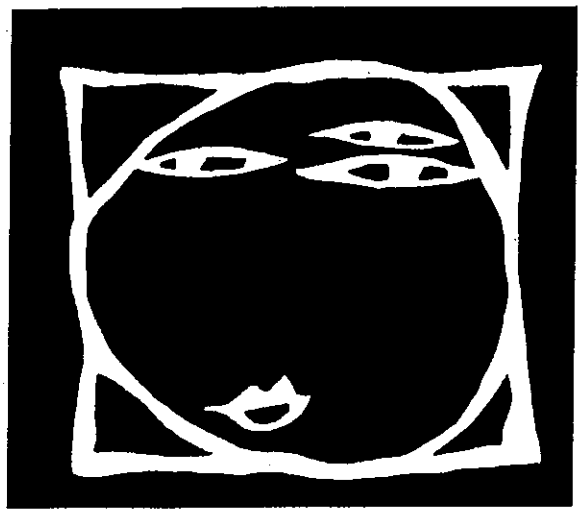

Therapeutic CONVERSATIONS 5

THERAPY FROM THE OUTSIDE IN

collected essays,
therapeutic questions
& workshop handouts

EDITED BY
STEPHEN MADIGAN

Yaletown Family Therapy

Embodying the Mind and Minding the Body:

Using Hypnosis in Brief Therapy

DOUGLAS FLEMONS
Fort Lauderdale, Florida

The control of our behavior is not located in our brains. It's all over our bodies. . . . So there's an argument that the whole structure of consciousness, and the human sense of self-control and purposefulness, is a user illusion. We don't have conscious control over ourselves at all. We just think we do. . . . Just because human beings [go] around thinking of themselves as "I" [doesn't] mean that it [is] true.

—Michael Crichton

Consciousness—our awareness of being aware—allows us to monitor and evaluate what we do and how we think and feel, facilitating rapid learning and rational decision-making. But such "fold-back knowing" also creates significant self-delusion, leaving us confounded about the nature of the self. This problem of consciousness is typically understood in terms of the Cartesian split between mind and body, but the relevant schism is not located quite there. Rather, it lies more precisely between the "Observing-I"—that part of us that conceives of itself as the insular knower and controller of our experience—and the rest of the "self," which includes not only non-volitional body processes and sensations, but also non-volitional thoughts, images,

memories, and dreams.

If you have a feminist, systemic, or narrative background, you are already finely tuned to the devastating personal effects of social othering, where hierarchies of value are assumed and enacted across lines of gender, class, color, sexual orientation, and culture. But if you also develop a hypnotic sensibility, you'll additionally recognize the problem-forming-and-escalating effects of *personal* othering—the process by which we attempt to consciously control or banish body- or mind-based experiences that scare, disgust, or hurt us. At such times, our Observing-I engages with the rest-of-the-self as if from behind an invisible wall, monitoring and attempting to reign in or destroy out-of-control sensations, emotions, and thoughts. Such internal battles guarantee a loser, inevitably some aspect of the self, which always makes matters worse.

When you engage in hypnosis and related activities—meditation, making love, playing sports, creative brainstorming, performing or listening to music—your invisible wall disperses, and, with it, the insularity of your conscious will and conscious awareness. As you become immersed in and absorbed by the flow of the experience, your fold-back knowing becomes "distributed knowing," with no Observing-I hanging back, claiming ownership of or responsibility for what's happening. Such immersion provides a marvelous associational context for effectively encountering and transforming hitherto out-of-control symptoms.

Consider and compare the following two client dilemmas, each of which is maintained by an ongoing process of personal othering—a distressing disconnect between the Observing-I and a non-volitional, troubling experience.

