A State of Trance: Integrating Counselling and Hypnotherapy – a new model

With ever greater pressure to deliver positive outcomes **Mike Bryant** proposes a model which aims at accelerating therapeutic progress by integrating two approaches – with no extra training required.

Hypnotherapy uses the therapeutic induction of altered states of consciousness, usually referred to as trance states, to enable the client to unconsciously generate spontaneous new behaviours and more constructive core beliefs. Most hypnotherapists understand that other clinicians apply these practices, but often unintentionally. Notable exceptions might be Gestalt techniques such as "empty chair" work or psychodrama.

The proposed model is based on an original, evolving working method by the author, currently a Staff Counsellor at Goldsmiths (1). Goldsmiths is one of an increasing number of University Counselling Services that offers hypnotherapy as part of the support services to staff and students. The Staff Counsellor role involves providing counselling to academic and support staff as well as to visiting tutors and PhD students. Additionally, undergraduate students are referred by the Service's counsellors for specific work involving hypnotherapy as an adjunct to counselling. The model assumes that by understanding key specific concepts a counsellor with no specific hypnotherapy training can offer the probability of rapid change and facilitate achievement of client goals, particularly useful when working within in a time-limited, solution –focused context.

Integrated Model:

Common negative assumptions involve beliefs such as "quick fixes do not lead to permanent solutions" or "hypnotherapy leads to symptom displacement". These two key prejudices were my own misconceptions prior to training as a hypnotherapist.

Our words have more influence than we realise or may be willing to admit. As counsellors we make suggestions but do not always acknowledge our subliminal influence due to professionally ingrained prejudices. Those from a theoretical training which emphasise a client-centred or "clean hands" approach may be particularly blind to our level of unconscious influence on clients and more importantly, how we influence them after having unwittingly led them into an altered stated of consciousness.

Consequently, it is essential to be aware of the conscious and unconscious clinical suggestions and interpretations we make and more importantly, to acknowledge how we may blind ourselves to our influence due to biases against hypnotherapy. Awareness can facilitate an integration of hypnotherapy techniques as another tool in our clinical repertoire to serve the client.

Freudian origins of anti-hypnosis beliefs

When Freud denounced his own hypnotherapy practice, he directly contributed to negative assumptions and inaccurate beliefs about the efficacy of hypnotherapy which continue to exist today. How did he come to this decision? Earlier in his career, in 1885 Freud had keenly studied under the French neurologist Jean-Martin Charcot, who pioneered

hypnotherapeutic approaches working with “hysteric” patients - an outmoded term for neurotic disorders. Charcot’s work transformed the image of hypnosis – previously tarnished by disreputable “performer” hypnotists - into an acceptable approach amongst French medical professionals.

Freud took his learnings to Vienna where he applied hypnosis to help his patients recall forgotten, disturbing memories. However, his success was inconsistent, perhaps due to his clinical technique, as the concept of establishing a collaborative therapeutic alliance was unknown to Victorian psychiatrists. Freud eventually abandoned explicit hypnotherapy practices but unwittingly developed a similar, more covert hypnotherapeutic approach - free association. [1] At the end of his career, Freud admitted his own shortcomings in his abandonment of hypnotherapy.

Developing an integrated model

Hypnotherapists tend to be more familiar with the counselling format than vice versa. To discuss an integrated model it may be useful:

a) to compare and contrast session formats and to describe some key hypnotherapy approaches that counsellors can incorporate .

Keep in mind that like counselling, hypnotherapy has a range of theoretical influences, from cognitive-behavioural to analytical and psychodynamic approaches.

<u>Hypnotherapy session format:</u>

Like counselling, a typical hypnotherapy session begins with case history taking. Learning about the client’s background helps to establish a therapeutic relationship as well providing information useful for treatment.

(Ironically, Milton Erickson (2), a key figure in the resurgence of hypnotherapy in the 20th century, demonstrated successful treatment in several cases where he bypassed taking a case history through the use of hypnotic metaphor and storytelling. He would simply follow the client’s conversational interest and use whatever material the client presented as a metaphor for hypnotic suggestions of change. In one case study, a client refused to pay him, despite successful resolution of her presenting problem, as she felt they had never done any therapy!)

Hypnotherapists tend to use initial sessions to demystify the treatment process, reducing client apprehensions which are often based on stage hypnosis and other misleading influences. Despite some negative coverage of counselling in the media, there are arguably more positive and accepting images of counselling than of hypnotherapy. It follows that counsellors are less likely to spend time addressing negative, media-influenced attitudes when first meeting a client, while hypnotherapists usually have work to do in this area.

The trance state is frequently explained in the first session. Trance may be defined as a split between the conscious and the unconscious mind, whereupon a heightened state of

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[1] Source: http://www.hypnosis.org/hypnosis/history.php

suggestion is available which allows the client to explore new possibilities, including behaviour and thinking that would lead to a change or even a solution to their problem. Although the trance state is unlikely to be mentioned or even acknowledged by counsellors and psychotherapists, the irony is that they readily invoke trance through routine questions such as: "tell me about your childhood" or "how did you feel about last week's session?"

