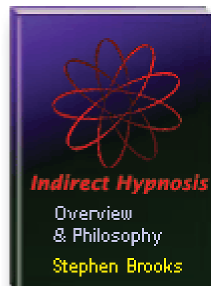
Indirect Hypnosis
Philosophy and Overview

The concepts, contexts, stages and components of an Indirect Hypnosis session.

Stephen Brooks



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Stephen Brooks

Stephen has a lifetime's experience of using indirect hypnosis with severe problems and difficult patients. Inspired and encouraged by top American Psychiatrist Milton H Erickson, he was the first person to introduce Ericksonian Hypnosis into the UK in the mid 1970's. Since then, his own innovative indirect therapy techniques have had a major influence on the health professions both in the UK and Europe and have changed forever the perception of hypnosis and how it should be used within therapy.

He was founder of British Hypnosis Research (1979) and the British Society of Clinical and Medical Ericksonian Hypnosis (1995), both major training bodies for the caring professions. His two-year Diploma courses became the standard training for thousands of health professionals and over a period of 15 years he taught indirect hypnosis courses in over 27 major British hospitals. His Diploma courses also became the standard training for hypnotherapy associations and organisations in France, Belgium, Spain and Ireland. In 1991 he was awarded special acclaim when archive recordings of his work were preserved in the British National Sound Archives.

He specialised in innovative approaches to Indirect Hypnosis with an emphasis on demonstrations with real patients during his training courses, something that many trainers are still afraid to do. A common thread in Stephen's work is his humour, compassion and creative approach to therapy and his deep respect for the unique needs of the patient. He treats problems by spontaneously doing what is often most unexpected but always most appropriate for the patient at the time, quickly tailoring each therapy session to the patient. His enthusiasm is highly contagious and he has the great quality of being able to teach his complex refined skills in a dynamic and simple to learn form.

In the mid 1990's, at the height of his UK career, he decided to retire and settle in the mountain rainforests of Northern Thailand where he studied trance healing with monks and shamans for several years. He is now responsible for the design and teaching of the British Hypnosis Research online academic hypnosis courses and he runs the British Hypnosis Research Summer School in the UK and America each year.

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Indirect Hypnosis

Philosophy and Overview of How To Learn This Approach

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Introduction

So often in psychotherapy, problems remain unexplainable and solutions elusive. This can happen despite all effort on the patient's part to explain the events and patterns that have led up to the symptoms developing, and despite the therapist asking the most pointed and searching questions. In such cases, where no concrete answers present themselves, therapists often ask patients to "trust their unconscious" and to allow therapy to happen all by itself. Trusting the unconscious is of course the stock in trade of the Indirect Hypnotherapist, and while this is often a powerful tool for inner healing, it can also be a dangerous weapon in the hands of a new, if enthusiastic therapist.

The reason for prescribing this form of DIY unconscious healing is often the therapist's ignorance about what to do next, so this approach to therapy can sometimes deliver unpredictable results, especially if the therapist does not have a basic understanding of how patients experience reality, the affect of trance states on that reality and vice versa.

Knowing that anything is possible when the non-conscious decides on its own therapy, without guidance, you might understand my concern about the way that many therapists practice Indirect Hypnosis or the Ericksonian approach.

Many trainees try to "model" established therapists in the hope that they may acquire some of the therapist's skills. This concept has primarily developed from the field of NLP. While this is positive in principle it can be misleading if the trainee then believes that he now can install the therapeutic strategies that will allow him to replicate the excellence of the therapist.

Take for example the innovative work of some eminent Ericksonians like Dr Ernest Rossi. Rossi appears to work with minimal verbal intervention or patient guidance. His therapy sessions seem to be the closest thing to non-verbal healing you might find in psychotherapy, so much so that it might be easy to discount his contribution to the talking therapies. Yet behind Rossi's approach lies a complete model of psychotherapy that not only respects the integrity of the non-conscious mind but also understands the dynamic of how problems develop and are maintained by patients.

Yet to see him working it would be all too easy to model what one sees and hears, believing that by replicating his minimalist approach, the same results could be achieved. So easy would it be to model in fact, that you could do it after watching one session, and it would most likely look and sound the same. Yet it wouldn't be the same because you would not have his unique life experience or the same understanding that lies behind the approach.

Modelling is a good way to learn, but only if supported with a detailed and precise analysis of the strategies being employed by the therapist being modelled. Sadly, not many great therapists allow us the opportunity of watching them do therapy and of those, not many have the additional skill to accurately communicate what they do at an non-conscious level as they

demonstrate their art. So we are left to model well known therapists only on video and usually without any ongoing commentary from the therapist themselves as to what they are doing.

Whenever possible, therapy trainers should walk their talk and demonstrate therapy in real time, ideally with a running commentary to the audience or at least a blow-by- blow analysis afterwards. Trainers should demonstrate why they believe that they have the authority to teach what they teach.

Trainee therapists are often let loose on the public with only a brief experience of modelling so-called excellence, when in reality what they are modelling is their own limited perception of excellence. What they really need is to get their hands dirty on courses and take the therapy trainer, demonstration patient and themselves apart piece by piece to analyse the structure of how it works. Regrettably this rarely happens as many courses are no more than the rote learning of inflexible techniques.

