Hypnosis is nothing if not confounding. Experts strongly disagree about what it is (an altered state? focused relaxation? a set of procedures?); researchers and clinicians differ dramatically in how they induce it; and whereas clinicians are able to employ it to hasten clients’ physical healing and bring them significant relief from pain, depression, and anxiety, stage hypnotists are equally adept at exploiting both it and their audience for the sake of cheap and easy laughs. Not surprising, then, that even the word itself is misleading. Coined by James Braid in the 1840s, hypnosis comes from the Greek hupnos, sleep, but brainwave research confirms that people experiencing the phenomenon are decidedly not dozing. Add to this the assumption of many family therapists that a tool for working intra-personally is likely to have limited relevance for professionals who more commonly attend to what’s going on inter-personally, and you’d be justified in wondering how the editors of this magazine got the idea to devote a whole issue to the topic.
A relational understanding of the quirky logic of hypnosis is key to grasping how minds and bodies think and communicate.

But despite the confusion and controversy surrounding it, hypnosis does in fact have much to offer—even to family therapists. In the same way that we are in systems ideas, family therapists are uniquely prepared to make sense of hypnosis in the relational way I’ll be developing here. Indeed, a relational understanding of the quirky logic of hypnosis is key to grasping how minds and bodies think and communicate, and so discovering how you can most effectively invite therapeutic change, whether you’re working with an individual, couple, or family. Even if you don’t decide to get the necessary training to add formal hypnosis to your practice, you can apply its logic to everything you do as a therapist. To help explain and illustrate this logic, I’ll walk you through a case, pausing now and again to elaborate the ideas.

I recently saw “Denise” and her husband “Stuart” for five sessions (over six weeks). In their mid-twenties, smart and happily married, they were both college graduates, thinking about going back to school, but needing to first work for a living. Except that Denise couldn’t. She’d lost a job six months earlier due to stomach problems, anxiety, and depression had started a few years earlier, after she and Stuart had endured a string of medical problems and surgeries. It was at the tail end of these difficulties that the anxiety and stomach problems had cropped up. All in all, Denise had consulted five gastro-intestinal doctors, and the consensus was that she was suffering from Irritable Bowel Syndrome (IBS), a condition that is exacerbated by emotional distress. Before all the medical involvement, she had led an active and normal life, able to eat whatever she wanted and to engage in any and all activities that interested her.

A psychiatrist had prescribed antidepressant and anti-anxiety medications for the sadness and hopelessness she felt about not being able to live her life in the normal way she had prior to getting swallowed up by her symptoms. The therapist who referred her to me had helped her better deal with her predicament, and Stuart provided her the reassurance and support she wanted and needed to engage in any and all activities that interested her.

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If you were referred this case and you didn’t practice hypnosis, you could try intervening by interrupting the interactional patterns encompassing the symptoms (Fisch, Weakland, & Segal, 1982); explore, perhaps via externalization, the effects of the problem on the person (and others) and the effects that the person (and others) might have on the problem (White & Epston, 1998); investigate differentiation of self and multi-generational anxiety transmission, a la Bowen (Kerr & Bowen, 1988); borrow some CBT {Cognitive Behavior Therapy} spectacles and challenge “irrational beliefs” (Ledley, Marx, & Heimberg, 2005); go in search of exceptions to panic attacks and stomachaches (de Shazer, 1988); or teach, say, progressive relaxation techniques (Bernstein, Borkovec, & Halet-Stevens, 2000). But all such methods would keep you one step removed from the physical symptoms themselves, and several would pit you and the client in opposition to the symptoms, doing your level best to help Denise better control them or, seemingly better yet, rout them from her body.

