Francis Group.

Wolberg, L. R. (1948). *Medical hypnosis*. New York: Grune & Stratton.

Wolberg, L. R. (1964). *Hypnoanalysis*. New York: Grune & Stratton.

Wolberg, L. R. (1965). *Short-term psychotherapy*. New York: Grune & Stratton.

Wolberg, L. R. (1967). *The technique of psychotherapy*. London: William Heinemann Medical Books.

Woody, E. Z., & Sadler, P. S. (2008). Dissociation theories of hypnosis. In M. R. Nash & A. J. Barnier (Eds.), *The Oxford handbook of hypnosis: Theory, research and practice* (pp. 81–110). New York: Oxford University Press.

Australian Journal of Clinical and Experimental Hypnosis
Vol. 38, No. 1, 2010, 44–51

Use of Hypnosis in Psychotherapy with Major Depressive Disorders

Elliott H. Schreiber
Professor Emeritus of Psychology, Rowan University

This article contains an analysis of case studies in hypnosis with clients who had major depressive disorders. The objective of this pilot research was to utilise clinical cases and determine if hypnotherapy was effective in treating major depressive disorders. Three clients manifested major depression and two patients had bipolar 1 disorder; all of the clients had suffered with depression for more than three years and had been diagnosed by a psychiatrist from a county in southern New Jersey and were referred to the author for psychotherapy sessions. Individual cognitive therapy techniques were used along with hypnosis. To provide a simple pre-post test, the clients were assessed with the House-Tree-Person Test in the session in which hypnosis was introduced into the treatment plan and again at the completion of the final hypnotherapy session. The analysis showed that the clients' behaviour evidenced less depression and less anxiety after seven hypnosis therapy sessions. Some suggestions for further research are made.

INTRODUCTION

Depression is an overwhelming problem in the United States today. Currently, nearly 20 million Americans are known to be suffering from depression. The rate of depression in the United States is on the rise in every age group (Yapko, 2006) and each afflicted individual directly affects others such as family members and friends (Weissbourd, 1996).

The work of Yapko (1997), Crasilneck and Hall (1985), Kroger (1977), Weitzenhoffer (1989), Schoenberger (2000), and Gafner and Benson (2003) has shown that hypnosis is very useful in the treatment of depression. It can be used as an adjunct therapy or a supportive technique (Schreiber, 1991).

However, in the past, some therapists felt that hypnosis was a controversial treatment technique for the severely depressed; for example, Burrows and

Correspondence concerning this paper should be sent to Elliott H. Schreiber, Rowan University, c/o 708 Camden Avenue, Moorestown, NJ 08057, USA.

Dennerstein (1980) and Spiegel and Spiegel (1978) indicated that deep depression was a likely contraindication for hypnosis and their concerns were mirrored by Waxman (1978) and West and Deckert (1965), who reported that hypnosis might stimulate suicidal thoughts in vulnerable clients. However, it was the more recent and interesting field work on depression and the research by Gafner (2005), Yapko (2001), and Rubaie (1999) that motivated this study.

This case study reports on five clients who were referred by their family physician and who had been diagnosed by a psychiatrist from a local hospital. The clients were informed that they would be involved in a research study and their names would be kept confidential. They all live in the south Jersey and Philadelphia areas, and were from a Euro-American background. They had all completed physical exams and were in excellent health. In the second session and the last session of hypnotherapy, each client was interviewed and administered the House-Tree-Person Test and the House-Tree-Person Interrogation Questionnaire by the author. The test features were used to determine personality changes and progress in the clients' behaviour in therapy.

The House-Tree-Person Test was used by the author because of its non-threatening value and its ability to tap unconscious feelings of clients. There are eight test factors which are evaluated on the House-Tree-Person Test to measure depression and anxiety. The test factors scored as present or absent are: size of the drawings, placement on the page, content, line movement, shading, broken lines, theme of the drawing, and mood of the people. The House-Tree-Person Test is a projective technique and was introduced by J. N. Buck (1948).

The author was interested only in within-treatment program healing, and thus no attempt was made to follow up the clients post completion of their therapy program to ascertain if the healing effect was sustained over time.

CASE STUDIES

Client A: James

James was a 30-year-old single male and a graduate student working on his master's degree in management. He was a B+ student who enjoys working in the financial field. James was diagnosed by a psychiatrist in 2007 as having a major depressive disorder with anxiety, and was given some medication and referred for psychotherapy. He had not received any therapy in the past.

During James's first session, a case history was taken and therapeutic techniques were discussed. A combination of cognitive therapy and hypnosis

was mentioned as an option for treatment. The client was motivated to begin psychotherapy and a second session was scheduled.

The second session was undertaken a week later. Some cognitive therapy was conducted in this session; also, some information was given on hypnotic techniques at the end of the session. James showed interest in hypnosis and this method of treatment was started in the third session. Sensory induction techniques of Erickson, Rossi, and Rossi (1976) were used to obtain a medium level of hypnosis. His average induction time was three minutes. Glove anaesthesia (Hilgard, 1965) was the technique used to determine a medium level of hypnosis. Since James enjoyed being on the beach during the summer, this was used as a stimulus for inducing relaxation while going into hypnosis. He was instructed to picture himself on a beach blanket and to experience total feelings of rest and pleasure. He would also be able to close off all external negative distractions and unpleasant feelings and enjoy a wonderful restful state while picturing the ocean waves. James needed 20 minutes to observe and benefit from the instructions for a relief of anxiety and depression.

The fourth through to the tenth sessions were held a week apart from each other. The same induction techniques and hypnotic instructions were used as in the third session. James reached a deep state of hypnosis in these sessions and reported less depression and lower anxiety about his job and environment. Each time, James needed an average of a 20-minute hypnotic session to achieve strong progress in treatment.

Client B: Susan

Susan was a 40-year-old single woman who lived in south Jersey. She had a two-year college degree and worked in an investment office. This individual had few friends, but was close to her brother. Susan enjoyed reading books and watching movies. She was diagnosed by Kennedy Hospital staff as having a major depressive disorder, was prescribed an antidepressant and was referred to this psychologist for psychotherapy.

In the first session, as with James, a case history was taken and various therapeutic techniques were discussed with the client. Cognitive behaviour psychotherapy and hypnotherapy were the techniques used for this patient. Susan had no previous psychotherapy sessions. She had a history of anxiety and depression and couldn't keep her job. She was interested in obtaining therapy for her conflicts.

The second session was held the following week. She reported fears and depressive moods, and was lonely, and spoke about numerous conflicts in her family background. Her self-concept was explored in the second and third therapy sessions. Hypnotherapy was started in the fourth session to relax the client; sensory induction techniques of Erickson and Rossi (1979) were used to obtain a medium state of hypnosis. Her average induction time was five minutes. Glove anaesthesia (Hilgard, 1992) was the technique used to determine a medium level of hypnosis. As with James, a beach scene was used for Susan to induce hypnosis as she loved sitting on the beach. She needed 25 minutes to observe and benefit from the instructions for a relief of her depressive moods.

The fifth through the tenth sessions were held a week apart from each other. The same induction techniques and hypnotic instructions were utilised as in the fourth session. She reached a medium state of hypnosis in these sessions and revealed less depressive moods and a better self-concept about her environment. Susan required an average of a 25-minute hypnotic session to achieve strong progress in psychotherapy.

Client C: Clive

Clive was a 33-year-old married man who had two children. He was originally from Texas, but moved to New Jersey. He held a bachelor's degree in Information Technology and supervised IT staff. Because his marriage had been rather erratic with numerous conflicts, he sought marital therapy and was diagnosed by a psychiatrist as manifesting bipolar 1 disorder with depression. Clive was referred to this psychologist for psychotherapy.

As with all other four clients, in the first session a case history was taken of the family background, and various therapeutic techniques were discussed. Cognitive behaviour therapy and hypnotherapy were discussed for Clive's particular needs. The second and third sessions dealt with his anxiety and self-image. He revealed good rapport and showed interest in hypnotherapy.