But where do you start when there is just so much going on? Isn't it just easier to sit back, trust your non-conscious and learn by going into trance and modelling what you think you see and hear? Sadly no, this isn't the way, although it can be a useful way of filling in the gaps that you may have missed consciously. I always try and give my students a multi-dimensional learning experience when I teach. There is no point in holding back and keeping strategies to myself. I am not happy unless I too have learnt something from my own therapy demonstrations and have been able to empower others by discussing those demonstrations in full.

Using Concepts and Contexts In Indirect Hypnosis

Over the years on my training courses I have been asked one question over and over again "How do you know what to do first, next and last?" Of course there is no simple answer, but most recently I have been telling trainees that there are two simple concepts that you can apply that will enable you to see yourself, your patient and their problems in perspective and therefore see how you relate to one another within the context of a therapy session. If you learn these concepts everything else will start to fall into place, often without too much effort.

The first concept relates to how we experience and maintain our relationship with reality, and the second to what we choose to include in our reality.

Behind any kind of therapy there should be a basic understanding of how people experience reality. Without this understanding, therapy will be a shot in the dark. Yet rarely is the nature of reality taught on therapy courses. Most course participants are hungry for "techniques" and pursue the learning and practice of these techniques without realising that a basic understanding of the nature of reality will itself enable the trainee to develop their own innovative therapeutic techniques.

Understanding The Nature Of Reality

A topic such as "Understanding the Nature of Reality" may sound a bit daunting and a bit like a hefty PhD thesis but this is not the case, as it can easily be learnt in just a few hours of training. Even given that the practice of this knowledge may require several sessions of concentrated effort and ongoing application of this understanding, it is still relatively easy to understand.

To know how a patient relates to his problem and how the problem is maintained, you also need to understand how you relate to your own experience of life events and how you maintain an interest in these events. By understanding the interaction between yourself and events you will also understand how hypnosis plays a part in your experience of everyday reality and be able to see how hypnosis also can also play a part in resolving problems for patients. Understanding reality will help you understand hypnosis and vice versa, because they are very closely linked.

Hypnotic Trance and Becoming One with Reality

The above title may sound a bit esoteric but any hypnotherapist knows that if you look at a spot for long enough, your eyes will de-focus and your visual field narrow, leading to eye fatigue and possible internal imagery, but why does this happen? There are many explanations, and all may play a part but by far the most important reason is that we cease to connect with reality. We are still looking at that spot but that spot is static, as are our eyes, so there is no movement and without movement we have no way of measuring our relationship with the spot.

When reality fails us externally we seek it internally and so we start to experience internal imagery, or at least some kind of connection with our inner absorption. Our internal reality becomes more real than our external reality, because it has more movement in terms of internal imagery and / or thoughts and feelings, by which we can measure our relationship to it. If we cease to experience movement in our internal reality we become one with it and dissociate from all conscious thinking or way of comparing or judging.

Everyday we continually test and measure reality by adding to it and observing it's response to our contribution. If you have an itch you scratch it and then you wait to see the result, if it's still there you scratch some more. If you do not scratch it in the first instance, there comes a time when it ceases to itch, not because the itch has gone but because you have stopped interacting with it and stopped knowing that you are separate from it. If you merge with the itch you become part of it and no longer feel separate from it and so no longer feel it.

People naturally fidget when they are sitting still, talking, sleeping or watching TV. Every movement is a deliberate, albeit non-conscious, mismatching with reality, a deliberate attempt to separate the self from reality in order to relate to reality. As contradictory as this seems, people try to feel part of reality by separating themselves from it and comparing themselves to it, moment by moment. While this does confirm that they are part of reality it also prevents them from becoming one with it. This is one of the reasons some people have difficulty going into trance. They are simply too keen to go into trance, and continually keep checking back with reality to see how they are progressing.

If you stop fidgeting, you blend into reality, you become one with it, but it is difficult for you to tell this is happening because you are no longer separate from it. So your instinct to survive tells you to keep checking to test that you are still independent, alive and part of the living world.

When we touch things we tend to incorporate movement into the touching and this increases the tactile sensations. A touch without movement gives you limited information. Likewise, the first thing you do when you look at something is to look away so you can see the difference between what you are looking at and what you have not been looking at. By comparing the two you give solidity to each. You continually test reality to know your relationship to it. Your patients do this too. They do it to you, to everything they experience and especially to their problems. The more you appreciate this simple concept the easier therapy will be.

Patients check how well they are doing in order to know how good their therapy is, but their observations can sabotage the benefits of the therapy. If you can get your patients to let go of needing to know how well they are doing then your work will be more effective.

There are two fundamental ways to stop your patient from continually checking how well they are doing; by decreasing how much content they have in their reality (by limiting how much access they have to their reality) and by increasing how much content they have in their reality (by getting the patient to see their problem in other contexts). It is your understanding of how these two concepts work together that will give you the therapeutic edge as a therapist.

Profound hypnotic trance requires a reduction in the need to compare oneself with the external world and an acceptance of the state of uncritical acceptance, in other words, a merging of the self with reality, initially by merging with external reality (de-focusing, immobility etc), and then by merging with internal reality (eye closure, visualisation, dreaming, states of non-self etc). When the patient has truly merged with their reality their problems can appear to cease to exist as they no longer feel themselves to be separate from them and so can no longer be critical, objective or governed by the rules of their external reality or everyday conscious ways of thinking.

