The Ericksonian Approach to Hypnotic Phenomena

Disclaimer:
"Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of mental health professionals. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice in accordance with and in compliance with your professional standards."

With great appreciation

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Demonstration

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What are hypnotic phenomena?

- Any response to a hypnotic scenario that does not seem to be the product of conscious intention (e.g., automaticity), or one that occurs in opposition to conscious intention (e.g., immobilization), or one that somehow alters the reality orientation on which conscious intentions are based (e.g., age progression). However…
- All hypnotic phenomena occur in ordinary, daily life but without being incorporated into goal-oriented activity (e.g., suddenly not remembering a name, or driving w/o thought). Hypnotic procedure merely activates ordinary behavior within a novel perceptual context.
- These phenomena are also necessary for any symptom complex: I didn't intent to do it, I can't stop it, or how can this be real.

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Why use Hypnotic Phenomena?

- To ratify the legitimacy of the hypnotic procedure, thus increasing positive expectancy effects associated with therapy outcomes.
- To produce a type of virtual reality in which any action or experience can be tested without any risk of real-world consequences.
- To transform liabilities into assets that can be utilized during lifelong problem solving. *"You have a unique gift!"* *

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Phenomenology versus Objective Reality

- Bernheim (1887): hypnotic blindness was successfully induced, the subject could not see people or objects in the room, however, she carefully walked around a lantern that would've set her dress on fire
- Bernheim (1887): with hypnotic deafness the subject cannot hear anything that is spoken, until you tell him to recover his hearing
- Steven Jay Lynn (1997): it is not that individuals lose control of their movements but rather they experience the movements as being non-volitional. Anything that can be done during trance can also be done outside of trance
  (Braid, Janet, Hull, Erickson, Hilgard, Weitzenhoffer, etc.)
- The subject is told a heavy box is filled with bricks, so he is unable to lift it. Then he is told that it is empty, so he lifts the box effortlessly. There is no change in physical ability. It is the perception of ability that is altered.

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Phenomenology of Consciousness Inventory Hypnotic Assessment Procedure

Pekala, 1995

Subjective Experience	Regression Coefficient
Altered Experience	+ .35
Altered State	+ .31
Volitional Control	- .28
Self-Awareness	- .27
Rationality	+ .23
Absorption	+ .19
Memory	- .14
Altered Time Sense	+ .13
Internal Dialogue	- .11
Altered Body Image	- .07

What this means:
Most clients will feel that their reality experience has been somehow altered. Their state of consciousness is likely to feel different.

Fewer clients experience changes in memory, time tracking, self-talk, or body image. Sensory input is least likely to change.

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Research Implications: Use an Incremental Approach

(Capitalize on the Domino Effect)

The 4 Step-Model

1. Offer a virtual boundary that somehow alters experience
2. Suggest nonvolitional behavioral compliance
3. Request a commitment to a change in rationality
4. Suggest changes in perceptual experience

Common Example

1. "Just look at that clock, without speaking or moving."
2. "Your eyes can close automatically, and your head can nod by itself, when you are in a trance."
3. "And you do not know what you will do next, do you? … But you can be certain that something good will happen."
4. "And you can now see yourself walking to some place special…"

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What makes hypnotherapy different from other Phenomenological Therapies?

- Expanding the Phenomenology of Consciousness: Strategic vs. passive changes in subjective reality (usually across 3 general domains)
- Non-Volitional Action (Kinesthetic Domain)
  - Automaticity – Low Muscle Tonus (feels stronger)
  - Immobilization – High Muscle Tonus (feels weaker or paralyzed)
- Altered-Awareness (Sensory Domain)
  - Absorption – Hyper-sensation – Replacement – Synesthesia
  - Dissociation – Hypo-sensation – Disembodiment
- Altered-Referencing (Orientation Domain)
  - Reorientation – Changes to Time/Place/Person/Memory (High Imaginative Involvement)
  - Disorientation – Confusion – Memory Loss – Catatonia (Loss of Rationality)