A more conscious awareness of the use and observation of a client's state of awareness is the first step in developing an integrated hypnotherapy/counselling model. Hypnotherapy students are trained to observe subtle changes in states of consciousness by observing the alterations in breathing and muscle tone (facial and overall body tension), as well as differences in speech rates. Trance is indicated by the client appearing to become relaxed (or eye-fixated) - a sign that unconscious functioning is becoming dominant and conscious control lessening, inhibiting (self) consciously-driven responses. An understanding of this process was at the heart of Freud's free association technique.

Another distinction which holds true in many cases, relates to the mind-body connection and what can be offered to clients whose difficulties have roots in this area. Hypnotherapists are trained to view the connection between the emotional and physical as unified and therefore, most matters relating to the central nervous system are typically listed as possible to treat. For an excellent source of the range of topics that can be effectively worked with in hypnotherapy see: "The Handbook of Hypnotic Suggestions and Metaphors (3). The information is compiled from members of the American Society of Clinical Hypnosis who offer their own wordings (aka "scripts") for how they might apply different therapeutic interventions.

Idea springboards:

Hypnosis scripts are offered as idea springboards and could easily be incorporated by counsellors. They do not need to be repeated verbatim; it is the concepts of trance and the power of suggestion that are key - and fundamental.

The range of treatable topics is broad (3) and includes: pain management, preparation for surgery, enhancing self-esteem, anxiety, phobias, dental disorders, working with cancer patients, medical disorders, including skin diseases, obstetrics gynecology, emotional and psychiatric disorders, sexual dysfunctions, eating disorders, addictions and habit disorders, concentration, performance-related (academic, athletic, artistic), hypnotherapy for children and time reorientation (regression, progression and time distortion).

Although such a list would be met with incredulity by many therapeutic practitioners, the basic concept is that there is a connection between the mind and body and that reducing anxiety can have a direct impact on lessening many physical problems or at least those that are in some connected to the central nervous system.

Establishing the right conditions

Both hypnotherapy and counselling involve helping the client achieve personal goals by identifying the obstacles the client may have unconsciously established through defence mechanisms or unhelpful thoughts. By establishing the conditions to work directly with the unconscious, this process of change can be accelerated.

Counsellors frequently invoke trance states and offer hypnotherapeutic suggestions but are unaware of doing so: as a clinical supervisor, I see instances of this on a regular basis. It is imperative for clinicians to realise how these states are invoked and in particular, how to ensure that sessions are not terminated with clients being sent away in trance state. This is especially important if a session has involved discussion of traumatic experiences.

Working directly with the unconscious:

When working with the proposed model you will be introducing concepts from the body of hypnotherapy literature. This does not imply the need for hypnotherapy training, but rather an awareness of the way that the therapeutic environment is "set up" to establish direct work with the unconscious for rapid change.

Four key elements to establish to work with the unconscious include:

a) **Information giving**: The initial work is about both demystifying the unconscious mind's ability to generate new behaviours through trance, and bypassing conscious thought. This is a key function of hypnotherapy. Trance work allows a dissociating or "split" between the conscious (logical part of the mind that uses words) and unconscious (the abstract part of the mind that uses feelings and intuition). Examples of everyday trance are daydreaming, focused attention on reading or watching TV or fantasising. Understanding this assuages any fears the client may have about becoming relaxed and is a crucial aspect of relationship building necessary before direct work with the unconscious can effectively take place.

b) **Agreeing realistic goals for therapeutic outcomes**. Importantly, the client must be committed to and actively involved in the trance work, rather than looking for a magical solution or adopting a "prove it" attitude.

c) **Use of metaphor and storytelling as trance induction.** The case studies of Milton Erickson are particularly useful. Following the client's own material and interests are the subject matter of the metaphors (3).

d) **Eliciting the client's ability to view life without the problem** (a.k.a., "The Magic Wand Question"). When directly asked, "If you had a magic wand and no longer required therapy, how would you *feel* if the problem were gone?" it is fascinating to see if a client can describe the feeling of the resolution of the problem from an *emotional* basis. Many retreat into a re-description of the problem, indicating the need for a certain amount of work in helping them to envisage life without the problem, their newly developed behaviours and more positive beliefs they have replaced the problem with.

Eight key concepts:

1) Demonstrating that everyone can visualise: Since visualisation is key to trance work, clients can be empowered with feeling that they can use visualisation as a therapeutic tool. Those who say that they "are not visual" simply could be asked, "What colour is your front door?" They will invariably answer, providing the client with proof of a simple example to the contrary.

2) Inner Critic and Parts Therapy Work: This involves working with the Inner Critic as a destructive part into which we can incorporate concepts derived from Ego State Therapy (4). This suggests that parts of our personality cause us to act in particular ways in certain situations and if unhelpful, can be modified. As early as the initial session the therapist enquires into the client's key critical themes that "loop around" in their mind, such as "I am unloveable", "I deserve to be punished" or "I am powerless". The goal is to first observe the Inner Critic and then gradually mutate it into a supportive voice.