The fourth session was started a week later with the introduction of hypnosis for relaxation. Sensory induction techniques of Erickson and Rossi (1979) were used to reach a medium state of hypnosis. His average induction time was three minutes. Glove anaesthesia (Hilgard, 1965) was the technique used to determine a medium level of hypnosis. However, this client went into a deep level of hypnosis. The beach scene was utilised again for this patient. He needed an average of 20 minutes to benefit from the instructions for a relief

of his depressive moods. (This client, like Catherine, differed from the others in that he went into hypnosis more quickly and went deeper.)

The fifth through the tenth sessions were held in successive weeks. The same induction techniques and hypnotic instructions were used as in the fourth session. Clive obtained a medium to deep state of hypnosis in these sessions and revealed less depression, less anxiety, and an improved self-concept. Clive needed an average of a 20-minute hypnotic session to achieve considerable progress in psychotherapy. He was told to practise at least one relaxation session per week at home.

Client D: Catherine

Catherine was a 35-year-old woman who had three children. She was from the Philadelphia area and was currently divorced and unemployed. She enjoyed working in the garden and loved flowers. Catherine was recently hospitalised at the University of Pennsylvania Hospital and was diagnosed as having a bipolar 1 disorder with depressive episodes. She spent several days at the hospital and was referred for individual psychotherapy for her depression.

In the first session, a case history was taken and a treatment program was discussed. The use of cognitive therapy and hypnosis was mentioned to the client. She showed strong interest in these therapeutic techniques and the author started this program in the fourth session. Good rapport was developed in these two sessions.

The second and third sessions dealt with the development of Catherine's bipolar 1 disorder and her emotional conflicts. Catherine indicated that she was hospitalised on two consecutive years, in 2004 and 2005. (Thus she evidenced a longer and apparently more serious problem with depression than the other four clients under study.)

The fourth session was held a week later. The same protocol and imagery were followed with Catherine as with the previous three clients. Hypnotherapy was started in this session. Sensory induction techniques of Erickson and Rossi (1979) were used to obtain a medium state of hypnosis. Catherine's average induction time was three minutes. Glove anaesthesia (Hilgard, 1965) was the technique used to determine a medium level of hypnosis. A beach scene was also used for Catherine to induce hypnosis as she too enjoyed sitting on the beach. She generally needed 20 minutes to observe and benefit from the hypnotic state for a relief of her depressive, bipolar moods.

The fifth through the tenth sessions were held a week apart from each other. The same induction techniques and hypnotic instructions were used as in the fourth session. Catherine reached a medium to a deep state of hypnosis in these sessions and displayed less anger and fewer depressive moods with regard to her environment. She also revealed better self-esteem and less anxiety. This client needed an average of 18 to 20 minutes under hypnosis to achieve adequate progress in psychotherapy. The tenth session was also used as a summary and evaluation period.

Client E: Beverley

Beverley was a 28-year-old single woman who lived in the southern New Jersey area. She had a university master's degree in Arts and had done very well at college. This individual had few friends and appeared to be a loner; she lived with her parents and there was a close relationship between them. She had suffered from major depression for over two years; she had seen a therapist for several sessions previously, but had stopped going for treatment. Her parents urged her to return for therapy, and she was subsequently referred to this psychologist.

In the first session, a history was taken of her background and emotional conflicts. The development of rapport was made in this session. A discussion of her depressive illness was elaborated upon, and she reported that her disorder was diagnosed by a psychiatrist in Burlington County, New Jersey. She was taking 50 mg of Zoloft for her depression and anxiety. The second and third sessions dealt with supportive therapy and the use of cognitive therapy and hypnosis as likely treatment techniques. Beverley revealed interest in these therapeutic techniques and this author started the program in the fourth session.

The fourth session was conducted a week later. Exactly as with the others, the same protocols and procedures were undertaken; however, because of her love of gardening, the beach scene was exchanged for a walk in her garden. Hypnotherapy was carried out in the latter part of this session. Sensory induction techniques of Erickson et al. (1976) were used to obtain a medium level of hypnosis. Her average induction time was four minutes. Glove anaesthesia (Hilgard, 1965) was the technique used to determine a medium level of hypnosis. A garden scene was utilised for this client to induce hypnosis as she loved sitting in her backyard to enjoy her flowers and greenery (Schreiber & Schreiber, 1998). Beverley usually needed 25 minutes to observe and benefit from the relaxation of the hypnotic state and the relief of her depression.

The fifth session through to the tenth session were held a week apart from each other. The same induction techniques and hypnotic procedures were used as in the fourth session. Beverley reached a medium to a deep state of hypnosis in these sessions. The hallucination of a fly on her arm revealed a deep state of hypnosis. She displayed less anxiety and less depressive moods with respect to her environment and her relationships. The client also revealed better self-esteem from the combined therapy techniques. The tenth therapy session was utilised as a summary and evaluation period for her, as with the other four clients.

SUMMARY OF OBSERVATIONS AND TEST SCORES

All five clients appeared to be able to move into a medium to deep state of hypnosis within three to four minutes of induction; they each took somewhere between 18 and 25 minutes of being in an hypnotic state to achieve their goal of empowerment in relation to their depressed and anxious states.

As indicated below, all five clients achieved a reduction in anxiety and depression levels following the treatment program.

An analysis of the five clients in this study revealed the following data based on the House-Tree-Person Test, the House-Tree-Person Interrogation Questionnaire, and patient interviews:

1. The five clients showed a 50% reduction of anxiety on the eight test factors by the ninth hypnosis session.
2. All of the patients related that they felt more relaxed and showed less anger in the sessions by the ninth hypnosis session.
3. The five clients revealed 50% less depression on the House-Tree-Person Test and the House-Tree-Person Interrogation Questionnaire at the end of the ninth session.
4. The reduced anxiety and depression levels in the clients were manifested by a more positive quality on half of the eight test factors in the final drawings.

CONCLUSION

These results from clinical case studies tend to support the investigation and work of Yapko (2006) and Gafner (2005) and indicate the need for further research on hypnosis and major depressive disorders, using more clients and varying populations. It is noted, however, that none of these clients had any history of suicidal ideation, and the warnings about utilising hypnosis with such clients, as indicated by Burrows and others, should be heeded accordingly.

REFERENCES

Buck, J. N. (1948). The H.T. P. Test. *Journal of Clinical Psychology, 4*, 151–158.

Burrows, G., & Dennerstein, L. (1980). *Handbook of hypnosis and psychosomatic medicine.* Amsterdam: Biomedical Press.

Crasilneck, H. B., & Hall, J. A. (1985). *Clinical hypnosis: Principles.* New York: Grune & Stratton.

Erickson, M. H., & Rossi, E. L. (1979). *Hypnotherapy: An exploratory casebook.* New York: Irvington.

Erickson, M. H., Rossi, E. L., & Rossi, S. (1976). *Hypnotic realities.* New York: Irvington.

Gafner, G. (2005). *Clinical applications of hypnosis.* New York: W. W. Norton.

Gafner, G., & Benson, S. (2003). *Hypnotic techniques for standard psychotherapy and formal hypnosis.* New York: W. W. Norton.

Hilgard, E. R. (1965). *Hypnotic susceptibility*. New York: Harcourt, Brace & World.

Hilgard, E. R. (1992). Divided consciousness and dissociation. *Consciousness and Cognition*, *1*, 16–31.

Kroger, W. S. (1977). *Clinical and experimental hypnosis*. Philadelphia: J. B. Lippincott Co.

Rubaie, T. A. (1999). The hypnotic treatment of depression. *Complementary Health Practice Review*, *5*, 151.

Schoenberger, N. (2000). Research on hypnosis as an adjunct to cognitive behavioral psychotherapy. *International Journal of Clinical and Experimental Hypnosis*, *48*, 154–169.

Schreiber, E. H. (1991). *Abnormal behavior.* Needham, MA: Ginn Press.

Schreiber, E. H., & Schreiber, D. E. (1998). Hypnosis in a case of acquaintance rape. *Australian Journal of Clinical and Experimental Hypnosis*, *26*, 72–75.

Spiegel, H., & Spiegel, D. (1978). *Trance and treatment: Clinical uses of hypnosis*. New York: Basic Books.

Waxman, D. (1978). Misuse of hypnosis. *British Medical Journal*, *2*, 571.

Weissbourd, R. (1996). *The vulnerable child: What really hurts America's children and what we can do about it.* Reading, MA: Addison-Wesley.

