

# Hypnotic Trance in Heart-Centered Therapies

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**Abstract:** This article traces the roots of the use of trance states in Heart-Centered therapies. A discussion of traditional hypnosis includes Brown and Fromm's (1986) proposed four treatment approaches with hypnosis: symptomatic hypnotherapy, supportive ego-strengthening hypnotherapy, dynamic hypnotherapy, and hypnotherapy of developmental deficits. We review several ways of defining hypnosis, and Holroyd's (1990) nine trance characteristics. Ericksonian and NLP techniques that fit well with the Heart-Centered approach are *calling to awareness senses within the body*, which encourage the client to exclude external stimuli and focus on internal realities; *stating permission to the unconscious mind* either for searching memory archives or for expression of unaccustomed feelings and experiences; and *nonverbal cues* such as changing voice patterns and modeling appropriate trance behaviors. We also review some of the hypnobeavorial approaches and behavior modification techniques utilized in Heart-Centered therapies, including systematic desensitization, modeling, anchoring, sensitization or aversion, flooding and implosion, role-playing (behavioral rehearsal), assertive training, and observational learning.

## Primary topics

1. Traditional hypnosis
2. Ericksonian and NLP techniques
3. Hypnobeavorial approach and behavior modification

Utilizing an altered state of consciousness in psychotherapy provides a powerful added dimension to the process. Hypnotic age regression accesses a much deeper level of material than cognitive psychotherapy can by following an *affect bridge* from a current intense emotion back to earlier and more traumatic antecedents of that emotion (Watkins, 1971). The experience is one of re-living, releasing and integrating the memory, not just remembering and analyzing it. Experimental evidence verifies that the most effective age regressions are those associated with highly affective events (Nash et al., 1979).

The actual steps we take in this journey, following Ralph Metzner's terminology (1998), we might call *digressive* transformational experiences, that is temporary states of consciousness that act as transport between the past and future, between trauma and incorporation, between fragmentation and wholeness. The shamans call this the intermediate world, where it is

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possible to move between the lower world and the upper world. These include, for example, visions and dreams, hypnotic trance states, meditation, or various transcendent states. Also included are physical alterations that provide transport, such as yoga, bioenergetics, and conscious breathing.

### **Traditional Hypnosis**

Brown and Fromm (1986) proposed four treatment approaches with hypnosis: symptomatic hypnotherapy, supportive ego-strengthening hypnotherapy, dynamic hypnotherapy (which they term hypnoanalysis), and hypnotherapy of developmental deficits. These approaches are used in many complex combinations, of course. However, it is helpful to effective facilitation to be able to identify which of the four is being utilized at any one time.

*Symptomatic hypnotherapy* focuses on physical, psychological or habitual symptoms (e.g., pain, anxiety or smoking), and employs techniques to alleviate, remove, transfer or substitute the symptoms. Examples of symptomatic relief are authoritarian hypnosis with post-hypnotic suggestion, or systematic desensitization. The underlying theoretical basis is learning theory, effective suggestion and imagery, and behavior modification.

*Supportive ego-strengthening hypnotherapy* emphasizes facilitating and increasing the client's relaxation, self-efficacy, confidence, and autonomy. The focus is on supporting and increasing the client's strengths and abilities to cope. The underlying theory is derived from psychoanalytic ego psychology.

*Dynamic hypnotherapy* emphasizes uncovering unconscious conflicts and deep dynamics, and working them through. Dynamic hypnotherapy focuses on ego strengthening and age regression techniques. The underlying theoretical basis is ego psychology, object relations theory, and self psychology.

*Hypnotherapy of developmental deficits* (or *developmental hypnotherapy*) emphasizes extensive regression work to trace current dysfunctional behavior back to source unresolved developmental patterns, and to assess developmental arrests. The underlying theoretical bases are several convergent psychoanalytic theories: object relations theory, self psychology, affect development theory, and the theoretical focus of "developmental lines" proposed by Anna Freud (1965). Under the various

formulations of developmental lines, each line of development charts the emergence of a specific developmental potential through a sequence of stages of growth. For example, there is a separate line of development for the consolidation of a sense of self (Kohut, 1971), for affect (Brown, 1985), and for the defenses (Vaillant, 1977). Thus, psychopathology is conceptualized as a failure in normal human development along one or more developmental lines. The focus of treatment is to repair the discovered developmental arrests with newly reframed beliefs and working models (Stolorow & Lachman, 1980). See a more complete discussion of the developmental aspects of hypnotherapy in “Ego States in Heart-Centered Therapies” in this issue (Hartman & Zimberoff, 2003).