Inner Critic Work consists of:

a) the client getting to know their own Inner Critic: by suggesting that the client both visualise their Inner Critic and begin to "listen" to its negative messages. The therapist should suggest that a destructive part exists within to be labelled the "Inner Critic". A discussion should ensue asking the client to give this critic an image – a creature, a known or unknown person or even an abstract shape. The image should be allowed to change when needed, thereby initiating an internal dialogue with this part.

b) Identifying Inner Critical Themes and Variations. One theme might be, for example, "I am powerless." Its variations could include "I will never get the promotion", "Everyone laughs at me", "Mary will make me look stupid", etc.. The work in the initial stages is not to halt the critical thoughts, but simply to categorise them and observe their variations. These themes and variations are discussed immediately after the client describes an incident involving self-condemnation. The therapist helps the client to identify the Inner Critical Message as if the Inner Critic is an entity bent on its destruction that must be countered. This eventually becomes an automatic, unconscious process for the client. The client begins to anticipate their own negative thoughts. Suggestions can be made that these critical thoughts become decreasingly painful and increasingly risible and predictable.

c) Turning the Inner Critic into an Inner Coach: Gradually, once there are few surprises left for the Inner Critical Themes, the client can begin to ask the Inner Critic "What is the positive intention behind your harshness? What do you need to become more helpful?" Suggestions may be made by the therapist if this draws a blank response from the client. Typical answers are that the Critic is trying to protect the client, or prevent them from being made a fool, etc. The following question should be "What do you need to feel safe?" A second inner resource for the critic is visualisations, e.g., "Mr. Reassurance" or "Ms. Inner Contentment", merged with the client and literally reinserted (through visualisation) back within the client's heart.

3) Teaching unconscious self-hypnosis: A key component of this model involves teaching clients how to cope better with anxiety – the source of many emotional problems – through the use of breathing slower and relaxing the body. Techniques such as Progressive Relaxation may be introduced. This is a process of tensing and relaxing all the muscles from head to toe. Combined with deliberate, slowed breathing, this becomes a power trance induction technique that the client can be encouraged to practice after a few run-throughs

with the therapist. The aim is that this becomes an instinctive cue to allow the client to become more relaxed. Suggestions are given that with relaxation comes an unconscious mindset that reinforces previous ego-strengthening work that automatically “kicks in” similar to a thermostat whenever the client is anxious.

There are many hypnotherapy techniques, such as “the control room of the mind”, that can supplement this unconscious self-hypnosis. With the “Control Room” technique the client goes on a guided visualisation where they stumble upon a room with machinery they are encouraged to adjust that allows them to alter their emotions, thoughts and physical reactions to cope better with any anxiety provoking situation. **It is suggested by the therapist that all this occurs without conscious awareness, simply by the cue of slowed breathing and muscular relaxation.**

4) Increasing emotional intelligence: Simply by asking clients what they are feeling after describing a narrative, through the simple multiple choice answer described by Yalom (5). The four emotional choices must be artificially limited to: “mad”, “bad”, “sad” or “glad”. This helps clients to quickly understand and differentiate between anger (mad) or self-loathing (bad) for example.

5) Ego strengthening ‘scripts’: Hypnotherapists will use techniques to reinforce a person’s sense of well-being and self-acceptance. It is a way of instilling hope by suggesting success, self-acceptance and problem resolution.

6) **Suggestions for imagining a future without the problem:** See the section d) above.

7) **Establishing a Safe Place to explore Traumatic Memories**: Discussion of traumatic memories can leave the client in a traumatic trance well after the session has ended. One way to avoid this is to teach the client to visualise a Safe Place. This place should be a place that is comfortable, protective and where no problems can be present and no other persons are present. This provides a place for clients to return to after discussion of traumatic memories, with the simple suggestion of the phrase, “...now you can end this (traumatic) memory and return to your Safe Place.”

8) **Use of Dissociative Imaging Techniques**: Powerful image work can be done suggesting that the client “see” their problem-free life as if they are literally watching it on a TV screen or even better, a cinema screen. Visualising in a projected image format (i.e. as opposed to a thought of the image) is referred to as “dissociative technique” as it creates a malleable object felt to be “outside” the client’s mind, and thereby empowering them to direct the images in a multitude of ways. “Director Cuts” if you will.

Conclusion: When to employ counselling vs. Hypnotherapy approaches

Hypnotherapy and trance techniques are best viewed as an *adjunct or tool* to counselling. Counselling, psychotherapy and hypnotherapy all work best when a therapeutic alliance is established and the client trusts the therapist as someone they can confide in and who has the expertise to help them. Trance techniques are *contraindicated* when the client needs to work on relationship issues, as the trance can be an escape from being in relation with the therapist.

Additionally counselling is useful for exploration of emotional feelings and history. Counselling is particularly important when insight is being sought to allow clients to understand their behavioural patterns. Hypnotherapy and trance work tend to be more useful for rapid problem solving, such as anxiety and phobia management, confidence building and performance enhancement issues.

The proposed integrated mode of working can be very beneficial with helping students and staff to resolve problems rapidly. It can also save time in terms of laboured history taking when limited sessions are available. Simply by reading the hypnotherapy literature – particularly scripts - clinicians may be pleasantly surprised at how rapidly their own therapy style begins to incorporate these concepts.

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