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Brian, a high-powered trial lawyer at the top of his game, was desperate about his insomnia. He got five to six hours sleep on a good night; two to three, or none at all, on a bad one; and for the last few years, most nights had been bad. He'd tried everything, from

warm milk and various medications, to relaxation tapes and hypnosis, but nothing had worked. When he'd lie down to try to go to sleep, a five-to-ten second "loop" would form in his head—the chorus from a pop song, a snippet of conversation from earlier in the day, a snatch from a trial—and torture him for hours on end. Despite making formidable efforts, he could never get the loop to stop. After a couple of hours of tossing and turning, he would roam the house, looking for some magic location that might afford him some relief. But the longer sleep remained elusive, the more agitated and strung out he'd become.

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Gordie, an emotionally young but intellectually advanced 9-year-old, still defecated in his pants most days. His parent's divorce two years earlier had been occasioned in part by their sharp disagreement over how to handle Gordie's lackadaisical attitude about where he pooped and how long he was willing to sit in it. Nevertheless, both of them, exhausted and defeated by their failures to effect change through punishment, encouragement, pleading, or operational conditioning, accompanied him to his appointments with me.

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In both of these cases, the clients came for therapy because some chunk of their experience was happening outside their conscious control, and it was scaring or driving them (and/or someone else) crazy. The brief therapy work I offered employed the logic and methods of hypnosis to invite a rapprochement between the Observing-I and an othered part of the self.

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Brian had a reputation for being relentless. If purposeful effort could help him achieve a goal, he'd apply himself with the focus of a laser beam. But this skill, which worked so well in the courtroom, backfired when he implemented it at bedtime. He couldn't *make* himself fall asleep and he couldn't successfully *will* the loop in his

head to stop—not because he wasn't trying hard enough, but because, given the nature of consciousness, he was trying too hard. By helping him shift his intentionality, I helped relief and sleep to develop non-volitionally.

I asked him if he could get a loop started as he sat there in my office. Having never tried to create one on purpose, he was a little taken aback, but he was willing, he said, to give it a shot. Within a few minutes, he had one going full tilt in his head, so I moved into hypnosis.

Douglas: While the loop continues, repeating over and over, you can listen to it with the back of your mind and to me with the front of your mind. Or you can follow the loop with the front of your mind while the back of your mind monitors where I'm headed. It doesn't really matter. You might even find them switching back and forth.

This morning at breakfast, I told my 6-year-old daughter, Jenna, to quit dawdling. "Finish up your cereal, Honey," I said. She looked at me with a twinkle in her eye and said, matching my tone of voice, "Finish up your cereal, Honey." "Hey, what are you trying to pull?" I joked, to which she replied, "Hey, what are you trying to pull?" I complimented her on how well she was able to imitate not only my words, but also the quality of my voice. She smiled at this, so I asked whether she could repeat what I was saying *while I was saying it.* Looking intently at my mouth as I said, "I hope you have a good day at school, Sweetheart," she managed to form each of the consonants and vowels of the words just a fraction of a second behind my articulating them. I found myself slowing way down as she spoke almost in unison with me, and at the end of the sentence, we both burst out laughing.

A funny thing happens when you have two or more people voicing the same thing at the same time. If you're in a choir, holding a certain note, and everyone around you is singing the same note, then the boundary separating you and them dissolves, and your experi-

ence of yourself melts a little. You and the other singers kind of blend together somehow.

I wonder what would happen if the front of your mind were to pull a Jenna and start imitating, in unison, that back-of-your-mind loop? Instead of trying to stop it, it could create an exact replica, so you'd have two loops going, the automatic one that you can't get to stop, and an on-purpose one, giving you a stereo experience. Go ahead and try that and let's see what happens. Match the voice or voices in speed, articulation, accent, volume, and tone.

When both are in unison, you may not be able to tell if the on-purpose loop in the front of your mind is following the automatic one in the back of your mind, or if the automatic one has synced up with the on-purpose one. Both can move together, in unison, around and around, giving you that stereo experience.

I continued on in this vein for a while, and when I checked in with him, Brian told me that the loop had petered out—something that had never before happened.

In asking Brian to initiate a loop, I helped him connect with something that he'd only ever tried to eradicate. And by inviting him to purposefully imitate it, I facilitated a dissolving of the boundary between his Observing-I and his symptom—a previously othered part of his experience.