The use of the hypnotic or trance state in Heart-Centered therapies incorporates all four of these approaches for various specific purposes. Even when Heart-Centered therapy is utilized as short-term psychotherapy, sessions of hypnotherapy and psychodrama virtually always include components of symptomatic, supportive ego-strengthening, and dynamic approaches. Often sessions also provide repair of developmental deficits. In any event, the client and therapist together identify the areas of the client’s life that he/she wants to improve with change, what Strupp and Binder (1984) call the *dynamic focus*: “a cardinal symptom, a specific intrapsychic conflict or developmental impasse, a maladaptive conviction about the self, an essential interpretive theme, or a persistent interpersonal dilemma or pattern of maladaptive activity” (p. 66). Hypnosis can aid in establishing the dynamic focus almost immediately, because the client’s unconscious is liberated from waking state defenses to do so. “In short, hypnotic techniques can reveal the patient’s dynamic conflict or ‘core conflictual relationship theme’ (Luborsky, 1984) with more immediacy and emotional availability than might otherwise be the case” (Sexton & Nash, 1990, p. 178).

What is the “hypnotic state,” or “trance?” The hypnotic or trance state varies greatly in quality, depth, and in the degree to which an “observing ego state” is present; however, certain qualities seem to be relatively constant. We follow the conceptualization presented by Lavoie (1990, pp. 82-83), wherein the following processes more or less define the hypnotic state (Gill & Brenman, 1959; Hilgard, 1965, 1977):

1. An exclusive relationship between patient and clinician that strikes the observer, as patient and clinician alike seem to be set apart from the surrounding world; it is the hypnotic

- transference, ancestor of the psychoanalytic transference (Lagache, 1952);
2. The selective, voluntary relinquishing by the patient of
    - critical judgment,
    - reality testing,
    - planning and executive functions, which are placed at the disposal of the development and maintenance of the trance;
  3. A feeling of effortless experiencing on the part of the patient;
  4. A particular attentional mobility that readily cathects representations that are more difficult to access in the awake state;
  5. An intense capacity for absorption and focusing on certain emotions and representations. According to the instructions, attention can be focused on something particular or it can diffusely float free to follow the pattern of primary process (Brown & Fromm, 1986; Gill & Brenman, 1959; Karlin, 1979);
  6. A strong imaginative involvement where the word takes on the significance of the thing and where what is ordinarily experienced as imaginary becomes real;
  7. The possibility of producing temporary modification of ego functions, including rearrangement of defense mechanisms;
  8. The possibility of establishing dialogue and intersubjective communication analogous to that of the waking state;
  9. An increase in suggestibility evoking a flexibility in which the patient has the tendency to appropriate the words of the clinician and genuinely live that which is expressed only in a complex play of introjection, projection, and identification.

Hypnosis is valuable as a therapeutic approach in that it assists an individual to access emotions and recognize and name them. This is important, since most people who have suffered trauma are primarily anhedonic (numb) (Smith, 1987) and alexithymic (unable to recognize and name feelings) (Krystal, 1988). Smith and Jones (1993) discuss the importance of helping the traumatized client to restore the connection between what they think, what they do, and how they feel, which is generally missing prior to treatment. The reconnection is facilitated by hypnosis.