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Kinesthetic Domain

Phenomenology	Traditional phenomena	Common therapeutic application
Automaticity (+)	automatic movement* (eye lids) arm/hand/leg levitation	Establish a virtual boundary (e.g., X will happen when your hand reaches your nose)
	automatic writing ideomotor signaling (fingers, head) Chevreul's pendulum	Communication with the unconscious mind
	posthypnotic suggestion* time framing (when it will happen)	Suggesting how and when something will occur—without conscious effort (outside the office)
Immobilization (-)	catalepsy arm/leg immobilization*	Begin a process of pattern interruption or therapeutic inhibition
	profound relaxation thought slowing	Stress reduction, anxiety relief, or sleep aid

** Items that appear on the Stanford Hypnotic Susceptibly Scales*

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Sensory Domain

Phenomenology	Traditional phenomena	Common therapeutic application
Absorption (+)	hypnotic dreaming* mystical encounters magic screen/crystal gazing /shell listening	Facilitate insight and creative problem solving (e.g., visiting the afterworld).
	revivification	Reexperience the sensations of a lost ability.
	positive hallucination (auditory, visual*, tactile, olfactory, gustatory, kinesthetic)	Increase imaginative involvement and/or top-down processing.
Dissociation (-)	dissociation (somatic or mental)	Increased tolerance for unpleasant events
	negative hallucinations (e.g., hypnotic deafness or blindness)	Reduce sensory stimuli in order to prevent emotional flooding or problems with distraction.
	analgesia or anesthesia	Pain control.
	sensory replacement (e.g., pain to warmth)	Eliminate or replace undesirable sensations.
	synesthesia (e.g., tasting a sight)	

** Items that appear on the Stanford Hypnotic Susceptibly Scales*

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Orientation Domain

Phenomenology	Traditional phenomena	Common therapeutic application
Reorientation (+)	age regression*	Recover forgotten memories, skills, or decisions
	age progression pseudo-orientation in time	Access knowledge of future behavior or test the emotional consequences of future behavior
	memory modification (new mem.) trance identification (new identity)	Alter the emotional value of past events or take on the identity of someone else to overcome inhibition(s), mental blocks, or gain perspective
	time distortion (expansion)	Alter the perception of time to accentuate positive experiences
Disorientation (-)	time distortion (contraction)	Alter the perception of time to diminish negative events
	depersonalization	Decrease emotional connection to self or others by removing the sense of self (for grueling work)
	posthypnotic amnesia*	Decreasing conscious involvement in subconscious process work or posthypnotic suggestions

** Items that appear on the Stanford Hypnotic Susceptibly Scales*

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Assessing Hypnotic Capabilities

- Rather than force a hypnotic phenomena, Erickson cultivated responses that came naturally. Similar to modern animal training.
- Fortunately, clinical objectives, such as pain relief, can be achieved using a wide variety of hypnotic phenomena.
- It is not necessary to administer special tests of hypnotic susceptibility, rather there are small tells that occur during casual conversation, which point to larger skill sets or specific hypnotic capabilities.

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Micro-Expressions as Tells

- A teen is shaking & crying, hardly able to speak of how overwhelmed he is with school. I ask if puppy dogs are relaxing to him. His left hand moves slightly as he nods. When given a rolled blanket to pet, he goes into a somnambulistic trance.
- A traumatized teen who cannot tell anyone what happened to him goes into deep trance but will not answer any questions. I see his pointer finger and thumb move together. So I place a pencil in his hand and he writes the name of the sexual predator (his youth minister).
- A woman looks to the corner of the room as I speak, so I have her hallucinate her future and watch herself make important adjustments.
- I move my foot and the client moves his foot. So I levitate my hand into the air, and the patient's hand automatically levitates into air—without trance.

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Hypnosis without Induction

- When you solicit responses that fit preexistent skill sets, hypnotic training, modeling, or inductions are unnecessary.
- Four major classes of ready hypnotic capability
  - Fantasy prone individuals (Positive Experiencing)
  - Forgetters/Not-noticing (Negative Experiencing)
  - Highly compliant (Kinesthetic Domain) * (e.g., Chevreul's pendulum)
  - Highly defiant (Kinesthetic Domain) * (e.g., "keep your eyes wide awake")
- These predispositions are not mutually exclusive. They represent skill sets that help ensure success when first attempting hypnosis.
- Modeled after T.X. Barber's theory (2000) based on high hypnotizables, Erickson's clinical casework, and personal experience.