Hypnosis, at least those varieties grounded in Milton Erickson’s notions of utilization (Erickson, 1980; Zeig, 1994), is unique in that it orients you and your clients alongside, rather than vis-à-vis, their symptoms, allowing you to discover together, in the moment, how this particular sensory-based chunk of experience right here, and/or that one right there—whether a painful or fearful sensation, an overwhelming emotion, a compelling desire, an automatic reaction, or a distressing image or thought—can begin, little by little, to shift, to change, to transform, no doubt in some unpredictably interesting way. This sort of work becomes possible because of the special nature of the relationships that develop in hypnosis between therapist and client, and between the client and his or her experience. The hallmark of hypnosis is a shift in the boundaries that normally divide self from other (i.e., client from therapist) and divide consciousness (the perceived source of awareness and willpower) from the rest of the self.

Conscious Awareness versus Hypnosis

For you to perceive and/or think about something—the smell of a bakery as you’re walking along a city street, the crosswalk signal up ahead, the glitch in your back, a friend’s voice calling out to you, a snatch of a memory—you need to be able to distinguish whatever the something is from whatever it is not. As Batson (2000) explained, mind is composed of differences, of relationships. This means that we never actually perceive things per se; rather, we perceive things as they are in relationship to whatever it is from whatever it is not.
perceive boundaries, edges, changes—the relationships between things. As you walk along, you isolate the aroma of baking bread from the exhaust fumes of passing vehicles; you foreground the crosswalk signal against the background of the sky; your back glitch can be felt right there but not further up, down, or to the side; you identify the timbre and lil of your friend’s voice through the cacophony of ambient city sounds; and when a memory suddenly presents itself, it crowds out most of your awareness of your physical environment. In each case, something becomes the object of your perceiving, of thinking about the fact that we are thinking. And just as we use the perception of difference to discern a world of objects, we construct our conscious awareness itself as an object, as a something—a mini “self,” separate, certainly, from the world “out there,” but also from our own non-volitional experience. This mini-self, this “observing-i” (Flemons, 2002), assumes that it is the independent source of our will and our choice making. Awareness of being aware, it experiences itself as separate not only from everything “out there,” but also from the rest of the self. From this removed position, the observing-i is drawn to judging, interpreting, drawing conclusions from events, sensations, emotions, behaviors, situations, thoughts—that hurts, scares, or repulses it. In so doing, it continually entrenches not only the existential split between self and other, but also the Cartesian split between the observing-i and the observed-me, that is, as mentioned earlier, between conscious awareness and the rest of the self (including the body and its attendant sensations, of course, but also uncontrollable thoughts, images, emotions, dreams, and behaviors).

Hypnosis, like meditation, is a means of bridging this-i-me split (Flemons, 2004), a means of undividing the divide dividing us from ourselves. During hypnosis or meditation (or any other fully engaging flow activity, such as sports, music, or sex), our observing-i stops calling the shots from a localized and removed place (Flemons, 2007). Our mind feels embodied and our body mindful, capable of initiating and maintaining action that feels systemically coordinated rather than willfully controlled. This phenomenon is best understood as an instance of indifferentiation.

Indifferentiation, Hypnosis, and Hypnotherapy

Have you ever been to California Pizza Kitchen? My kids love it, so we wind up there fairly often, and when we go, my wife, Shelley, typically orders their signature “two in a bowl”—two different soups served side by side in the same bowl. The first time our waiter brought the dish to our table, I was struck by the surprisingly clean line distinguishing one kind of soup from the other, so I asked him how they pull off such a culinary feat. He explained that as long as the chef ladles the two soups simultaneously into opposite sides of the bowl, the line that forms is invariably quite straight.

The most interesting thing about the line of demarcation is that it doesn’t actually exist, at least not as a stand-alone entity. We “see” a boundary between the two sides, but only by virtue of the differences between them. Absent these distinguishing features (in this instance, color and texture), the boundary, the line, would disappear.