Weitzenhoffer, A. M. (1989). *The practice of hypnotism.* New York: Wiley.

West, L. J., & Deckert, C. H. (1965). Dangers of hypnosis. *Journal of the American Medical Association*, *192*, 9–12.

Yapko, M. (1997). *Breaking the patterns of depression.* New York: Random House/ Doubleday.

Yapko, M. (2001). *Treating depression with hypnosis: Integrating cognitive behavioral and strategic approaches.* New York: Brunner/Routledge.

Yapko, M. (2006). *Hypnosis and treating depression.* New York: Routledge.

Australian Journal of Clinical and Experimental Hypnosis
Vol. 38, No. 1, 2010, 52–61

Treating Physical Pain and Low Self-Esteem With Hypnosis: A Case Study

Catherine Suey
Clinical Psychologist, Sydney

This case study describes the inclusion of hypnosis in treatment to enhance self-esteem, the management of stress, and the management of pain resulting from injuries and in particular, fibromyalgia. Initial treatment focused on cognitive behavioural therapy for enhancing self-esteem and managing stress. Previously learned pain management strategies were reapplied, including relaxation and activity pacing. Hypnosis was included with positive results enhancing self-esteem, workplace relations, and general functioning.

BACKGROUND

Chronic pain can influence general functioning and emotional states which can then have an impact on chronic pain. Using hypnosis focusing on specific body sites to manage pain may not be effective when there are underlying psychogenic issues related to the pain, because the pain may transfer from the original site to another site. Consequently, underlying psychogenic issues need to be assessed and addressed prior to focusing on hypnosis for pain management (Barabasz & Watkins, 2005).

According to the gate control theory of pain proposed by Melzack and Wall (1965), two pathways transmit pain stimuli to the brain. The first pathway is the sensory-discriminative system that transmits impulses regarding pain location and severity. The second pathway is the motivation-affective system that transmits impulses of suffering. They are separate transmitting systems, but can allow pain and suffering to occur at the same time. If the pain and suffering co-occurrence is prolonged, intensity can increase and enmeshment can result. The theory posits that a neural network of "gates" in the dorsal horn of the spinal cord open or close to allow or impede pain messages travelling up the spinal cord from reaching the brain. The brain also sends pain signals

Correspondence regarding this paper should be sent to Catherine Suey at Catherine.Suey@sswahs.nsw.gov.au.

down the spinal cord to open or close the gates. Factors that open these gates include injury, inactivity, stress, anxiety, tension, depression, focusing attention on pain, and negative cognitions. Factors that close the gate include a positive attitude, contentment, optimism, relaxation, and involvement in activities. For further information about theories of pain, see Horn and Munafo (1997).

Research (Ray & Pescalis, 2003; Spiegel, Bierre, & Rootenberg, 1989) has indicated that use of hypnosis in pain management involves a gating of perceptions that reduce pain messages being recorded in the brain, while still allowing recognition of pain stimuli. This means that suffering can be reduced without eliminating the protective warning signal that pain provides.

Fibromyalgia is a condition of "chronic diffuse widespread aching and stiffness affecting muscles and soft tissues" (Dirckx, 2001, p. 361). Martinez-Valero et al. (2007) found that hypnosis was useful in helping people with fibromyalgia manage symptoms. Castel, Salvat, Sala, and Rull (2009) concluded that cognitive behavioural therapy plus hypnosis was more effective in treating pain in patients with fibromyalgia than cognitive behavioural therapy alone or pharmacological treatment alone. Derbyshire, Walley, and Oakley (2009) discerned that patients' subjective experience of fibromyalgia pain could be increased and decreased with suggestion without a preceding hypnotic induction and also with suggestion following a hypnotic induction. However, patients reported greater control over their pain and greater pain reduction with hypnotic induction.

PRESENTING PROBLEM

Louis was a 41-year-old man who self-referred seeking help to increase his self-esteem and to cope with chronic pain and work-related stress resulting from conflict that he experienced with staff. He described feelings of stress and frustration that fluctuated with his pain levels. Louis noted that his pain had worsened over the last 18 months to two years. He also reported that he had been diagnosed with fibromyalgia five years ago and had sustained injuries in falls at work between 2001 and 2006. He noted that injuries of torn disc, bursitis in both shoulders, and capsulitis in left shoulder exacerbated the fibromyalgia-related pain that he experienced all over his body except in his head and hands. He recalled pain intensity levels of 8 out of 10 most days on a scale of 0 (zero) to 10, with 0 being no pain and 10 being the most intense pain level. Louis reported that on some days, the pain intensity increased to 10 or 11 out of 10. He said that his sleep was poor because of pain and that

the pain intensified and was usually between 10 and 11 out of 10 upon waking in the morning.

He told me that he took codeine for analgesia as needed and was engaged in treatment with a pain management specialist who did not use hypnosis. He stated that he had learned pain management strategies for monitoring pain, altering activities, activity pacing, and relaxation, but had not applied such strategies for several weeks due to forgetting and feeling overwhelmed. His presentation and description of symptoms did not meet the criteria for depression. He was engaged in treatment with specialist medical practitioners, a general practitioner, and a physiotherapist during his time with me. Louis reported that he had experienced low self-esteem and low self-confidence since childhood. Now, Louis's low self-esteem influenced him to decline social invitations as he assumed that others would not want to talk to him at the social event and that he was not really wanted there anyway. He would withdraw and feel isolated; such behaviour served to reinforce his low self-esteem.

When he was given compliments, he would think, "I don't deserve it" and disregard the compliment. Even when he was nominated for, and won, an award at work, he felt undeserving. When Louis believed that he was not contacted socially often enough by other people he would think, "People could not be bothered because I am not a good person." Louis would not initiate contact himself and this resulted in isolation that reinforced his low self-esteem. Through discussion, we discovered that Louis used pain as an excuse to avoid social events, even when pain was not at a significant enough level to prevent attendance.

HISTORY

Louis was born in Belgium. His mother was a homemaker and his father worked as an engineer. Louis migrated to Australia at age nine months with his parents and brother who was five years older. His parents settled easily and became involved with the neighbourhood council and developed good friendships. Some friendships Louis developed at school are currently maintained. He reported that during childhood his parents had been supportive and tried to encourage him to have a positive self-image. He said that as a student he had been bullied by some peers at school and had been "put down" by some teachers. Louis attributed this behaviour to jealousy of his performance, as his academic performance was above average at school.

Consequently, he started putting himself down in an attempt to appear more acceptable to other people. Louis completed his Year 12 education, then worked as a station hand for a year. He then completed a Bachelor of Science degree and worked as a station hand for four years. He then started teaching in high school and has maintained this job for more than a decade.

THERAPY SESSIONS

We focused on cognitive behavioural therapy for the first six sessions. Louis resumed applying previously learned pain management strategies; he increased his activity level as he resumed gardening and reading. We identified the core belief of "I am not good enough"; the conditional assumption of "unless I do everything perfectly, I am not good enough," and the compensatory strategy of working harder than other people to try to prove his worth. This compensatory strategy led to his doing more than his share of the work in the job-share position he held with another staff member. This imbalance of duties led to Louis feeling resentful towards the other staff member, because he perceived that she was not doing her share and thus conflict would ensue. This compensatory strategy also interfered with Louis applying the pain management strategy of pacing his activities.

Louis also personalised other staff members' negative moods and negative behaviour and this contributed to his having poor staff relations and feeling stressed. He interpreted other people's negative moods and negative behaviour as "evidence" of his own lack of value. Louis started practising cognitive strategies to minimise personalising and to challenge negative self-talk regarding his worth. Also, as recommended, he began saying "thank you" in response to compliments and documenting them, regardless of whether he felt deserving of them or not. Initially Louis felt awkward saying "thank you" instead of dismissing compliments, but he began to feel more comfortable doing this. Pain still disturbed his sleep and was still intense upon waking.

TREATMENT GOALS

Treatment goals were jointly identified as being to:

- Enhance self-esteem,
- Learn stress management strategies, and
- Engage in pain management.