However, while this is an ideal state in which to work therapeutically during therapy sessions, it is not a practical state for patients to maintain in the real

world. In the real world, patients usually try and stay out of trance by fidgeting and doing anything that prevents a merging with reality in order to check how well they are doing or otherwise in therapy. Reality contains events, behaviours and many shades of experience, which act as reference points by which people measure how they feel. Patients can be both limited and empowered by the amount of reference points they hold in their reality. And this is why by decreasing how much access they have to their reality and by increasing how much content they have in their reality we can break patients out their current rigid ways of thinking about their problems.

When the patient enters therapy he brings in a fixed number of reference points. He refers to these continually, usually throughout the first interview. Your job as therapist is to use a combination of techniques and language patterns to help the patient increase and decrease the number of reference points available to him at given times during the therapeutic process so as to steer him, albeit indirectly, across the map of his recovery.

The less information patients have in their reality, the less reference points they have with which to assess the state of their problem, so the harder it will be for them to make conscious decisions. This is often useful when they are over active consciously and want to manipulate the treatment in some way, even with the best intentions. Some patients however need more reference points, not so much to assess their own progress in therapy, as this would not be useful, but to help them see their problem in a new light.

This is where the concept of contextual change comes in. Shifting the problem to a new or different context, either by transforming the context through expansion to include more reference points or by moving the problem to a new and novel context or by seeing the problem as if embedded in a different time frame, the patient can gain insights that can then be applied therapeutically to the problem when in trance.

If reference points are removed with hypnotic trance, either formal or indirect, a patient can often reach the point where they lose awareness of their problem. At this stage they are “ripe” for change. Armed with the insights from the prior contextual shifts they can enter the world of trance, often without bias or interpretation and apply their insights non-consciously to resolving their problem without the contamination of conscious interference and with a sense that they no longer need to check their progress as they sense that it has already started happening anyway.

Your job as therapist is to open up new worlds that have remained illusive until the patient enters therapy with you. These new worlds require the patient to be active both consciously and non-consciously, but for different reasons and at different times and within a safe and caring environment. It is your responsibility as a therapist to provide this environment, to know how to affect the patient’s awareness of their reality and to know how and where you can learn to develop your skills to do this.

A Brief Introduction To The Six Stages of Indirect Hypnosis

- Rapport
- Information Gathering
- Identifying Resources
- Trance Induction
- Therapeutic Interventions
- Motivating Your Patients

Rapport

The first time someone telephones for an appointment, and if I get the chance to speak to them personally, I will start work right there on the phone. Part of this will be building rapport and part will be giving post-hypnotic suggestions. I will start with something very simple. A woman phoned me because she was pregnant and wanted to know if I could teach her self-hypnosis for pain control.

To build rapport and to insert some pre-session suggestions for pain control I told her this story:

"I had a woman telephone me recently who wanted the same thing and all I did was, ask her to come into my office and sit down and listen to me. I told her that her hand was getting very, very numb and I allowed this to happen over the next few minutes. I then I taught her how to do this for her self. She then just placed her hand wherever she wanted and she was able to anaesthetize that part of her body. It just happened all by itself automatically."

After this story, my new patient booked an appointment and when she turned up I started talking to her and she started to go into trance, she just drifted off, and I said, "What's happened to your hand?" and she said. "I can't feel it".

The indirect post-hypnotic suggestion was given on the phone, and she'd had a few days to allow it to become integrated and fixed in her mind and it just happened by itself without me suggesting it directly. So work starts right at the very first contact with a patient. In this case it was on the phone before we had even met. The first step is to build rapport and prime the patient for the session. Unless you have that, nothing will happen. So rapport is the prerequisite of successful therapy.

Information Gathering

The next step is Information Gathering – questioning and observation. If you pay attention with your eyes you will pick up a different class of information from when you only listen. You need to use all of your senses to pick up information because you are looking for a mismatch in the way that the patient communicates. Every mismatch will give you valuable clues about what to do

next with your patient. You are looking for incongruity. For example, you ask your patient the following question; “How are things with your mother?” The patient answers “Fine” but at the same time shakes her head as if disagreeing with herself. You then ask; “How are things with your father?” Again the patient answers “Fine” but then digs her heels into the floor as if she is uncomfortable talking about her father. The patient’s words sound positive but there is a mismatch between her positive verbal responses and the negative non-verbal communication, and these are the things you need to watch for.

You ask; “Can you remember what it was like being a teenager?” The patient answers “Umm yes” and the heels dig in again. When you see a simultaneous positive verbal and negative non-verbal behaviour repeated as a response to further questions you can be sure that your line of questioning is evoking important clues about the source of the patient’s problem.

The patient’s non-verbal behaviour is a running commentary on what the patient is thinking non-consciously. For example you may ask; “Please tell me about your relationship with your father”, and the patient replies, “Oh we don’t see each other much anymore”, and as she replies, she non-consciously massages the back of her neck as if experiencing tension there. So you notice a physiological non-verbal ideo-motor response accompanying her verbal response. You might even in some instances interpret the non-verbal response as a kind of non-verbal metaphor, implying that she feels that the father is a pain in the neck. Look for verbal and non-verbal incongruities and this will give you valuable information.

Identifying Resources

I believe that every patient has within them the non-conscious resources necessary for solving problems, but that usually they don’t know they have these resources, or, they know they have them, but are unable to access them. Most psychological problems require more than just everyday rational thinking but because most people have no conscious awareness of the non-conscious mind’s ability to solve problems effectively they only use their conscious resources. The patient’s failed conscious attempts at problem solving usually increases their anxiety. So when a patient comes in to see you they usually come with two problems. Firstly, they come in with their actual problem and secondly the problem of not being able to resolve their problem.