Late in the session, I taught him a self-hypnosis technique to use at night and suggested that he practice "singing in unison" with whatever loops appeared at bedtime. He came back two weeks later, having slept well almost every night, and he no longer felt "trapped" by the workings of his mind. He liked the irony, he said, of feeling empowered by *not doing anything* to the loops. We did some fine-tuning of his self hypnosis, and he left, able to sleep and no longer at war with himself.

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Gordie, an avid reader of *Popular Mechanics* and *Popular Science,* was captivated by the invention and workings of machines, but he

wasn't interested at all in biology. I thus used engineering metaphors in talking about what had been going on with him. I pointed out that various parts of the body, just like radio stations, are forever sending out signals, and other parts, just like radios, are forever receiving the signals, converting them, and passing them along. He had a good appetite and he always peed in the toilet, so, I mused out loud, the signaling systems in his stomach and bladder must be in good working order. "Hey Gordie, time for some food! Hey Gordie, time to pee! Hey Gordie, enough food! Stop, already!" Such messages were successfully being sent, received, and acted upon, so most of the relays, capacitors, switches, and transformers in his body must be correctly calibrated. Clearly, then, there must simply be some glitch in the message system in and around his rectum. Maybe the signals weren't being sent, maybe the signals weren't being broadcast with enough juice, or maybe the signal-to-noise ratio was simply too low.

A previous therapist—a behaviorist—had recommended that the parents require Gordie to sit on the toilet every evening for half an hour before bedtime. They had followed this prescription closely, allowing Gordie to pore over his engineering and science magazines. This structuring of his time had cut down on the number of in-the-pants accidents, but it certainly hadn't eliminated them, and despite various other interventions, the parents had seen no change in Gordie's habit of not cleaning himself up until he was explicitly told to do so.

I asked Gordie and his dad to draw up some blueprints of his broadcast/receiving system and to locate possible sources of signal interruption or corruption. They agreed. I then suggested that further information could be obtained from their doing a couple of scientific experiments. Since Gordie never seemed to notice when he'd pooped in his pants, it was clear that he wasn't getting poop-relevant signals either before or after his bowel movements. Reading on the toilet was pleasurable, and structured times for sitting in the bathroom were convenient, but neither were helping in the develop-

ment of signal sensitivity. Indeed, since his parents were so good about reminding him to sit on the toilet in the evening, his body had probably adapted to the signals coming from them, rather than those coming from his rectal area. I thus suggested that they take all reading material out of the bathroom and that Gordie only head to the bathroom when he received a signal about the necessity for a bowel movement.

If, during the time until our next appointment, Gordie only realized at some point that he had gone (rather than that he had to go), then before cleaning himself (and, if necessary, his clothes), could he close his eyes and notice the various sensations that came to his attention? How did the poop feel on his bottom? Warm? Hard? Soft? Sticky? How did it smell? How did his rectum feel now that it no longer had poop in it? Could he feel the relief, there? And could he remember back to just before he pooped and how it felt in his rectum then?

I speculated that once he started getting post-poop signals, the system would be activated for his acting on "I-gotta-poop" signals. No doubt he would continue to have accidents for awhile, but these would, at least, be helpful for information gathering. The parents agreed that when he pooped in his pants, they would help him tune into the various sensation-based signals (and the memory of pre-poop sensations) before addressing the mess.

Within two weeks of the first appointment (and few days after the second), Gordie had his first successful bathroom experience in years. Playing on his own, he'd received a signal that he needed to poop, and he'd made it to the toilet in time without anyone telling him to go. He'd also had a few accidents, which had served their purpose for information gathering.

By the next session, a week later, Gordie had had only one accident, and his parents were ready to stop therapy. Five months later, during a follow-up conversation, his mother reported "considerable improvement," not only in the occurrence of accidents, but also in

Gordie's proactive participation in the resolution of the problem.