Using hypnosis in therapy provides heightened attention to relevant signals or suggestions and inattention to irrelevant ones. The attentional hyperacuity of hypnosis increases susceptibility to suggestion. This also brings an individual's resources to bear in a focused way for self-exploration and change. It enables most people to "tap forgotten assets and hidden potentials" (Lazarus, 1973). It enables most people to let down defenses and loosen their reality testing and habituated identity, providing access to forgotten experiences. It heightens affect tolerance, allowing most people to mobilize and experience emotions that they otherwise repress and deny (Davanloo, 1978). The suspension of disbelief inherent in hypnosis facilitates imagery and rehearsal experiences by accentuating primary process thinking (Brown & Fromm, 1986). Hartmann (1958) identified two types of fantasy: (1) symbolic fantasy or imagery, which is the cognitive mode of the unconscious ego; and (2) reality-testing fantasy, which one uses to plan ahead for real anticipated situations. The hypnotherapist utilizes both forms of fantasy; the first for direct communication with the unconscious, and the second for rehearsal experiences to gain mastery in fantasy which then leads to eventual mastery in reality.

This expanded context of mentation relies on dialectic reasoning, also called *cognitive flexibility*, and on the capacity for *diffuse attention*. Dialectic reasoning permits expanded awareness through simultaneous consideration of opposite poles of bipolar meaning structures (e.g., life – death, intimacy – isolation, purpose – meaninglessness, abdication – responsibility) (Slife & Barnard, 1988). In other words, cognitive flexibility permits one to accommodate multiple solutions, even mutually exclusive ones. It carries the ability to shift cognitive strategies and states of awareness, shifting from details (attending to selected content and disattending to other content and to the context) to holistic view (attending to both content and context) and back again. Complex, novel or unpredictable events are appraised as opportunities for growth rather than as personal threats requiring reflexive response. Contrast this with demonstrative reasoning, which is constrained by a mechanical logic. John Welwood (2000) refers to these two types of reasoning as *focal* attention and *diffuse* attention.

*Focal* attention screens out wholes in favor of differentiated parts, becoming preoccupied with the foreground content, e.g., with the waitress' inattention or the performance anxiety preceding a lecture or the discomfort of being in a crowded elevator. *Focal* attention is a telephoto

lens through which to concentrate on selective details. It is very useful, but over-reliance on it leads to obsessive mentation, narrow-mindedness, and disconnection from purpose and meaning in life. *Diffuse* attention is receptive, alive, a wide angle lens through which to experience the whole context all at once. The two forms of attention represent thought (focal, the contents of consciousness) and awareness (diffuse, consciousness itself).

Hypnosis and meditation are two methods of cultivating diffuse attention (Welwood, 2000; Wolinsky, 1991) utilized in Heart-Centered therapies.

*Awakening* from dissociation is one way to describe the experience of loosening the limited nature of normal consciousness, fixated on momentary figures (content) rather than the underlying ground (context). Diffuse attention, an aspect of cognitive flexibility, allows one to focus on the whole situation underneath one's thoughts and emotions, and to tolerate ambiguity regarding the meaning of an experience. John Welwood (2000) refers to awareness in a contracted state as *ego*, and awareness in a relaxed state as *egolessness*. For a detailed discussion of egolessness, readers are referred to "The Ego in Heart-Centered Therapies: Ego Strengthening and Ego Surrender" (Zimberoff & Hartman, 2000). Suffice it to say here that cognitive flexibility and diffuse attention are intricately related to the experience of humility and non-defensiveness, i.e., ego surrender, and that the experience of hypnosis increases one's cognitive flexibility.

Holroyd (1990) identified nine trance characteristics from experimental research and clinical observations, and hypothesized how they can potentiate psychotherapy. Following is a brief description of her results.

1. *Attention*. Attention changes in two ways during hypnosis, becoming either more focused or more free-floating (Fromm et al., 1981). Each type of change facilitates psychotherapy. Concentrated focus assists in defining a dynamic focus upon which to work as well as sufficient cathected energy to motivate change. In contrast, the deautomatized free-floating attention aspect of hypnosis facilitates free association and the ability to follow affect, somatic and linguistic bridges without inhibition.
2. *Imagery*. Imagery vividness is an important aspect of many types of therapy (Sheikh & Jordon, 1983), and increases with hypnosis (Coe et al., 1980). It is likely that visualization promotes awareness of emotional and primary-process material (Reyher &