Everyone knows how hard it is to try and do certain things which really ought to be done non-consciously, like tying shoelaces, tying a necktie or driving a car. All of these things can be best performed at an non-conscious level and once learned are really difficult to manage consciously.

If I asked you to explain how to tie a shoelace, your fingers could probably show me a lot faster than you could tell me. This is because, by letting your fingers demonstrate how to do it, you would be letting go and allowing the non-conscious part of you to do it for you.

So Indirect Hypnosis is about teaching the patient how to go inside, say hello to their non-conscious mind and getting it to heal them. You, as a therapist do not do any healing, you only help the patient open up the channels for their own self-healing and you do so with as little visible intervention as possible.

You should never give your patient the impression that you are doing the therapy - it is always the patient who does the work. You should be empowering them by acknowledging their ability to heal themselves, not disempowering them by being the super-talented therapist. With your help the patient is taught to go inside to gain access to their natural ability to heal themselves with the resources that they have at an non-conscious level, and they should be encouraged to realize this so that they feel an active part of their success.

Let’s talk about the difference and similarity between healing with non-conscious resources, meditation and the placebo effect, where the patient’s belief that they will get better allows this to happen. If the patient can get better with the non-conscious mind utilizing inner resources, or by meditating on candle flame or through the placebo effect then I think that all of these approaches are viable and are good therapy. Therapy is only good when it gets reseults and as long as it can be reasonably replicated in others it is good therapy.

The placebo effect is very active in psychotherapy, maybe much more than is given credit. If I could teach therapists to be charismatic enough to just sit in front their patients, and have their patients get better, without them having to say anything, then I would do it. I think that although you are being taught therapeutic structures as part of your training in hypnotherapy, sometimes, the less you do, the better. This is the origin of my Minimal Therapy approach, something that I developed as a result of my work with Buddhist monks in Thailand in the 1990’s and something I hope to write about more fully in the future.

Your patient’s needs will determine the direction of therapy. If you force your patient to match your model of how you believe therapy should be done then you will severely limit your patient’s ability to get better by themselves. The more open you are in your approach and the more flexible and non-authoritarian you are with your language, the more successful the treatment will be. So rather than forcing your patient to follow a particular therapeutic model I suggest that you sow the seeds of therapy indirectly and then step back two or three paces and just watch your patient get better. It can work all by itself, on one condition; that you work from the heart, but more about that another time.

Trance Induction

People go in and out of trance on a day to day basis. Your role is to evoke these naturally occurring trance states indirectly in a conversational and naturalistic way that respects the patient’s integrity. The actual art and science

of evoking these trance states is a lot more complicated than it at first appears, and you should set your sights on mastering this particular stage of the therapeutic process. If you are unable to put people into trance simply by your presence in the room with them then you haven't been studying hard enough. Keep this in mind as you learn everything and put it into practice. Trance is both the vehicle for the therapy and the adhesive for making it stick. It is your means of accessing the patient's non-conscious mind which holds the memories and resources required for problem solving.

Successful trance induction is based on two things, your ability to induce an appropriate trance state and the patient's ability to experience it. There can be many variables and no two trances are the same, so it's a little bit like juggling with reality. Successfully trance induction is contingent on your ability to master hypnotic language and to do so with integrity, understanding of non-conscious processes and compassion for other people. Hypnotic language can be highly manipulative in the wrong hands but is rarely successful in these cases because it lacks the integrity and compassion to have deep lasting meaning for a patient.

Therapeutic Intervention

Therapeutic Intervention is where you actually step in and do something when you have to. So far I've been talking about stepping back and being as visibly inactive as possible but of course there are certain things you need to do more directly sometimes in order to help people, especially in the field of couple or family therapy, so I often give people tasks in order to bring about outcomes. The indirect therapeutic skills you will learn are multiple, that is, there are many, many skills you'll take away from your studies and training, and of course you can use skills in different combinations, which is why it's never the same set of skills for each patient.

For example, one day you may have a particular patient, and you will suddenly decide to reach into your box of skills and pull out a skill that you have never used before or a new skill that is an integration of several others. Once you have learnt how to use each of these skills, and to create your own by combining the principles behind each skill, you will be able to be very creative. Good therapeutic intervention is based on your ability to be observant, innovative and flexible in your approach and skill development, most of which happens spontaneously as you work.

Motivating Your Patients

Regardless of how well you progress through the various stages of a therapy session there is one deciding and in many cases, elusive factor that will determine your success as a therapist. This concerns the patient's degree of motivation.

There seem to be two common patterns that often prevent patients from getting better. Patients are usually confused about how to help themselves so they consistently repeat failed attempts at problem resolution, thereby increasing their anxiety and frustration, which often aggravates the symptoms. Secondly they consistently apply these failed attempts through conscious effort. This has the negative affect of training the brain to devalue the role of the non-conscious and often reinforces the severity of the symptoms by giving them more conscious attention.

Many patients seem divided by doubts about their ability to get better. This is usually caused by previous failure, either with their specific problem or from a general lack of confidence caused by past experiences of failure. Patients sometimes say things like “There’s a part of me that wants to change and there’s another part which says I can’t”.