THE ROLE OF HYPNOSIS IN THIS CASE

Hypnosis has been effectively used to enhance self-esteem (Hammond, 1990), for pain management (Goldberg, 2006), specifically for pain management of fibromyalgia (see background section), and for stress management (Hadley & Staudacher, 1996). Hypnosis has also been found to enhance efficacy of cognitive behavioural therapy (Kirsch, Montgomery, & Sapirstein, 1995). Also, Louis confirmed that hypnosis had been effective previously for him (as described in suitability of hypnosis paragraph below). This indicated that he may find hypnosis helpful again.

SUITABILITY OF HYPNOSIS

No contraindications regarding hypnosis were evident in Louis's presentation, symptoms, or history. Louis had tried hypnosis for stress management at age 16 years when he was worried that he would perform poorly in exams because of a week's absence from school due to illness. He found hypnosis helpful and performed well in the exams; however, Louis had no specific recall of this hypnosis experience or content. Nevertheless, he expressed interest in trying hypnosis again.

PREPARATION FOR HYPNOSIS

We discussed the benefits of hypnosis, its limitations, and common misconceptions about it. We decided to try hypnosis for relaxation first to see how Louis responded and to identify his strongest sense modality. We collaboratively constructed a relaxation scene. Louis indicated that he had no questions regarding hypnosis. We planned the first hypnosis session to take place in one week. After that, we planned to use hypnosis to try to improve self-esteem but before using hypnosis in an attempt to help manage pain. This decision was made because increased self-esteem and confidence may enhance activity level and enjoyment further and pain control works best when mood is enhanced (Walker, 2002) and psychogenic issues are addressed first (see the background section).

FIRST HYPNOSIS SESSION

Louis verbally consented to begin hypnosis. The induction phase involved alternating between Louis staring intently at a spot on the wall and focusing on relaxing with every breath out. He closed his eyes voluntarily and I

counted from 1 to 20 with instructions for him to relax more deeply with each count. The deepening phase consisted of my counting from 21 to 50, with instructions to go further into hypnosis with each count. The content of the session was imagining walking through a rainforest and included experiences of the five senses. At my suggestion of Louis hearing the sounds of birds, a bird just outside the window began to chirp for a short while. I noticed that Louis's lower left leg and his right forearm momentarily twitched. I incorporated this twitch into the script by saying that the twitch helped him relax even deeper as it released energy. I counted back from 20 to 1 in the dehypnotising phase and Louis roused from hypnosis on cue. He described his experience of hypnosis as "good" but reported that he had no memory of the whole experience after I suggested the sound of the birds when the real bird outside the window chirped. This occurred early in the content phase; I normalised his experience by saying how people often do not recall all of the content. He commented, regarding the bird outside the window, that I could not have planned it better if I had tried. He reported his visual sense as being the strongest sense modality in hypnosis. He advised that the pacing of the induction was fine. Louis commented that he felt his leg and forearm twitch and such body spasms were normal for him and did not disrupt the hypnosis process at all. Louis reported that his pain intensity level was 11 out of 10 prior to hypnosis and reduced to 6 out of 10 following hypnosis. He told me that the headache he felt coming on prior to hypnosis was now gone. A taped recording of the session was given to Louis to utilise at home. We collaboratively planned next week's hypnosis script with the goal of increasing his self-esteem.

SECOND HYPNOSIS SESSION

Louis reported that he had experienced hypnotic trance while listening daily to the hypnosis session tape recorded the previous week. He advised that he has been sleeping better and feeling less stressed at work and had joined a painting club and was enjoying it. Louis verbally consented to begin hypnosis and trance was induced as before. The content involved imagery of a blackboard with previously identified negative labels that Louis applied to himself written on it (Hadley & Staudacher, 1996). Louis then visualised himself erasing these labels and writing previously identified positive labels on the board. We chose the imagery of a blackboard because Louis was a teacher and related well to it. Content involved suggestions of confidence,

focusing on positive interactions with others, approaching problems positively, and focusing on previously identified positive qualities. After hypnosis, Louis reported that he felt relaxed and had no recall of the hypnosis content from the time of the image of the blackboard and that was very early in the content phase. He reported that he was aware of pain in his body during hypnosis, but felt detached from it. Again, a taped recording of the session was given to Louis to use at home. We collaboratively planned the next session of hypnosis with the goal of pain management in mind.

THIRD HYPNOSIS SESSION

Louis reported that he had experienced hypnotic trance while using the self-esteem tape recorded for the hypnosis session at home. He noted that he was relating better with a female staff member at work with whom he had previously experienced difficulty sharing a job; he reported that he was better able to see her perspective and thus was able to incorporate this into an effective compromise. Louis indicated that this had helped to reduce his stress at work. Louis advised that he has let go of trying to control the job totally and was allowing her autonomy to make decisions that she deemed appropriate when she was doing the job. He now refers all inquiries about the job to her when it is her day to do the job, instead of dealing with the inquiries himself. He reported that she had responded positively, was now putting more effort into her share of the job, and seemed to be enjoying it more. We discussed how this allows Louis some time out and reduces pressure on him. Louis noted that he feels better in himself and is conscious of a positive change within him and that his mood has been more consistent and stable. He said that he had not put himself down for two weeks and feels a greater sense of self-worth; he no longer uses pain as an excuse to withdraw from social events and is attending more social events, including work-related social events. He now enjoys accepting compliments.

Louis verbally consented to begin hypnosis and trance was induced as before. The hypnosis content involved pain symbol and pain relief symbol (Goldberg, 2006); and it involved Louis's previously identified pain symbol of his body as black and feeling heavy, and transforming this image into Louis's pain relief symbol of his body as sky blue in colour, feeling light, and experiencing a cool sensation, like cool water washing away discomfort. Included in the script was a statement that he would not entirely lose his ability to perceive pain, as it is a warning device for his body and that he will

retain a small residue of pain to monitor his condition, but that his suffering will diminish so that he is aware of the small residue of pain, but it would no longer bother him (Newton, 2005). After hypnosis, Louis reported no recollection after the hypnotic induction. He felt totally relaxed, was more energised and felt a lot brighter; and his pain intensity had reduced from 9 out of 10 to 7 out of 10. As previously, a taped recording of the session was given to Louis for use at home. We collaboratively planned another hypnosis script for pain management in the next session.

FOURTH HYPNOSIS SESSION

Louis mentioned that he had experienced hypnotic trance while using the pain management hypnosis tape in the evenings before going to bed. His sleep had improved further and he now woke in the morning with a pain level intensity of 6 out of 10, instead of the usual between 10 and 11 out of 10 upon waking. He indicated that he is more aware of when he is physically tense and then applies relaxation strategies that help to reduce the pain intensity. Louis reported that he has ceased personalising other people's negative moods and behaviour. He now tells himself that the person is just having a bad day. He also noticed that a particular staff member, whose negative moods Louis usually personalised, actually interacts with all staff in the same negative way, so he no longer personalises it. Louis reported that this has helped him to reduce stress at work and to prevent the deterioration of self-esteem that used to occur when he blamed himself.

Louis verbally consented to begin hypnosis and trance was induced as before. This time, the content involved Louis visualising himself walking down the corridors of his mind and coming to a door that opened onto his "special place" (Goldberg, 2006). The scene Louis had previously selected was a beach. The suggestions were that he would feel free of pain and stress in this place and that it would be a place of healing for him. After hypnosis, Louis had no recollection after entering the beach scene. He reported that he felt good and was relaxed and that his pain intensity had reduced from 9 out of 10 to 7 out of 10. A tape recording of the session was given to Louis, with which to facilitate hypnosis at home.

FOLLOW-UP FOUR WEEKS LATER

Louis reported that his energy had increased, he feels well, and has been coping well. He said that the improvement in his self-esteem has been maintained

and that he enjoys accepting compliments easily now and also accepts credit for the work he has done. He advised that he had won a place in a competition in the painting group and felt proud of himself. He commented that improvements in sleep and mood stability had also been maintained, as were the improvements in staff relations. Indeed, a staff member had told him that he had "changed for the better." He noted that he was aware of his pain, but was not suffering as he had been previously. He indicated that he is enjoying social activities and is looking forward to leaving for a seven-week holiday with friends. This was Louis's discharge session with the option of his re-engaging with the service in the future if required.