- Smeltzer, 1968) and facilitates creative problem solving (Dave, 1979).
3. *Dissociation*. Dissociation can provide psychotherapeutic access to the unconscious (Shevrin & Dickman, 1980). Gestalt techniques, such as encouraging the client to “talk to” the split-off parts of the self, foster temporary dissociation to facilitate emergence of previously unconscious attitudes. Hypnosis-facilitated ego state therapy (Watkins, 1978) also relies on dissociation of a given ego state in order to discover unconscious attitudes or roles held by another ego state.
  4. *Reality Orientation*. Reality orientation decreases during hypnosis. Correspondingly, there is a preoccupation with internal processes (Bowers & Bowers, 1979), increased primary process thinking (Fromm et al., 1970), and a higher frequency of dream recall (Stross & Shevrin, 1967). The fantasies and primary process material available during hypnosis provide expanded opportunities for self-exploration. On the other hand, cognitive interventions such as reframing (Watzlawick et al., 1974) and rehearsal also may be facilitated by the absence of continuous reality checking.
  5. *Suggestion*. Openness to suggestion is a hallmark of hypnosis (Weitzenhoffer, 1980), and the effects of a client’s willingness to receive therapist suggestion is obviously positive for outcome.
  6. *Mind-Body Interface*. Hypnosis reveals the mind-body interface in an unparalleled manner (Black, 1969), sometimes resulting in motor paralyse, automatic movements, altered sensation or perception, changed physiology, or shifted cerebral lateralization. Intensifying mind-body communication is one of the cardinal processes in behavior therapy, and one of the fortunate intersections between hypnotherapy and behavior therapy.
  7. *Feeling of Compulsion*. Another attribute, a feeling of compulsion to do what the hypnotist suggests, is closely related to increased suggestibility (Bowers, 1982) and implicates processes of rapport (Sheehan & McConkey, 1982) and an ego shift into receptive mode (Fromm, 1977).
  8. *Affect*. Affect becomes more available with hypnosis, as evidenced by the spontaneous occurrence of emotion as well as the easy arousal of emotion with hypnotic suggestions (Blum, 1979). Emotional expression is important in psychotherapy; it is not just

catharsis that is important, but also the emergence of associated memories and conflicts.

9. *Archaic Involvement*. The relationship between hypnotist and patient entails a *fusional* or *archaic* element that differs from the psychoanalytic concept of transference (Chertok, 1982; Diamond, 1987; Shor, 1962). Recent research suggests that the hypnotist-subject relationship is reflected even at the neurophysiological level (Banyai, 1985). Intense mutual involvement between therapist and patient traditionally enhance treatment process and outcome by permitting the development of a therapeutic alliance; by neutralizing resistance in selected situations; and by permitting regression with primordial fantasies and childlike transference.

### *Level of trance depth*

We agree with the three observations on level of trance depth by King and Citrenbaum (1993) that (1) each client seems to have a natural depth of trance that he/she goes into for optimal therapeutic results, determined by cognitive style and personality characteristics; (2) clients will naturally lighten and deepen the level of trance in the course of each session to suit the particular needs of the moment without much effort on the part of the therapist; and (3) the level of depth of trance rarely matters for clinical work, because the techniques employed in hypnotherapy usually work well for clients in a deep trance state and for clients in a relatively shallow trance state.

## **Ericksonian and NLP Techniques**

Milton Erickson was a master therapist and healer who relied on his intuitive skills to determine interventions with patients. He saw the uniqueness and the depth of each patient that came to him. He naturally perceived the various ego states within the individual, including those working at cross-purposes, whether they were conscious to that individual or not, or evident to most observers. His therapeutic interventions were *direct* communications with these ego states, which may appear as *indirect* communication to the executive, conscious ego state of the individual. As Beahrs (1982, p. 9) states: "Ericksonian treatment methods might appear unusual, if not bizarre, because communication is directed to a part or an aspect of consciousness not experienced as conscious by the overall self

and not evident to most observers. Most of us respond primarily to the most overt levels of words and behavior. When we respond to what is or seems hidden, this appears bizarre – bizarre but appropriate, and therefore effective.”