The patient’s chance of success is very low while they have such doubts. Patient motivation is the pre-requisite to the acceptance of your therapeutic interventions and is the key to really successful therapy, so it’s very important that you deal with the part that says “I can’t”.

I believe that you can do anything you want to if the goal is realistic. If you want to accomplish something within a reasonable time frame, and you have the resources and the skill to do so, then I think that there is every reason to believe that it is possible. I often tell this to patients and give examples from my own history.

In therapy we are dealing with the realm of the possible. So when people come to see me, I try and access whether they have the resources and time to achieve what they want. If they want something reasonable I will deal with any doubts and go for it immediately. If what they want is unreasonable, either in terms if time, context or resources I will try and get them to re-evaluate their goals so they are reasonable and attainable. Then I go for it. The whole process is to get them motivated by convincing them that realistic change is possible. This is an integral part of the therapy process.

When you have a patient with a habit, compulsion, or phobia then I think it’s quite reasonable to believe that they can overcome it, even if they say “I want, but I can’t”. Sometimes, when looking for the cause or a reason why a problem has not been resolved, you might have to look further than the patient. Often there are other people, maybe at home, socially or at work that make it difficult for the patient to overcome their problem. In which case if you really want the patient to achieve what they want, you also have to work on those other people as well, and you can do so in many ways. You can either work on them directly by asking them to attend the therapy sessions, or indirectly through the patient, by giving the patient tasks that involve the third party outside of the therapy sessions.

Usually if a problem is self-contained, that is, other people or contexts are not reinforcing it, you can work on it relatively easily. Ideally, successful therapy is

based upon the patient having a good level of motivation where the patient can work without contamination from others or external influences.

We need energy to exist, and that's how we keep going. We thrive on energy and we try and direct it into the different areas of our lives. If you direct all your energy into negative things then life will be negative, if you direct it into positive things then it will be positive. It sounds very simplistic but it is true.

I believe that people are like sponges that soak up whatever comes along and are habitually drawn towards soaking up what is familiar, even if it is not good. I remember when I was young I caught my hand in a door. This wasn't enough to make me obsessive. It wasn't even enough to make me cautious, because I did it a second time. When I'd done it a third time however I had the beginnings of a nice little phobia, which I could have nurtured if I had wanted to take it further. As it happened I was content to just want to avoid doing it again.

The way people usually try to get over their problems is to avoid them. If they're agoraphobic, they stay indoors but this actually makes the problem worse. If you stay in, you become a confirmed agoraphobic because you never learn to face your fear. So if you get your hand caught in a door, you run the risk of developing a minor obsession if you deliberately start avoiding doors. The crazy thing is that it is human nature to avoid what hurts rather than confronting it. This is why I think we're basically victims of our own habitual thinking. If you walk past the door and you say to yourself "I must not catch my hand in the door this time", then you are reinforcing your fear.

A woman came to see me about a chocolate compulsion and I asked her how often it occurred. "She said "Every afternoon". She said "I went to a hypnotherapist, but it was no good, it got worse". He taught her self hypnosis and then instructed her to practice at the start of every afternoon and repeat to herself that she shouldn't eat chocolate." All she could think about all afternoon was that she shouldn't eat chocolate, which she desired even more by thinking about it continually and her need became even greater because she felt so guilty about her increased desire to eat, that she comforted herself by giving in and eating the chocolate.

Patients either avoid their problems by consciously telling themselves not to have them or they try and resolve them through repeated failed attempts, and then they wonder why the problem is still there The way to avoid thinking about the things you don't want, is to think about something else.

As discussed earlier, many patients spend a lot of time negating their own healing potential. "I can't, "maybe", "yes but". This effort takes up a lot of energy. Change the "yes but" to "yes and" and then everything you say will be positive. Everything you say after a "yes but" is negative, the tonality is even negative. Say "yes and" instead and everything is positive, even the tonality. John Grinder taught me that trick.

If you go through life as the kind of sponge that gets your hand trapped in the door and says “Done it again”, just realize what you are doing to yourself, the implication is that it happens a lot and it’s going to happen another time. “I’ve done it again, can’t believe it” or “life has done it to me again and I wonder what will happen next”. You must know patients like that? They start to look out for things to go wrong in order to avoid them, and by looking out for them they keep finding them, bang, bang, bang, and they have an awful life. They have a negative life because they spend all their time putting energy into avoiding things that they don’t want to happen. And people who are accident-prone tend to do that. They’re not born accident-prone, they teach themselves to be accident-prone. They keep looking for things to go wrong, and sure enough they find them.

So often, people maintain their problems by trying to solve them. Because “trying” occurs at a conscious level the patient usually only has his conscious resources available for problem solving, the root of most problems are at an non-conscious level, if they were purely conscious it would be easy for people to solve them themselves and they wouldn’t need a therapist. So it’s necessary to help patients gain access to their non-conscious resources for problem solving. The word “try” implies difficulty; so the harder they try to solve the problem the more difficult it becomes. This is because they’re using only limited conscious resources. They may try to stop eating in order to loose weight by telling themselves not to eat a particular food. However the very thought of not eating the food requires them to think of the food before deciding not to eat it. By doing this they’re reinforcing the thought of food in their mind.