CONCLUSION

I believe that hypnosis increased the efficacy of cognitive behavioural therapy, as it helped Louis experience cognitive shifts at a deeper experiential level. For example, Louis did not just theorise that a particular staff member might interact negatively with all staff and not just him—he actually noticed it. I consider that Louis's previous positive experience with hypnosis helped him to develop an expectation that hypnosis would be effective this time also. It appears clear to me that that this expectation facilitated the efficacy of hypnosis.

REFERENCES

Barabasz, A., & Watkins, J. (2005). *Hypnotherapeutic techniques* (2nd ed.). New York: Brunner-Routledge.

Castel, A., Salvat, M., Sala, J., & Rull, M. (2009). Cognitive-behavioural group treatment with hypnosis: A randomised pilot trial in fibromyalgia. *Contemporary Hypnosis, 26*, 48–59.

Derbyshire, S., Walley, M., & Oakley, D. (2009). Fibromyalgia pain and its modulation by hypnotic and non-hypnotic suggestion: An fMRI analysis. *European Journal of Pain, 13*, 542–555.

Dirckx, J. (Chief Ed.). (2001). *Stedman's concise medical dictionary for the health professions* (4th ed.). Baltimore, MD: Lippincott, Williams & Wilkins.

Goldberg, B. (2006). *Self hypnosis.* Franklin Lakes, NJ: The Career Press.

Hadley, J., & Staudacher, C. (1996). *Hypnosis for change.* Oakland, CA: New Harbinger Publications.

Hammond, D. (1990). *Handbook of hypnotic suggestions and metaphors.* New York: W. W. Norton.

Horn, S., & Munafo, M. (1997). *Pain: Theory, research, and intervention.* Philadelphia: Open University Press.

Kirsch, I., Montgomery, G., & Sapirstein, G. (1995). Hypnosis as an adjunct to cognitive-behavioural psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *63*, 214–220.

Martinez-Valero, C., Castel, A., Capafons, A., Sala, J., Espijo, B., & Cardena, E. (2007). Hypnotic treatment synergises the psychological treatment of fibromyalgia: A pilot study. *American Journal of Clinical Hypnosis*, *50*, 311–321.

Melzack, R., & Wall, P. D. (1965). Pain mechanisms: A new theory. *Science*, *150* (3699), 971–979.

Newton, B. (2005). *Pain.* Transcript provided for the Advanced Module of the Australian Society of Hypnosis training course.

Ray, W., & De Pescalis, V. (2003). Temporal aspects of hypnotic processes. *International Journal of Clinical and Experimental Hypnosis*, *51*, 147–165.

Spiegel, D., Bierre, P., & Rootenberg, J. (1989). Hypnotic alternation of somatosensory perception, *American Journal of Psychiatry*, *146*, 749–754.

Walker, W.-L. (2002). *Hypnosis and pain: Clinical applications.* Prepared for the Advanced Module of the Australian Society of Hypnosis training course.

Australian Journal of Clinical and Experimental Hypnosis
Vol. 38, No. 1, 2010, 62–71

Metaphors to Reawaken Resiliency in Patients

Consuelo Casula
Private Practice, Milan

Is it possible for a small puff of wind to restore a soul after a tsunami? Is it possible for a metaphor, with its lightness, to help a patient pass over the weight of his pain? Is it possible for a metaphor to represent the way to recover the sweetness of life after having tasted much bitterness? I believe it is. Through metaphors, as therapists, we can send messages which are the fruit of a combination of scientific reasoning and therapeutic intuition to strengthen in patients the resiliency needed to face and overcome pain and to regain enough self-confidence to undertake new action. In this article I demonstrate how stories about life and living can assist patients in tapping into their innate resilience or to draw on that of others, real or imagined. Only the metaphor "The Loss of a Teddy Bear" is a creation of mine; the others are old stories read in many books rewritten and readapted for the purpose of this article. The References list indicates the works from which I have drawn ideas and examples.

Metaphors are impertinent and outside the logic used by patients. They are irreverent and provoke mental elasticity which stimulates the patient to set aside his ideas, convictions and rigid emotions. They create, therefore, new views and renewal, destabilise habits, and bring forth unusual but plausible comparisons. Metaphors are also a method and an enigma: a method because they open up a new path which takes you elsewhere and beyond; an enigma because they stimulate magical and mysterious awareness of others' answers. They offer an exercise in mental creativity and vitality, in that they express existing likenesses and generate something which did not exist before. For these reasons, therapeutic metaphors may help patients find the resiliency they need to overcome their problems.

Resiliency (from the Latin word meaning "to bounce back") is a process

Correspondence concerning this paper should be sent to Consuelo Casula at consuelocasula@gmail.com

fed by the conviction of being in control of oneself and being able to influence future events. It is a process that leads one to work hard in existing activities and transform pain into a challenge: If pain forces a person to lower his head, challenge instead helps that person to lift it up. It helps relate and contextualise, transform adversity into the development of one's potentiality, realise that one is stronger than desperation, and discover, in suffering, an important agent of change and self-realisation. Resiliency designates not so much an aptitude for happiness as a stimulus to react with empathy, calm, courage, optimism and emotional intelligence to the suffering imposed by destiny. This stimulus leads to abandoning sad and destructive emotions and adapting positive emotions, as well as flexible and efficacious behavioural and cognitive strategies. The story below represents resilience in tough times.

The Donkey in the Well

Once upon a time a donkey felt in a deep well. It started to bray so loudly that all the villagers went to see what had happened. When they arrived at the well, they realised that it was impossible to help the donkey to get out of the well, because they didn't have any suitable tools. So they sadly decided to help the donkey not to suffer too much and to die as fast as possible. So they started throwing earth into the well to bury the donkey. After a while, the donkey stopped braying. Assuming the donkey had already died, the villagers looked at the well and saw the donkey on top of a pile of earth. What had happened? As soon the donkey realised what was happening, every time it received a shovelful of earth, it shook the earth off its body and put itself on top of the soil.

The metaphors, which are told with the specific aim of reinforcing resiliency in patients, contain stories in which the characters overcome their difficulties by using attitudes typical of resilient people: the conviction of possessing self-control, of being able to influence future events, the ability of feeling fully involved in the activities needed for change. Metaphors may also represent a model of flexible responses, as well as supplying ideas on how to solve problems.

The characters in metaphors demonstrate resiliency and show that it helps them solve their problems more easily. The characters in metaphors may either have gifts of active wisdom, such as extroversion, availability, reliability, emotional stability and maturity, or passive virtues such as patience, hope, renunciation, and detachment.

This article contains a selection of metaphors with the aim of bringing messages of resiliency to patients. These metaphors communicate the acceptance of reality, control of one's emotions, and senses of responsibility, self-determination, confidence, compassion and altruism, which are all appropriate in depicting the main characteristics of resiliency.

Acceptance of Reality

Simple factual truth is sometimes difficult to accept. It is, however, an indispensable ingredient in starting out on the road to recovery through resiliency. An ancient Zen proverb states: "Inclement weather does not exist, only unsuitable clothes exist." And Homer points out that not even Zeus can change what has already happened. Resiliency begins by accepting reality for what it is and in the way it has manifested itself. The resilient person, well aware of his powerlessness, becomes powerful by accepting reality and finding in it the teachings for change.

When something serious happens, the resilient person does not wonder "why did this happen to me?", or "what have I done to deserve such suffering?"; nor does he complain about it being unfair and that it should not have happened to him. He does not ask questions about the past, searching for causes and explanations that cannot be found, because life deals out ambiguities and uncertainties which need to be accepted calmly. The following story is one such example.

The Loss of a Teddy Bear

Once upon a time a child was in despair because he had lost his favourite teddy bear. His nearest and dearest tried to console him by making him understand that it was useless to cry for an object which could be purchased again. They tried to teach him detachment, encouraged him to be strong and hold back his tears, to act like a man, lose without getting upset, and not become attached to objects. The child listened to the consoling words of his loved ones. He listened and understood their good intentions. He realised they understood his genuine pain and interpreted his suffering as love for his teddy bear. He also realised, however, that nobody understood that his despair was not so much due to the loss of the bear, but above all to the loss of being able to hug its innocent softness and naïve warmth. Thanks to this loss, the child understood that his childhood had finished and that adulthood, with its reality challenges, had begun.