With this thought in mind, I made a return visit to the restaurant, family in tow. I informed the waiter that I wanted to conduct a perceptual experiment and thus needed to make a request that he would likely consider to be rather strange. He cocked his head, expectantly. I told him that I wished to order the “two in a bowl” menu item, but I wanted the chef to pour the same soup from each of his two ladles. He raised his eyebrows, much like my kids do when they think I’m acting hoopy, so I reassured him that I was serious and, indeed, happy to pay the additional cost normally associated with ordering two different soups. But, I underscored, I wanted to be sure that the chef didn’t cut corners and just fill the bowl with one ladle. Could he make sure that I received my order as specified?

When the waiter brought my soup to the table, he announced that not one but two eye witnesses had been present to confirm that the chef followed my request to the letter. The gravity with which he issued this statement indicated either a missing sense of humor or a sophisticated deadpan, I wasn’t sure which; nevertheless, his delivery contributed to my accepting the credibility of his claim. I thanked him for his efforts and then challenged my family to locate the line separating the two ladled sides. They couldn’t find it, and nor could I, because our eyes could find no difference between them. Despite there being two different ladles of soup in my bowl, the boundary between them was indifferentiated and thus imperceptible.

For hypnosis to develop, an analogous (albeit more complex) process of indifferentiation needs to unfold, over the time of the trance, in the relationship between the therapist and client, as well as in the relationship between the client’s observing-i and his or her observed-me. And then for hypnotherapeutic change to be possible, this latter indifferentiation needs to extend to include the relationship between the client’s observing-i and his or her problem. In each case, the perceived differences between the two sides of a boundary (self/other, conscious awareness/rest of the self, or conscious awareness/symptom) become indifferent enough for the boundary to fade in significance and the distinct identities of each side to begin transforming in interesting and spontaneous ways.
When clients are experiencing the embodied knowing of trance and their attention finds its way to their problem, they find themselves able to encounter rather than counter it.

Denise, as you sit in here, next to Stuart, the traffic, whether you bother to notice it or not, will continue to flow out there, and whether your eyelids continue to close only when they . . . blink, or they find themselves closing for a . . . blink and then not bothering to open for awhile, the light in the room will remain pretty much constant, like the sound of the air coming . . . out . . . of the register. Let it interest you how something that’s constant—whether it’s a . . . sound, or . . . a sensation, such as the feel of the couch . . . supporting your back—tends in . . . fade . . . into the background after awhile? Like pictures on a wall . . . always there, so familiar that you find yourself not really . . . noticing them. So curious that what’s so constant . . . can so easily change, drifting out . . . of awareness . . . and back into it. The light . . . so constant, can . . . shift, . . . just as a thought—about what’s happening, right now, perhaps, or just some . . . random curiosity . . . rising to the surface of awareness, like a splash of color . . . making a refreshing appearance—a thought can come . . . and go . . . and sounds—the ringing of Stuart’s cell phone, the siren . . . can so easily change, drifting out . . . of awareness. . . . just as a thought—about what’s happening, . . . can so easily change, drifting out . . . of awareness. . . . just as a thought—about what’s happening, . . . can so easily change, drifting out . . . of awareness.

When your words coincide—in both content and timing—with your clients’ experience, you facilitate the further indifferentiation of the difference between what you’re saying and what they’re noticing. In the process, you and they become “of one mind” (Flemons, 2002), which is the necessary precondition for the next step in the hypnotic process.

**Observing-i and Observed-me**

In the midst of the swirl of disagreements throughout the field about what hypnosis is, most theorists agree that the movement into hypnotic experience is marked by the appearance of non-volitional responses to the therapist’s suggestions. That is, clients notice changes happening, changes that they themselves are not purposely initiating or carrying out. As they become more and more immersed in the process, possible distinctions—unexpected or loud noises in or out of the office, uncomfortable sensations, random thoughts—typically fade into the background as they become aware that their arms and maybe their legs have started feeling altogether too comfortable or heavy to move; their eyes often get the notion that it would feel better if they were to just close; their hands may become comfortably numb; their breathing and pulse will typically slow down; various muscles throughout their body often discover themselves twitching; the therapist’s voice may seem to fade in and out; if their eyes have closed, colors and/or images will probably appear more striking than usual; they may feel like they’re floating in space and/or in time, and they may be able to see something that isn’t actually there (a positive hallucination) or not see something that is (a negative hallucination).