We tend to gravitate towards what is uppermost in our minds. Think about something you don’t want and you will surely get it, so if a person is constantly thinking, “I don’t want this anxiety state” or “I don’t want to smoke” or “I don’t want this phobia” etc. the thought will be reinforcing it. If you say “I mustn’t forget this” then you are giving yourself a direct suggestion to forget it, the thought that should be uppermost in your mind should be, “I must remember this”. Think about what you want rather than what you don‘t want.

I know a lady who when she was young had a father who in the process of doing amateur radio repairs on the kitchen table would cause chaos in the house. She swore to herself repeatedly that she would never marry a radio engineer, and, yes you‘ve guessed it, she did.

It’s only natural for a patient to try and make him or herself better, but they are usually unaware that the act of trying reinforces the problem. It’s not always a good idea to tell the patients they are doing this. You will get better results if you introduce the idea indirectly in the form of metaphor or with analogies, mainly because patients sometimes try and defend themselves if you confront them with the reality of the situation. When people start to defend their actions it usually results in them becoming even more fixed in their views as they search for more evidence to prove they are right.

Often patients will get themselves into situations, which leave no room for success. They will put themselves into double binds whereby any decision will bring about a negative outcome. In the same way that if you loose your keys you may return to the same place many times to look for them rather than looking somewhere totally new. Patients will often try to solve a problem the same way over and over again even if it fails because the problem takes all of their attention and they're unable to step back and look at it objectively. This saturation of subjective experience tends to severely limit their awareness.

Often, when patients realize how they have been trapping themselves through their limited awareness, they find it funny. Sometimes this realization can be very enlightening and even therapeutic. But it isn't usually enough for them to change because they need to learn new ways of behaving. They don't know how to behave in a different way, so you need to help them create alternatives. These alternatives can be offered in the form of tasks or new strategies. Alternatively you can suggest that changes occur indirectly by using hypnosis and indirect suggestion.

The Meta Components of an Indirect Hypnotherapy Session

This section is about how to learn indirect Hypnosis. It is not about Indirect Hypnosis but about how best to study the subject. I am going to share with you information about the set of perceptual filters that I teach my students to use when they watch me teach Indirect Hypnosis or watch me do a live demonstration. If you have these filters, it will help you to home-in more specifically on what will make a difference for you in your application of Indirect Hypnosis, especially if you ever get to see me work live or on video.

Approach, Technique, Strategy and Skills

There are four components that make up the way I work. They are Approach, Technique, Strategy and Skills. These are the four components I am talking about here but they vary considerably.

Approach

- Approaches – are philosophies and interpretations:
- Approaches are based on beliefs about how and why people have problems and how they can be resolved
- Approach is broken down into its linguistic application and its behavioural application
- Linguistic: General tonality, vocabulary and speech patterns
- Behavioural: Demeanour and general manner

Are you familiar with the stone sculptures made by the artist Barbara Hepworth? I first saw her sculptures in the 1970's. I didn't know it was her

work at the time. I saw several pieces in different locations and didn’t realise they were by the same artist but I was drawn to them for some reason. When I found out they were all by Barbara Hepworth I realised that I obviously have a feeling about this woman's work. Recently there was a programme about her on TV. The programme had archive footage of her working with a huge block of limestone and a simple chisel and a hammer. Basically what she had there were the same tools that a Neolithic homo sapien would have had 3,000 years ago during the Bronze age, just a bronze tool and a rock, nothing sophisticated. In the programme she was shown just chipping away, chipping away, chipping away for 14 hours a day, every day of her life. When she started she had a solid block of rough stone and when she finished she had created this sensual spherical shape in smooth stone. It had movement and it followed the natural forms that you also see in nature. She discovered that she could put a hole through the middle of a sculpture to give it another dimension, and then that she could put two sculptures together and let sunlight shine through one hole and into the other hole. She created a communication between the two sculptures. What is fascinating is that she started with a huge solid block of rough stone and when she finished she had something of unbelievable beauty that had a sensual quality that you felt compelled to touch.

Researchers did some research on how people feel compelled to play with spherical objects. They secretly filmed people standing at an office reception desk on which they had deliberately left a soft rubber ball. The receptionist would say "I'll go and see to your paperwork", then go into the backroom and the person waiting would be waiting there at the desk being secretly filmed. After a minute or so, everyone being filmed picked up the ball, played with it and quickly put it back when the receptionist returned. Everybody did this without exception. Barbara Hepworth’s sculptures are like that. You feel that you want to touch them, they are very sensual and tactile. You want to touch them. I think that this instinct is hard wired into us from birth and is something to do with our maternal relationships.

At home I have some Neolithic bangles, prehistoric bangles from Thailand taken from gravesite excavations. I have one bangle, which is absolutely beautiful and made of serpentine, and it is an absolutely perfectly circular bangle. It is about half an inch across and about a quarter of an inch thick. These days we are so used to seeing factory made bangles that we take their manufacture for granted. But when you realise that this pre-historic bangle was originally a solid block of serpentine rock, and that somebody had to hollow out that bangle from a block of rock by hand 3,000 years ago with only a basic primitive tool it is quite breath taking. The chance of it splitting or cracking must have been so high and to actually chip away until you've got this very, very fine bangle made of serpentine must have required a lot of patience. Just imagine the commitment that person must have had to create something so beautiful.

What I am talking about here is my attitude or my approach to my work. Patients come in as a rough rock and I am here to help shape their lives, and I have to do so with commitment and care, and if I have this, it will

communicate through the way I speak and do things and the results will be beautiful and strike a chord in everyone watching.