Control of Emotions

A resilient person wonders: What shall I do with my wound? How can I manage it? What can I, or must I, change? How can, or must, I change it? How can I change the situation? The resilient person starts with what has happened and gathers her resources to find a remedy or solution. She does not look for explanations but acts.

The resilient person does not exaggerate her suffering with sad passions or destructive emotions, such as despair, resentment, rancour, envy or pride. Although she feels the distressing and incessant pain, she does not waste energy in sterile complaints. Instead she confronts the challenge as an ordeal which is both character-forming and ego-strengthening. She readies herself to cooperate with destiny. On the one hand, she detaches herself from what has happened, and on the other hand she observes her own reactions, studying the effect of her thoughts on her emotions and behaviour.

Resiliency is the ability to fight back, to acquire reflective awareness. It is not merely survival after great trials. What matters is no longer survival, which is only an extension, but how much we thrive emotionally: The growth conditions themselves become an object of reflection. Suffering and pain are transformed by being considered relative, contingent and temporary. We face suffering and pain to understand their complexity, as well as the mysteries of life, and use them to reinforce compassion, gratitude, joy and wisdom. The next story underscores these points.

The Two Wolves

Once upon a time, a little girl asked her grandmother why they had nicknamed her "Two Wolves." The grandmother replied that on several occasions she seen two wolves fighting each other inside her. "One wolf is a growling, ferocious, hungry animal, thirsty for revenge, recognising only its own needs, and prepared to do anything to get quick satisfaction, in any way possible. The other wolf is tame, playful, sly and happy. The two wolves are in conflict with each other, because the ferocious one is aggressive and wants to bite and win, whereas the tame one is able to wait and be patient, generous and trusting." The little grand-daughter asked: "Which one wins?" The grandmother replied: "The one I feed the better."

Sense of Responsibility

After having accepted reality and managed his own emotions, the resilient person shifts attention, detaches himself from the situation and concentrates

on his only true power, which is to react intelligently; that is, to make appropriate and wise decisions. He does not allow pain to stun him, he does not let unanswerable questions confuse him, nor does he look backwards. He concentrates on his own attitude and reactions and strives to act efficaciously in the changed situation proffered him by life.

The resilient person does not stubbornly persist to return to the past, he does not deceive himself with trying to change what cannot be changed, but he channels his energies in the direction of feasible change, striving to transform adversity into realistic and feasible objectives. The futures begin as soon as the trauma occurs, after we decide what to do and how to use our resources and energy. The future begins with an act of faith and hope as well as with planning what we want to become, as the story of the broken jug depicts.

The Broken Jug

Once upon a time, a man went every morning to draw water from a well in his village. The man had two jugs: one intact and the other cracked. By the time he arrived home, some of the water in the cracked jug had leaked out along the way. One day one of his neighbours said: "I don't understand why you keep on using that jug which makes you waste so much energy. Don't you see that when you get home, the jug is almost empty? Why don't you buy a new one?" The farmer replied: "When I saw the jug was cracked, I planted some seeds along the way home. The cracked jug waters them every day and the path home is always decorated with fragrant flowers, thanks to my cracked jug."

Self-Determination and Confidence

The resilient person can be recognised by his sense of responsibility, self-determination, and confidence; he cultivates an optimistic attitude, so that he can overcome difficulties and turn them to his advantage. He can verify that courage is stronger than destiny and the pain can be entrancing. He understands that stupidity, blindness and deafness are only permitted in routine situations, but are absolutely banned in situations of danger.

The resilient person, therefore, determines to govern himself with caution and to grasp the value of life and its limitations. He chooses to smile in the face of adversity and to use moderation and trust. Moderation aids the resilient person to bear losses and grief without transforming them into resentment or envy. Trust and confidence stimulate a positive approach to the future, build

tolerance in ambiguous situations and activate appropriate behaviour. The resilient person sets himself realistic and feasible objectives, both short and long term, and makes a serious commitment to reaching them. He is grateful for the extension that life has offered him. He is not downcast, but proceeds with uplifted spirit along the path of life.

The Eagle

An eagle will die at 40 years of age, unless it breaks its beak in order to renew it, uses its beak to crack its claws in order to renew them, and uses its claws to pull out its feathers and renew them. By doing this for five months, an eagle can live another 30 years.

Compassion and Altruism

The resilient person understands the value of compassion and tolerance. Compassion means understanding that no one is immune to the twists of fortune, that everyone has similar chances to suffer misfortune and that tolerance brings acceptance. Compassion means being able to identify with the suffering of others. Compassion is a precious means to extending ethical awareness and comprehending the human value of painful events.

In addition, altruism, dedication to others and compassion take away our concentration on ourselves and empower us help others. For the resilient person, self-realisation can only happen through collaboration, acting together with, and for, others. In this way, the resilient person grows and becomes fully himself through giving himself to others, and taking upon himself the consequences that his actions have on him and on others. The following story about the monk demonstrates this.

The Monk Who Recovered His Health

Once upon a time, there was an old monk who saw death approaching in a young and sick disciple. He therefore decided to send the young man home, so that he could end his days with his loved ones. After three months, the disciple returned, beaming with life and health. The old monk was filled with curiosity about what had happened in those three months to so change a destiny of death into a destiny of longevity. He therefore asked the young man to tell him how he had spent his time.

The young monk told him that it had taken him a long time to get home, because he had to walk bent over with his eyes on the ground because of pain.

> *And while he was walking slowly, he heard the wail of an animal. He followed the sound and found a hare that had fallen into a hunter's trap. The young monk helped the animal get out of the trap, nursed its wounds, and finally set it free. Later on his way home, he found a little boy on top of a big tree unable to get down. So he stopped to help him learn how to come down. And still later he arrived in a village which was being flooded. So he stopped to help the villagers build a protective wall, and then continued on his way until he reached his home. The old monk understood that he who is useful to life, deserves to live long.*

Before concluding this article, I would like to present a case in which, besides other hypnotherapeutic means, metaphors were useful to help the patient create a better destiny for herself.

Valeria, a beautiful 45-year-old woman, came for therapy as a result of suffering caused through being jealous. Francesco, her partner, is very fond of a friend's daughter. The little girl is like a daughter, although he is not her father. When the little girl calls, he runs to her side, is anxious for her; he gives her many gifts and is at her disposal. He has behaved like this since the girl was born. Now this seems strange on the surface of things, because the child's mother had been briefly Francesco's girlfriend, but they had quickly separated because of incompatibility. Additionally, the ex-girlfriend had the little girl to another man, and subsequently married someone else with whom she had a second child.

Valeria had met Francesco many years ago; first they had been friends and later had fallen in love. When Valeria came to me for therapy the couple had been together for four years. My first question was why had she fallen in love with him, well knowing his fondness for the little girl. And why had she decided to come for therapy at exactly this time? The reason given was that Francesco had asked her to live with him, and she was undecided. Other reasons for getting together came over time.

In telling her story, Valeria said that initially she accepted the relationship between Francesco and the little girl, but with the passing of time, a mixture of jealousy and envy arose due to the excessive attention awarded the child … and seemingly away from her. She hoped that with time and with the strengthening of their ties, the relationship with the little girl would change, but this did not happen.

Very sensitive to being downgraded, Valeria described a life of pain, lack of love, deceit, lies and manipulation. She spoke first of the happy years of her early childhood with her hairdresser mother in a village on the outskirts

of Milan. However, when she was about four, her father arrived. She was sent to boarding school where she spent hours behind the bars of the school gate crying in despair. Many years passed without any gesture of love from her father, only much criticism. She was unable to study and so at a young age went to work as a pedicurist. She married, separating after a few years when she discovered that her husband had taken a lover.

After reconstructing her past, lightening the shame of a fragile ego, and overcoming the sense of guilt for no reason, Valeria discovers the right to know and claims the right to happiness. After three years in therapy, Valeria is ready to ask her mother if there is a family secret that perhaps now, as a mature woman, she can know.

Valeria's mother reveals that the person she has always believed to be her father is not her real father. Valeria is the daughter of a past employer—a married but childless man who desired a child. But when the baby turned out to be a girl, the father did not want her. He disappeared and only saw little Valeria a few times. The mother had made a mistake in saying to Valeria, "This is your father" instead of saying, "This is my husband."