In Heart-Centered hypnotherapy, we utilize some of the concepts and techniques developed by Milton Erickson. We find traditional hypnotic inductions such as eye fixation and progressive relaxation preferable to the indirect methods often used by Erickson, such as *casual conversation, confusion, surprise, questioning, double-bind questions, recalling previous trancelike experiences, boredom, reverse suggestions, and partial remarks and dangling phrases*. Ericksonian techniques that do fit well with the Heart-Centered approach are *calling to awareness senses within the body*, which encourage the client to exclude external stimuli and focus on internal realities; *stating permission to the unconscious mind* either for searching memory archives or for expression of unaccustomed feelings and experiences; and *nonverbal cues* such as changing voice patterns and modeling appropriate trance behaviors.

One of the great contributions that Erickson made to psychiatry as well as to hypnotherapy is his instinctive appreciation for the individual differences in style of cognitive processing. One client is primarily visual while another is primarily kinesthetic, one responds well to direct confrontation of defenses while another needs to be ingratiated. Erickson established a new personality theory for each new client, rejecting a “one size fits all” model of psychic structure and functioning.

Another basic element in Erickson’s approach is recognizing that defenses serve an ecological purpose for the individual and therefore need to be respected. The purpose may be understood as secondary gains, and changing symptomatic behavior requires recognizing and addressing the secondary gains which are being defended against loss. Thus, paradoxically, the process of changing symptomatic behaviors requires symptom utilization. With *utilization*, the therapist neither denies the existence of the client’s symptoms, nor his/her right to have them. They are accepted as a natural consequence of the person’s life experience up to this point in time, and incorporated into the behavior change strategy as a baseline. Symptoms are defenses, and one of the advantages of hypnotic trance is a relaxation of those defenses. An unwanted symptom becomes much more amenable to change when it is accepted and embraced than when it is rejected and resisted.

Some of Erickson's tactics in hypnotic induction as well as in symptom alteration were intended to conceal the intention from the client. Edelstien (1982, p. 16) defines such tactics, affectionately, as "benevolent deceit." He states that these include "engaging the patient in therapy, or even in hypnosis, without the patient's awareness that either was happening." Edelstien attributes Erickson's great therapeutic success to his "unique ingenuity." Without judgment on the ethics or effectiveness of such "hypnotic ploys" (Stricherz, 1984) or "trickster methods" (Bergantino, 1981), we have found more straightforward interactions to be powerfully effective with our clients in the structured hypnotherapy process. However, we utilize many of these tactics in therapist-client interactions that occur during appointments before and after the actual hypnotherapy session, as well as in group therapy and in psychodrama sessions.

Some of the tactics for symptom alteration utilized by Erickson, "hypnotic ploys" that are basically incompatible within the structured Heart-Centered hypnotherapy process include *symptom scheduling* (permission to control an uncontrollable symptom by scheduling its appearance at a specified time, or moving symptoms to unobtrusive parts of one's life), *providing a worse alternative* (encouraging the cessation of symptoms by suggesting that until they disappear, they will be accompanied by some highly undesirable experience), *symptom prescription* (instruction to practice a symptom that already exists, encouraging the continuation of a symptom that appears to be extinguishing, or instructing the client to desensitize while performing the symptom), and *double binds* (set up to reinforce the symptom, so the patient will either rebel against the therapist and rid himself of that symptom, or follow the therapist's suggestion which results in removal of previously unconscious secondary gains for the behavior). In psychodrama we often *provide a worse alternative* for an individual who is experiencing the dysfunctional comfort of familiarity of a symptomatic behavior. For example, when a client feels overwhelmed by responsibilities in her life, we might simulate the burden with a kinesthetic experience of weight on her shoulders accompanied by voices representing the many demands she "can't say no to." Often the client relaxes into the familiarity of the situation, losing motivation to change it. Then the facilitator must help the client discover the motivation to change by increasing the weight, making the burden harder to bear. In group work, we often give assignments in the way that Erickson gave to his patients.