So the first component here is approach. Every therapy has its own approach. Erickson had an approach, which in fact is very different from the approach that Ericksonian therapists have today. During Erickson's peak, which was in the 50s, his approach was based on maintaining the American dream. Everybody had to get married by a certain age, and they had to settle down and have x number of children and look after their grandparents, it was that kind of pattern, in America. If you look at Erickson's case studies you will see that a lot of his work was based on getting people to conform to what society said was the American ideal. That's not the case now. Ericksonian psychotherapists in America don't follow that approach any more. If you look at the big frame, his approach was based on a model of the perfect society. Within that was embedded another approach, which was based on his belief that everybody could help themselves. Bandler and Grindler have taken this belief on board too. Erickson believed people could do this and maybe this came about because of his own disabilities where he had to learn to walk again after being paralysed with polio. Your view of what to do and how people change and get better is called your approach.

When therapists watch one of my demonstrations or when they listen to my lectures, I often ask them to get a filter, call it an approach filter, and place it over everything they here me say and do and then to only pick up those elements of what I do that fit into the category that we call approach. If you meet with other therapists for supervision or practice sessions you can do the same thing with your partners in exercises. What is their approach? What is it they are doing? Where are they coming from? Place an approach filter over what they do, to separate their approach from everything else they are doing.

These four components have their linguistic application and their behavioural application. With approach we have first got the linguistic application which is the tonality, the vocabulary and the language patterns. You communicate the linguistic application of your approach with the words you use and by the way you use these words. That's the linguistic side. The behavioural application of the approach is how you sit, how you move, your body movements, even the way you use your eyes, everything that is non-verbal.

Have you ever just looked at a patient in a particular way and they have burst into tears? Has that ever happened to you? That's an example of a behavioural application of an approach. You haven't said anything, you have just been present. Your approach in this example was probably one of compassion and acceptance.

So once again:

- Approaches – are philosophies and interpretations of how therapy should be done.
- Approaches are based on beliefs about how and why people have problems and how they can be resolved

- Approach is broken down into its linguistic application and its behavioural application
- Linguistic: General tonality, vocabulary and speech patterns
- Behavioural: Demeanour and general manner

Technique

- Techniques – are maps and templates
- Techniques are sets of instructions based on the strategies and skills of a given approach
- Technique is broken down into its linguistic application and its behavioural application
- Linguistic: The things that you say to guide your client across your map
- Behavioural: The gestures and use of non-verbal communication

The second component is technique. Techniques are embedded into the approach. So the approach is the big frame and embedded inside the approach is the technique. I rarely design techniques before I meet a patient. I create techniques as I go on, and at the end of a session I have usually created several new techniques. A lot of Bandler and Grindler's techniques came out of workshops, where they presented ideas and people just got around in exercise groups and would come up with new concepts etc. And they would say "Oh, we've got a technique here. Let's try it again next time and refine it. And they narrowed it down to a set of refined steps.

Techniques are a great way to learn. But once you've got them just let them go. Techniques are maps to guide you through the session. Again, when I am demonstrating, I teach my students to use their technique filter so that they identify when I am developing or using a technique. Techniques can also become templates. A template replicates a process. So techniques that do not evolve are just a replication of something that worked at one time. NLP has succeeded because there are many hardcore templates within NLP that can be taught and learnt quite easily by most people. And so it has spread like a happy virus. In the latter days of NLP development in the 1990's people started to move around the templates and make them into maps more than templates, they made them more flexible, which is better.

Again with Technique you've got the linguistic part of the technique, which is basically the instructions, the things you say to guide the person across the map you are using. How you guide them from A to Z etc and you have the behavioural aspect of the technique, for example the gestures and other non-verbal parts, which help illustrate that technique, for example, "look at my hand here, now look at my hand there." Now, if I'm demonstrating a technique, there is usually a behavioural component to that technique. I'm using my hand as part of the technique to get them to hallucinate something on my hand, for example. That's the behavioural part of the technique.

So once again:

- Techniques – are maps and templates
- Techniques are sets of instructions based on the strategies and skills of a given approach
- Technique is broken down into its linguistic application and its behavioural application
- Linguistic: The things that you say to guide your client across your map
- Behavioural: The gestures and use of non-verbal communication

Strategies

- Strategies – cognitive processes:
- Strategies are based on ways of thinking within a given approach and are defined by the rigidity or flexibility of that approach
- Strategy is broken down into its linguistic application and its behavioural application
- Linguistic: Your internal dialogue and the non-conscious messages you receive
- Behavioural: What you visualise, hear and feel

Embedded inside of techniques are strategies and skills. Strategies are cognitive processes, ways you think through things. They are a series of steps based on what to do next. You can't see them because they are cognitive, so you can't see somebody's strategy, apart from eye accessing cues or whatever. I never ever go into a session thinking I am going to use this or that strategy because every session is unpredictable. I have to be just there at that moment and decide what to do, based on what the patient gives me. The strategy comes out of the session, I don't create it before hand.

Strategies are harder to break down into linguistic and behavioural components but they are still distinct. Strategies are invisible and internal, so they can't be seen but they are there never the less. When I am working with a patient I am constantly receiving non-conscious internal dialogue and images from my own non-conscious. It's as though I've got somebody there in the Control Tower giving me advice all the time and telling me what to do. I can't clearly hear a voice in my head, but I hear and I see messages which give me instructions on what to do next. I call these non-conscious messages. I then make a decision on what advice to follow if the message is combined with an intuitive feeling of some kind. The feeling is the behavioural component of the strategy. It is what you feel kinaesthetically.