By revealing the secret that had been hidden for 40 years, the mother spilled her shame and at the same time freed Valeria. Valeria had been carrying inside herself both her mother's and stepfather's shame. The mother was ashamed of being an unwed mother (we need to imagine a village in the outskirts of Milan about 45 years ago), and the husband was ashamed of being a polio victim and of having married an unwed mother. The mother thought she was protecting Valeria from a traumatic truth with her silence, but in so doing she created in Valeria's head and heart enormous confusion which prevented her from fully expressing herself.

The therapy helped transform images and sensations from the past into words, and to make sense out of them. We began to understand why Valeria felt so much jealousy and envy about a little girl who was receiving so much love from a man who was neither her father nor the mother's husband. This was not what had happened to her. Francesco represents the type of father/non-father Valeria had wanted, but didn't have. By choosing Francesco as her partner she was able to relive her trauma, resolve it and free herself from unnecessary suffering.

Valeria understood why she felt unloved and manipulated: It was the fruit of her experience. For this reason, she had been unable to study; her mind was confused and she was unable to concentrate. After her mother's revelation, Valeria repaired her childhood and started to feel better, see opportunities and

find within herself a desire to study. In the space of one year, she went through a four-year high-school curriculum. She passed all her exams, and in the following year she was awarded a school certificate. Now Valeria is attending university at the age of 45. Valeria's suffering was not in vain and she finally has some satisfaction. Valeria is the demonstration of the saying, "It is never too late to have a happy childhood."

CONCLUSION

With this article, I have offered readers a few metaphors which are useful in awakening resiliency in suffering patients. Metaphors with their irreverent and irrelevant lightness point to different flexible and fluctuating destinies which help loosen the rigidity of patients. Metaphors are an indirect and gentle instrument that prepares the unconscious of patients for the therapist's messages.

We should be aware that at times the most useful therapeutic message is the one that manages to awaken, on the one hand, common sense and, on the other hand, new aspects, such as in Valeria's case.

White Roofs

One cold, but sunny, winter's day, a Zen master and his disciple were going through a snow covered village. The master was enjoying the beauty of the blinding whiteness and of the harmonious silence, when his disciple asked: "Master, all the roofs are white, covered with snow. When will the roofs regain their natural colour?" The master meditated a little, because he wanted to give his pupil not a reply, but a lesson. And when he had found the appropriate message, he said to the young man: "When the roofs are white, they are white. When the roofs are not white, they are not white."

REFERENCES

Barker, P. (1985). *L'uso della metafora in psicoterapia*. Rome: Astrolabio. [*Using metaphors in psychotherapy*. New York: Brunner Mazel]

Benasayag, M., & Schmit, G. (2004). *L'epoca delle passioni tristi*. Milan: Feltrinelli. [*Les passiones tristes, souffrance psychique et crisis sociale*. Paris: La Découverte]

Casula, C. (Ed.). (2009). *Le scarpe della principessa: Donne e l'arte di diventare se stesse* [The shoes of the princess: Women and the art of being themselves]. Milan: Franco Angeli.

Casula, C. (2002). *Giardinieri, principesse, porcospini: Metafore per l'evoluzione personale e professionale* [Gardeners, princesses, hedgehogs: Metaphors for personal and professional evolution]. Milan: Franco Angeli.

Cyrulnik, B. (2000). *Il dolore meraviglioso*. Milan: Frassinelli. [*Un merveilleux malheur*. Paris: Odile Jacob]

Cyrulnik, B. (2005). *Parlare d'amore sull'orlo dell'abisso*. Milan: Frassinelli. [*Talking of love on the edge of a precipice*. Harmondsworth: Penguin]

Dalai Lama & Goleman, D. (2003). *Emozioni distruttive*. Milan: Oscar Mondadori. [*Destructive emotions*. New York: Mind and Life Institute/Bantam]

Goleman, D. (1998). *Le emozioni che fanno guarire*. Milan: Mondadori. [*Healing emotions*. Boston: Shambala Publications]

Goleman, D. (1998). *Menzogna, autoinganno, illusione*. Milan: Saggi Bur. [*Vital lies, simple truths: The psychology of self-deception*. New York: Simon & Schuster]

Gordon, D. (1978). *Metafore terapeutiche*. Rome: Astrolabio. [*Therapeutic metaphors: Helping others through the looking glass*. Cupertino, CA: Meta Publications]

Nussbaum, M. C. (2004). L'intelligenza delle emozioni. Bologna: Il Mulino. [*Upheavals of thought: The intelligence of emotions*. Cambridge: Cambridge University Press]

Owen, N. (2004). *Le parole portano lontano*. Milan: Ponte alle grazie. [*The magic of metaphor: 77 stories for teachers, trainers and thinkers*. Carmarthen: Crown House]

Owen, N. (2004). *More magic of metaphor*. Carmarthen: Crown House.

Short, D., & Casula, C. (2004). *Speranza e resilienza: Cinque strategie terapeutiche di Milton H. Erickson* [Hope and resiliency: Five psychotherapeutic strategies of Milton H. Erickson]. Milan: Franco Angeli.

Short, D., Erickson, B. A., & Erickson-Klein, R., (2005). *Hope and resiliency: Understanding psychotherapeutic strategies of Milton H. Erickson*, Carmarthen: Crown House.

Australian Journal of Clinical and Experimental Hypnosis
Vol. 38, No. 1, 2009, 72–75

Sleep Script

James Auld
Dental Surgeon

A relatively common clinical problem is sleep disturbance. The following script may be used to assist clients overcome many of the "blocks" they have to experiencing sound sleep, in conjunction with the more direct treatment of its probable causes.

After any form of hypnotic induction, or following on other suggestions, you can say to your client (with the relevant pauses in the right places and with the emphases as indicated by bold type):

You know that you think with your conscious mind, and interestingly, the vast remainder of your mental capacity is that part of the brain we call the unconscious. We can't directly access the unconscious, except maybe in hypnosis, but it is an active part of our existence, monitoring all that happens in our bodies and everything that we perceive. Some people have proposed that we are quite unable consciously to process the total amount of information which we perceive, so the unconscious acts as a filter which only allows the passing on of the things in which we are ***immediately interested****, or which are* ***immediately important****, and just keeps monitoring the others at some level. Perhaps this is a* ***defence mechanism*** *where we can focus on what is* ***important****, while letting another part of us do the housekeeping, but still be monitoring the environment for things which* ***might be of importance*** *for survival. Whatever the reality, we know that* ***you can't not sleep*** *and whatever you feel about the* ***experience*** *of* ***sleep****, you can* ***sleep without being aware of the experience****.*

It's interesting when you try to think about ***sleep****. What do you know as* ***sleep****? You can measure sleep physiologically, you can recognise different levels of "****sleep****" with brain wave tracings, you can observe someone* ***asleep****, but y****ou don't know*** *subjectively what it is to* ***be asleep****. You may think you know you have been asleep, but how do you know this, if you* ***don't remember*** *being asleep? Is it the changes you feel in your body, or a change in the way you think, or just the way you think that you have changed?*

Correspondence concerning this script should be sent to James Auld at jamesauld@bigpond.com.