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Fantasy Prone Individuals

Automaticity * Absorption * Reorientation

- Highly creative
- Rich fantasy life, with spontaneous sensory experience
- Might have seen angels, ghosts, energy auras, or supernatural events
- Vivid memories, even from a very young age (e.g., birth)
- Emotionally animated
- Highly empathetic
- Mental states are expressed somatically (e.g., blushing)

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Forgetters/Not-noticing

Immobilization * Absorption * Reorientation

- Psychologically isolated, may have a hx of abuse
- Do not have a full and rich autobiographical memory
- Difficulty remembering appointments, paperwork, or directions
- Easily confused: fail to hear instructions or lose their line of thought while speaking
- Reduced body awareness, clumsy, ill-fitting clothing, messy hair
- Emotionally flat

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Highly Compliant Individuals

Kinesthetic Domain

- Questioning: *"Where should I sit?" "What should I tell you?" "How should I handle this?"*
- Extremely polite, pausing to allow you to interrupt, deferring their needs
- Automatically imitate your motor movements (e.g., their gaze follows where you look or where you gesture)
- Will change their subjective terminology to match yours
- Very responsive to authority figures (cooperative)

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Highly Defiant Individuals

Kinesthetic Domain

- Argumentative, quick to disagree, willing to challenge you
- Not really interested in your advice
- May test you, or make small boundary violations (e.g., taking your chair or arriving slightly late)
- Prone to interrupt, with impunity
- Doubt that they can be hypnotized, afterwards, likely to insist that they were never in a trance
- Very responsive to authority figures (rebellious) *

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Hypnotic Phenomena that Occur the Most are Least Likely to be Recognized

- For maximum success, always aim to use those hypnotic phenomena in which the client is most proficient.
- Begin with paradoxical recreations of the symptom, then utilize the phenomena in more elaborate, productive ways (Wolinsky, 1991)

Anorexia = Positive hallucination (they see fat where none exist)
Top expert on anorexia does not know that is wife is anorexic = Negative hallucination
Parent dependency on a child = Age regression
Child knows the parent will never let her have her own life = Age progression
Serial domestic violence victim = Hypnotic dreaming or Trance identification
Sexual dysfunction = Sensory distortion or dissociation

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How to Achieve 100% Success Rates

1. Only attempt the strategic use of hypnotic phenomena with those who have provided consent
2. Solicit responses that are natural and readily available to a given individual
3. If the client is having trouble, tell him/her to just pretend that the phenomena is occurring, or do it in a way that works best for him/her.

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Mitigating the risk of psychotherapeutic methodologies

It should be noted that approximately 10% of the treatment population report mental deterioration following participation in psychotherapy (Boisvert & Faust, 2003). This problem can be addressed by adhering to the following principles:

- Use a formal, written survey at the end of each session to assess therapy effects and the status of the therapeutic alliance (Miller, et al., 2005) or (SAS-B, available at www.iamdrshort.com/sas.htm).
- Never force knowledge, theories, ideas, or memories onto the client. Give a privileged status to the client's own self-knowledge and estimation of what he/she is ready to discuss or explore.
- Provide a context in which the client can inform you of his/her psychological limitations and then respect those boundaries (e.g., treatment contract).
- If there are painful memories that the client wishes to modify, make certain to obtain informed consent, seek to modify emotional reactions or problematic images associated with the event, while leaving the factual nature of the storyline intact. Never suggest the existence of a negative event that the client has not already identified as factual.
- Avoid any technique or procedure in which the client might feel trapped, threatened, verbally condemned, belittled, violated, emotionally injured, controlled, shamed or humiliated. The use of therapeutic directives, ordeals or psychological shock can result in mental deterioration or death if it violates any of these principles.

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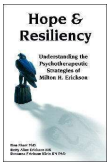

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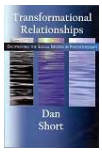

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