So once again:

- Strategies – cognitive processes:
- Strategies are based on ways of thinking within a given approach and are defined by the rigidity or flexibility of that approach
- Strategy is broken down into its linguistic application and its behavioural application
- Linguistic: Your internal dialogue and the non-conscious messages you receive
- Behavioural: What you visualise, hear and feel

Skills

- Skills – are behaviours and actions:
- Skills are the behaviours of a therapist working within a given approach and are defined by the rigidity or flexibility of that approach
- Skill are broken down into its linguistic application and its behavioural application
- Linguistic: The language patterns you use
- Behavioural: The non-verbal application of a skill

The last component is skills or behaviour. When you lift your eyes and you raise your eyebrow, and you put your hand out, what are you doing? You are actually communicating non-verbally. That is part of the skill base that we use here. Skills are behaviours that you can actually observe. So when you see me do a demonstration what you need to notice is the approach, the technique, the strategy and the skills and you need a different filter for each, so that you can separate them out for study. Break down your learning into these 4 components. Imagine that you have four different pairs of glasses, use one for looking at approaches, one for techniques, one for strategies and one for skills.

Then with skills we have the linguistic and behavioural components as well. The linguistic component is the language pattern. A specific skill will use specific language patterns at that very moment. And the behavioural component is the non-verbal application of that skill. For those of you who know about analogue marking, this is an example of a behavioural application of a skill. There is the linguistic application of the skill by placing emphasis on a part of a suggestion you are giving, by maybe pausing or changing tonality, and the behavioural application of the skill by maybe changing the position of your head.

Learning All Of This

If you want to consciously remind yourself of this, please go over it again several times. It will help you break down what I am doing, rather than just

trusting your non-conscious and being a sponge, trying to absorb it all first time around. If you are a sponge and just absorb it all non-consciously, you will put down this book with a lot of hope and not a lot of knowledge. You can go to a concert and watch a fantastic pianist and wish you could play the piano as well, but unless you sit down on your own and practice the scales you aren't going to learn how to play.

Overlapping

These components are not running sequentially, they are all happening simultaneously. You have approaches, and then within approaches you have techniques – technique 1 and technique 2 for example and within them you have strategy, and behaviour, and within all of these you have got the linguistic and the behavioural aspect for each of these. That's how they are embedded within each other. That's the big frame, smaller frame, smaller still, and they all happen simultaneously.

When I'm working I don't pay attention to this structure, because I know it well and I don't need to pay attention to it anymore but I am able to stand back and see it in operation, almost as I was someone else.

While learning this you should be mindful of it. These components are sieves. Use a big sieve when you want to look at approach and smaller sieves to get the detailed stuff. So there are a series of sieves, or a series of filters that you use for examining what I do and then what you yourself do. It is unlikely you will be able to do all of them simultaneously consciously. When you do therapy you do them all simultaneously and non-consciously, but initially, to study someone else, it will be very difficult for you to see them all simultaneously. You cannot keep your mind focused clearly on each of these filters simultaneously, so you will have to move from one to the other. You can say "Right, for 5 minutes I'm going to pay attention to the approach, for 5 minutes just the technique, 5 minutes to the strategy and then the skill". You move your focus of attention from one to another and then they will become more distinct. You will then be able to recognise the approach, without you even thinking about it, because you have trained yourself to do it. The same for the other components.

You will be conditioning yourself to think along these lines. It's a bit like training yourself to tie a shoelace. Initially it has to be conscious. When you play the scales on a piano for the first time it is conscious, even if your playing is a little bit wooden. But then after a few times it become non-conscious, you don't have to think about it. It is the same with learning to see the components of indirect hypnosis.

This will be invaluable in your work as a therapist, because if you apply the same observational model to your patients you will see patterns in the way that they communicate with you. They have an approach too. They come to you with their problem, They have the big frame, how they approach life, how they approach problems. They have their own techniques for either trying to

resolve the problem or trying to maintain the problem, and within that they will have strategies, cognitive processes, and they will have behaviours which assist them in maintaining their problem and they will communicate that linguistically and behaviourally.

It is a model which applies to all interactions, all communication. Once you learn this model it will be an integral part of your work as a therapist when you look at your patients, you will be less likely to think, "What do I do next?" because you will have so much more information about them. It's a model, which will enable you to get a deeper understanding of another person. The more you practise it and the more mindful you are of using this when you are watching people and talking to people the quicker it will become an non-conscious process and then your intuition will kick in and you will start to have feelings about people and about how they have got their problem. You won't be paying attention any more to all these components, you will just have the sense. That's when you can just be with them. You just home straight in and you know intuitively what you need to do. It’s not magic, but it seems like it.

Like all disciplines, this requires careful study. If you are uncertain, go over this book again and again until you can recall it easily. It is worth the time and effort to get this right if you are serious about learning indirect hypnosis. The next step is to attend a course or watch videos of my work. Read, get good training, understand the principles and then practice.

For further information about free Indirect Hypnosis publications please visit: http://www.indirect-hypnosis.com.

For further information about training in Indirect Hypnosis please contact British Hypnosis Research.

For further information about Stephen Brooks click here