*We have all had the experience of **being unaware** of things when we are asleep, hearing expected sounds in the environment—a bird call, a dog barking in the distance, the **sounds** of someone moving about in the early morning. But if you are alone in the house, that sound will alert you instantly! You can safely **let go** of **conscious awareness**, because you can be sure the unconscious is monitoring everything and has the capacity to alert and awaken you, if necessary. Maybe this comes from our evolutionary past; rest was needed to allow tired muscles to recover and energy reserves to regenerate, but **constant alertness** was also needed to minimise the risk of being surprised by a predator or enemy, and this awareness **reduced the efficiency** of the rest. Over time, a skill developed which allowed another part of us to carry out the passive monitoring process and still **retain the capacity to alert** us in time in times of need. You can **remember sleeping** in a strange environment—a strange sound alerted you and let you analyse the sound for what it was, and to decide whether or not it was relevant to you, and then **going back to sleep**, if that was appropriate, possibly **without remembering** the incident.*

*Sleep can be like that veil of mist we can't see through on a foggy day, when all the **outlines are blurred** and colours are faded and muted so that it is **hard to see** what is out there, and the further you **go out there**, the further **the details recede** so that you never reach that limit of your vision … like looking for the end of a rainbow. If the mist is thick enough, you really can't be sure just how far you can see; it's only if something moves that you realise that where you thought your vision stopped was not where it was when you weren't thinking about it. Is sleep just the stopping of remembering, the stopping of conscious recording? Perhaps it is not necessary for us to remember what goes on while we are asleep, or is it that nothing goes on while we are asleep for us to be able to remember it?*

*This is true in one sense, because we lose conscious awareness of the passage of time, but we all have **memory of dreams** which we **think** have occurred when we are asleep, but are we really asleep when we dream? Is the dream a memory of something we were thinking about in our unconscious mind, while our conscious mind was resting? And do we use this time when our **conscious mind is resting** to reprocess and reorganise thoughts, memories and experience in our unconscious mind?*

*It is fascinating how sometimes you can remain wide awake when **you want to sleep**, and at other times when you want to stay awake, when you watch a movie, or listen to music, or listen to someone talking to you, you find your eyes becoming so heavy and closing slowly no matter how hard you try to keep them open. Sometimes, it is as though you think you still have your eyes open, because you can still see things in your mind, and only a little later realise that you have started to dream and that what you see is internal, not external.*

Sometimes that ***dream can be so real*** *and so much part of what you were thinking that* ***you can't know*** *where the dream started and where reality ended. And how much of reality is incorporated into your dream? We can have c****onscious dreams****, where you seem to guide the direction of the dream in some way, and have an awareness of being "not asleep," but also an awareness of being "not awake." And* ***it's your perfect right*** *to let your mind* ***enjoy the dream*** *while your body* ***enjoys the rest****. The things you dream about are based on your experience of reality, even though it's sometimes a bizarre connection of different parts of your reality experience. Just as you can allow your thoughts to switch rapidly from one subject to another, so can your unconscious mind switch from one set of memories to another, and do so in such a way that you are not aware of the discontinuity between the facts, and you can* ***accept those connections*** *in such a way that they seem* ***perfectly normal*** *at the time. It is only on reviewing them later, with the logic of your conscious mind, that you realise that this could not be so and that it* ***must have been*** *a dream.*

Some dreams can be so real that you have to carefully analyse their content and compare it with the ***reality*** *that you* ***know to be true****, in order to be able to determine whether it was the* ***reality of a dream*** *or a* ***dream of reality****. We all know haw fallible memory can be, remembering something we think we have done but have not, and not remembering doing something which we have done. Now thinking about whether something is* ***real or imagined*** *can become very confusing, as we try to determine the difference between reality and memory* ***which can be confusing****. I don't know how you think about your memory, whether you can think about it with your conscious mind, while your unconscious mind analyses the veracity of the recalled events, or whether you determine the events' veracity while your unconscious mind works on the problem of memory.*

When ***you realise how fallible memory can be****, it can become difficult to know whether what you are aware of is really true, or whether it is a product of your* ***internal distortion of remembered events.*** *Knowing that something has happened then becomes a* ***subjective assessment*** *of the veracity of your memory and the way in which you actually experienced and recorded your awareness of what happened at the time.*

How do you know whether you have been asleep or not? It can be difficult to tell the difference between awake reflection or daydreaming, and the unconscious dreaming or true dreaming of sleep. How do you tell the difference between a ***memory of a dream*** *and a* ***dream of a memory****? Is it the feeling of reality associated with the* ***memory of the experience*** *or the remembered reality of the* ***feeling of the dream****? You* ***know you can sleep*** *and* ***you know you can dream****, and it is just when* ***this is going to happen*** *that is the thing you are interested in* ***right now****.*

I wonder whether you can accept that ***you can sleep*** *without realising you are asleep,* ***without remembering*** *that you have been asleep, and* ***without knowing*** *the reality of the sleep experience. You know* ***you can dream****, you know you can remember the experience of that dream, even if you don't remember the dream. You know you can* ***remember dreaming*** *without realising that you have been asleep, thinking that you have just been daydreaming or lost in your thoughts, and it is only after you remember the content of that dream that* ***you realise*** *that you have been asleep. If you* ***don't think*** *about this too hard, it is easy to get lost in the thoughts of being* ***asleep without knowing*** *that you have been asleep, of* ***dreaming without knowing*** *that you have been dreaming.*

You may ***be very curious*** *about how this new awareness will affect you in the future. I wonder whether* ***you will dream tonight****, but maybe that's far too soon for you to integrate this and* ***change your old patterns****, and it may be in three or four days from now, but it will certainly be* ***before this time next week****. And you might be very surprised to realise that you have had a dream, and that the dream could only have occurred when you were asleep. Perhaps after this you won't dream again for a few nights, and then have another dream about something quite different, maybe something related to the sleep difficulties* ***you used to have****, or maybe about something else quite different, but just as interesting.*

It can be very interesting to see what your unconscious mind presents for your enjoyment in the form of dreams. They often are not easily interpreted; the ancient Egyptians used dream interpreters, and this has continued down the ages in both primitive and modern societies, and you might want to discuss your dreams with me or someone else you trust to help you make sense of them.

But ***right now****, you can* ***know you can't not sleep****, and you can* ***trust your unconscious*** *to care for you while you review all those things you don't have time to think about when you are awake, and that* ***you will remember*** *those things when you wake, if they are important to you, but maybe you will be* ***aware*** *of the* ***lack*** *of memory of the sleep experience.*

And now you can hear all the things you want to hear here now, knowing that you can know many things ***without "no-ing"*** *them, and without having to be aware of knowing them, just knowing that they are there for your benefit in whatever you do and wherever you go, and come on back with a* ***comfortable feeling of something changed*** *within you, something new, something important, and* ***something you can look forward to*** *learning about over the days and weeks that follow.*

INFORMATION FOR AUTHORS

1. Contributions should conform to the style outlined in the *Publication Manual of the American Psychological Association* (5th ed., 2001), except that spelling should conform to the *Macquarie Dictionary.* Page references in the following notes are to the *Publication Manual.* The attention of authors is especially drawn to the organizational overview in the fifth edition (pp. xiii–xxviii).
2. Manuscripts (pp. 283–320), not usually to exceed 4500 words, should be typed clearly on quarto or A4 paper, double-spaced throughout and with margins of at least 4 cm on all four sides. Three copies are required. Duplicated or photocopied copies are acceptable if they closely resemble typed copies.
3. Title page (pp. 296–298) for the manuscript should show the title of the article, the name(s) and affiliation(s) of the authors, and a running head. The bottom of the page should also include the name and address (including postal code) of the person to whom proofs and reprint requests should be sent.
4. An abstract (p. 298) should follow the title page. The abstract of a report of an empirical study is 100-150 words; the abstract of a review or theoretical paper is 75-100 words.
5. Abbreviations (pp. 103–111) should be kept to a minimum.
6. Metric units (pp. 130–136) are used in accordance with the International System of Units (SI), with no full stops when abbreviated.
7. Tables (pp. 147–176) should be typed on separate sheets with rules (if any) in light pencil only. Please indicate approximate location in the text.
8. Figures (pp. 176–201) should be presented as glossy photographic prints or as black-ink drawings on Bristol board, similar white card, or good quality tracing paper. Diagrams and lettering must have a professional finish and be about twice the final size required. On the back of each figure there should appear in light pencil the name(s) of the author(s), the article title, the figure number and caption, without the front of the figure being defaced. Indicate approximate location in the text. The two copies of figures may be photocopies.
9. References (pp. 215–281) are given at the end of the text. All references cited in the text must appear in the reference list.
10. A copy of the MS must be kept by the author for proofreading purposes.
11. Send submissions by email to ashltd@optusnet.com.au

Electronic Copies

An electronic copy in pdf only will be emailed to authors.

Copyright

In view of the increasing complexities of copyright law, copyright of material published in the *Australian Journal of Clinical and Experimental Hypnosis* rests with the Australian Society of Hypnosis Limited. Authors are at liberty to publish their own papers in books of which they are the author or the editor, and may reproduce their papers for their own use.

ISSN 0156-0417