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Although I only use formal hypnotic techniques with about half of my clients, I employ hypnotic *logic* with all of them. Given that personal othering is central to the creation and/or maintenance of symptoms, I never sign on to help obliterate clients' problems or to get them "under control." Instead, I invite non-volitional shifts in experience by helping to dissolve the boundary between the Observing-I and the rest-of-the-self, particularly the slice of experience that the clients have been holding at arm's length. Therapeutic change becomes possible when people are able to head toward, rather than away from, their problem, when they can *connect* with it. Hypnosis—a way of minding the body and embodying the mind—helps create the relational context to do this both respectfully and effectively.

HANDOUTS

Embodying the Mind and Minding the Body: Using Hypnosis in Brief Therapy

Despite the fact that brief therapy approaches—solution-focused therapy, MRI, and strategic therapy—were derived from the techniques of Milton Erickson, many current brief therapy practitioners know little about what hypnosis is, how it works, or how it relates to the work they are already doing.

This workshop introduces a *relational* understanding of hypnosis, one that emphasizes the potential for the collaborative and creative involvement of clients' bodies in therapeutic conversations. Hypnosis provides unique entry into the relationship between the "Observing-I"—that part of us that conceives of itself as the insular knower and controller of our experience—and some despised or feared slice of experience. Hypno*therapy* is a process of shifting this

relationship so that the problem can be accepted, transformed, and/or left behind.

Freedom within Relationship

My focus is always on relationships—relationships between people, but also between people and various parts of their experience, whether a body part, physiological response, idea, emotion, memory, dream, or behavior. I assume that a relationship is most viable when the relata—the parts at either end of it—are free to change or stay stable in coordination with each other. I thus conceive of therapy as a means of facilitating encouraging, and enhancing the possibility for such relational freedom.

Personal "Othering" and Therapeutic Change

Problems are formed and escalated when clients "other" a piece of their experience that scares, pains, or disgusts them. Responding to an unpredictable and uncontrollable symptom, they come to therapy, desperately hoping that they'll get help in banishing their problem or at least getting it under control. We are best off going in the opposite direction, making sense of the symptom within the context of their relationships and connecting them back to the wisdom and possibilities of their body.

Therapeutic change is made possible when we help clients—

1) **embrace the problem**
   When we join our clients in their intention to cut off contact with their problem, we risk making things worse. But when we to help them connect to it, creative possibilities for change open up.
2) **get curious about the problem**
   Curiosity helps clients reverse the way they orient to their problem, to connect with what they've been trying to keep separate. Instead of attempting to flee from or stamp on it, they find them-

selves picking it up and holding it near enough to learn something new about it.

3) **increase the problem**
The more out of control a symptom feels, the more clients strive to rein it in. But doing this puts them at odds with themselves, fighting a battle they can only lose. The therapeutic alternative is to facilitate a truce, helping them to relax their efforts at negating their symptom, or to even *increase* it.

4) **discover variation in the problem**
When clients are in relationship with their symptom, they can begin to discover subtle variations in how it manifests and changes. If the problem can express itself and/or change in *this* way, then it can also probably change in *that* or *some other* way.

RESOURCES

Therapeutic Questions

Following is a list of the sorts of questions I ask clients, but I must say that I profoundly dislike such lists, for they can give the impression that therapeutic change happens as a function of asking questions and that each of the questions somehow exists independently of the others (after all, each one is on a separate line) and from the answers clients provide. The invention and articulation of each question I ask is always connected to the answer I got from one or more earlier questions. Thus, this list gives you about as much information as you'd get from listening to only one half of a telephone call. It can't tell you much about how to conduct a therapeutic conversation.

1. Do you have any questions about me or about my work?
2. What do you know about hypnosis?
3. What differences in X [your symptom] have you noticed since we talked on the phone?
4. When have you been noticing X happening?

5. How long has it been happening?
6. When does it *not* happen?
7. When it happens, how does it take form?
8. What have you done to deal with it?
9. What have others suggested?
10. Have you ever been surprised by its not happening?
11. How did that come about?
12. Can you tell the difference between X and Y?
13. Would you like to try an experiment?

RESOURCES

Books

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