That clients are able to experience such non-volitional shifts makes sense when you remember that inviting them into trance is a process of indifferentiating the difference not only between you and them, but also between their observing-i and their observed-me. With their conscious awareness no longer functioning to distinguish itself as an isolated entity, separate from the rest of their experience, there is, for the time they are engaged in the hypnotic, no removed mini-self looking on with detached scrutiny and taking credit for the changes that are unfolding. It thus feels to them that the changes are happening on their own.

When clients are experiencing the embodied knowing of trance and their attention finds its way to their problem, they find themselves able to encounter rather than counter it. This shift in orientation indifferentiates the boundary that has been defining and thus determining the nature and expression of the symptom, and when this happens, changes can be invited and elaborated. Partway into our second session, having invited Denise into trance and with Stuart continuing to sit beside her, I asked her to tell me what she was noticing in her body. She said that she could feel some fluttering in her upper abdomen, a sensation that often presaged the impending development of more severe stomach distress.

Anxiety heightens the everyday dissonant nature of conscious awareness. The observing-i recalls from frightening sensations and thoughts, doing its level best to control or exorcise them. But this invariably exacerbates the situation. Hypnosis is an ideal treatment, because it reverses the logic of the failed attempted solution (Fisch, Weakland, & Segal, 1982). Rather than seeking relief by engineering a successful separation from the symptom, it facilitates connecting to it (Flemons, 2002), indifferentiating the difference between the observing-i and the problem and thus creating the conditions for the symptom to begin transforming non-volitionally.

I asked Denise to follow the fluttering and notice any changes that might occur, perhaps a change in the location (after all, I said, butterflies are able to flutter about, able to go higher or higher and explore new territory) or some other subtle shift in the sensation itself—perhaps in its intensity or in the quality of the feeling. I continued on in this manner for a few minutes, and when I checked in with her again, Denise said...
Denise became appropriately angry, holding her own with confidence and strength. And on two or three occasions—once when their dog got sick and another when she and Stuart were late for a dinner with her parents—she surprised herself by being able to let her guard remain calm. She'd had no panic attacks, but she had experienced some cramping and subsequent diarrhea after eating something she wouldn't have expected to cause a problem. 

Noting that Denise’s body seemed to be doing an excellent job of automatically differentiating times when it was appropriate to be anxious from those when it was appropriate to be upset, I asked her if she was able yet to tell the difference between regular “freaked out,” it hadn’t turned into a continuous state of affairs during the week. “trusting her gut” and that she and Stuart were able to recognize unique, but she couldn’t keep a problem in check typically make matters worse. Therapeutic change will always be facilitated by making cognitive-behavioral therapy work: Clinical process for new practitioners. Copyright © 2007 by Ledley, R., Marx, B. P., & Heimberg, R. G. New York: Norton.

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Denise's anxiety would get hold onto the ability to feel the tingle of anticipation.

At the fourth session, Denise and Stuart noted a continued improvement in Denise’s anxiety. They'd had another couple of fights, during which, they happily reported, Denise was again able to feel angry, rather than anxious, and she'd stayed calm upon hearing disturbing news about a relative’s health. However, her stomach had been a mess, and, in fact, it was hurting now in the session. Her sensations were的经验的, menstrual cramps were recognizably unique, but she couldn't the lightness of it could shed its light on the lightness of it could shed its light in any number of ways. I commented that the lightness that could shed in light all through her and then ended both the hypnosis and the session with a suggestion that Denise experiment in trusting her gut and that she and Stuart both notice and communicate differences in the usual state of affairs during the week.

At the beginning of the third session, the couple described getting into a fight a day or two after our previous appointment. In the past when they would argue, Denise’s anxiety would get hold onto the ability to feel the tingle of anticipation.

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References