Some of Erickson's techniques for working with client resistance, while highly effective in our group work, are also incompatible within the structured Heart-Centered hypnotherapy itself. In general, we address client resistance when it surfaces by using its manifestations (e.g., being late for or missing appointments, avoiding or refusing to address certain areas of the client's life, consistently preferring trivial or superficial symptoms to work on, withholding vital information from the therapist, acting out defiance) as the basis for an affect bridge age regression to the early source of the behavior or attitude. Thus the client comes to understand directly the scope of the pattern of resistance in his/her life, and its developmental source. Some of Erickson's techniques are *ingratiation* (flattery), *challenge* (chastising), *overhearing* (discussing a similar patient within earshot of the resistant patient to give direct feedback indirectly), and *encouraging a response by frustrating it* (the so-called "reverse psychology" of instructing a resistant individual *not* to perform a specific desired behavior). We certainly utilize these tactics in the context of communications outside the structured Heart-Centered hypnotherapy session, e.g., in group work or in psychodrama.

### **Hypnobeavioral Approach – Hypnosis and Behavior Modification**

The hypnobeavioral approach to psychotherapy connotes working directly to alleviate the client's neurotic or dysfunctional symptoms within the trance state, i.e., integrating hypnosis with behavior modification or behavior therapy techniques. Addressing many of these techniques directly to the unconscious rather than to the cognitive mind, as in conventional behavior modification, can be much more powerful as a change agent. It is our experience and belief that hypnobeavioral techniques contribute the most to effective therapy when they are combined with deeper psychodynamic (age regression and cathartic) experience rather than being the sole focus of the session. Behavior modification techniques are much more effective when used in experiential therapy than within the cognitive verbal approach. That is, we find real limitations in simply placing a person into a trance state, providing behavior modification techniques and related suggestions, and then waking the client from the trance. Changing a behavior pattern works most effectively when behavior therapy techniques are applied to the client's ego state most closely associated with the behavior needing to be changed.

As earlier noted, using hypnosis in therapy provides heightened attention to relevant signals or suggestions and inattention to irrelevant ones. The attentional hyperacuity of hypnosis increases susceptibility to suggestion. The suspension of disbelief inherent in hypnosis facilitates imagery and rehearsal experiences.

One behavioral technique that is extremely effective in the trance state is extinguishing an unwanted symptom, a form of systematic desensitization (Wolpe, 1958). The method rests on the premise that a person cannot experience two incongruent mental states simultaneously. Therefore, the person creates a positive mental state that is incongruent with the unwanted dysfunctional state, and anchors that resource state for easy retrieval. Then when experiencing the unwanted negative state, the client uses the anchor to bring back the resource state, shifting the hypnotically focused attention, and thus supplanting the unwanted state. Thus, the client rehearses and becomes proficient at readily entering a self-induced hypnotic trance state, even in the presence of previously distracting stimuli. This enhanced capability for self-control is itself reinforcing. This process works well to alleviate such unwanted dysfunctional symptoms as shame, guilt, self-blame, unworthiness, phobias, anxieties and fears. Performing desensitization within the trance state is more powerful than nonhypnotic desensitization because the capacity for visualization is enhanced in hypnosis (Deiker & Pollock, 1975; Glick, 1970); because posthypnotic suggestions can influence the client to make contact with the phobic stimulus in real life (Gibbons et al., 1970); and because information processing in hypnosis is nonsequential, allowing the client to master progressively more difficult items on the hierarchy simultaneously (Spies, 1979). Another advantage to applying behavior modification techniques in the context of hypnotherapy is described eloquently by Watkins (1978, p. 210):

Behavior modification methods of desensitization and reinforcement have proved to be effective, but they must be applied to the person requiring them. If the 'person' whose behavior needs modifying is a repressed ego state, such techniques will be ineffective. One gains no constructive therapeutic effect by treating "the little man who isn't there." A reinforcement to be effective must be applied to the one whose behavior needs change. If that "one" is an underlying ego state, it should first be activated before attempting to modify it.

Another important behavior treatment is *modeling*, or social reinforcement (Bandura, 1965). Modeling is a technique to induce a subject to imitate a constructive behavior so that it can be further positively

reinforced. We use modeling in cathartic expression by raising the voice and using demonstrative language, for example, and in empowerment experiences by using assertive statements. The client in hypnosis is highly receptive to such modeling by the therapist.

One of the most important behavior modification techniques used in our hypnotherapy is that of *anchoring* (Bandler & Grinder, 1979). Based on the process of *paired associates* from learning theory, anchoring associates a feeling of being powerful with a mental or visual image which represents a desired behavioral outcome for the client. In the therapeutic setting, the client mentally rehearses the desired behavior (which is itself helpful), and experiences an independent sense of empowerment simultaneously. Thus, a link is established between doing the behavior and feeling powerful. This greatly increases the probability that the client will exhibit the desired outcome behavior subsequently in his/her life. We use anchoring in virtually every session to embed the client's newly reclaimed inner resources for predictable retrieval.

Kroger (1976, 1984) has elaborated several phases of treatment using hypnotherapeutic techniques in psychotherapy. The first is taking a careful history, making a diagnosis, and establishing good rapport. The second phase is hypnotic induction, using standard induction and deepening techniques. The third phase is autohypnosis, learned as a response to a triggering cue such as closing the eyes and letting the eyeballs roll upward. Under autohypnosis, the individual establishes the appropriate suggestions and gives them to him/herself. The fourth phase is imagery conditioning. Conditioning involves all senses to rehearse the experience of a highly relaxing setting, and strengthening the ability to enter it at will. The fifth phase is posthypnotic suggestions, or affirmations. These suggestions, offered in a highly susceptible ego state, are the means for incorporating new behaviors into the client's repertoire. The suggestions form correctively conditioned responses to triggers.

These phases of hypnotherapeutic techniques are incorporated into Heart-Centered hypnotherapy, integrated seamlessly with the age regressions, catharsis, and corrective experiences.

Research (Kline, 1976; Paterson et al., 1976) shows that conditioned responses established under hypnosis are more durable and less likely to fall into extinction. The hypnotherapeutic techniques studied include systematic desensitization, sensitization or aversion, flooding and implosion, role-playing or behavioral rehearsal, assertive training, modeling, and observational learning. These techniques can be performed

covertly (*in vitro*) through imagining, or overtly (*in vivo*) through experiencing the actual stimuli. Most of these behavior therapy techniques in hypnbehavioral sessions are performed *in vitro* in the client's vivid imagining.

Creating the resource state itself is a matter of modifying behavior, and in many cases of modifying autonomic responses, such as blood pressure, heart rate, brain wave frequency, or immune system functioning. This is especially important because most states of anxiety are manifested by autonomic hyperactivity, such as restlessness, distractibility, and stress response.

The client's increased awareness of the constellation of symptoms, i.e., the "personal signatures" of their anxiety or other unwanted state (Gilbertson & Kemp, 1992), is extremely helpful to enhancing the individual's sense of self-mastery. When one becomes aware of previously unconscious and automatic responses, there is an enhanced expectation for the degree to which those responses can be deliberately affected, bringing the behaviors under conscious control.

The experience of rehearsal of new behavioral responses contributes significantly to permanent changes in the client's symptomology. This can be viewed as a kinesthetic post-hypnotic suggestion, selected and administered by the client rather than by the therapist. Hypnotic rehearsal utilizes attentional hyperacuity, loosened reality-testing, suspension of disbelief, and enhanced capacity for fantasy.

In the hypnbehavioral model, client and therapist work together. Clients experience the therapist's warmth, interest and confidence, and through the strength of the relationship are motivated to make behavioral changes. Kroger (1984, p. 122) states that "there is 'no space between' patient and therapist" in successful hypnbehavioral therapy, and that it is "a collaborative and reciprocal effort between therapist and patient – each learning from the other."

### *Behavior modification and the existential approach*

Bergantino (1981) identifies the intersection between these two approaches to psychotherapy. He states:

The real art of behavior modification, especially in relationship to existential philosophy, is to make behavioral prescriptions that will help patients deal with and move beyond the existential crisis in their lives. People are stuck. Choice is difficult because of internal conflict. Knowing how to manipulate the environment so people will be able to choose beyond that impasse is part of the art of behavior modification, and is a tie into

existentialism and the creation of existential moments because the behavioral prescription often captures the essence of patients' lives and all that they are grappling with. The therapist's aid in helping patients move beyond their deadlock opens up the path for free choice in the future (pp.201-202).

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