ORIGINAL ARTICLE

Waking Hypnosis as a Psychotherapeutic Technique

Warwick D. Phipps^{1*}

¹Therapy Works Wellness and Training Centre, Midrand, Gauteng, South Africa

ABSTRACT

Today the practice of hypnosis for therapeutic purposes—hypnotherapy—is recognised as an adjunct to many psychotherapeutic approaches. One important type of hypnosis is waking hypnosis. In waking hypnosis, the client exhibits an altered state of consciousness and a somewhat uncritical acceptance of (beneficial) suggestions *without* having undergone a trance. This is distinct from somnambulism, another form of hypnosis, wherein the client, through the process of trance, subsequently opens his or her eyes and continues to maintain the hypnotic state. In his seminal work *Findings in Hypnosis*, Dave Elman (1964/1984) explains that in waking hypnosis the critical faculty—the client's sense of everyday judgement—is immediately suspended and selective or new thinking subsequently established. Although waking hypnosis has been applied in other fields, for example in medicine and dentistry in the management of pain, it appears that there has been limited purposeful application in the field of psychotherapy. After investigating the phenomenon of waking hypnosis, the paper shows how waking hypnosis, using the example of the *REACH technique*, may be applied in the field of psychotherapy.

Keywords: Elman, critical faculty, hypnotherapy, interactional, REACH technique, selective thinking, somnambulism, suggestion

INTRODUCTION

For centuries people have been fascinated with the phenomenon of hypnosis and, although it has been the subject of extensive investigation, there remains much controversy and even scepticism about its very existence. Despite this, the practice of hypnosis for therapeutic purposes—hypnotherapy—has developed to the extent that it is now recognised as an adjunct to many psychotherapeutic approaches (American Board of Examiners in Psychological Hypnosis, 1961; Mottern, 2010).

Hypnosis, however, assumes different forms or states, one of which is referred to as *waking hypnosis*¹ (Elman, 1964/1984). In waking hypnosis, the client is said to have been hypnotised in the awake state—awake in the sense that he or she was hypnotised without having undergone the *sleep*, that is, the eye-closure and accompanying increase in self-awareness and relaxation typically associated with hypnosis or trance (Elman, 1964/1984).

Although waking hypnosis has been applied in fields such as medicine and dentistry, there appears to be limited *purposeful* application of it in psychotherapy. The objective of this paper is to investigate the phenomenon of waking hypnosis and to explore how it might be applied in the field of psychotherapy.

*Correspondence: warwick@therapyworkscentre.com
Warwick D. Phipps, P.O. Box 6282, Halfway House, South Africa, 1685

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Introduction to the History of Hypnosis

A complete examination of the history of hypnosis is well beyond the scope of this paper. A cursory overview will therefore be presented. Franz A. Mesmer, a German physician, first drew attention to the phenomenon of

hypnosis in 1766 (Mesmer, 1766/1980a). Expounding on his theory of animal magnetism, Mesmer proposed that animate or living beings were comprised of a magnetic fluid and that an alteration in its flow, through contact with a magnetic force, could bring about healing (Mesmer, 1775/1980b; 1779/1980c; 1799/1980d). Using magnets, or his or her own physical presence as the magnetic force, the practitioner was said to induce a *crisis* in the patient—involving, variously, tears, laughter, gastric disturbances, coughing, loss of consciousness, and convulsions resembling those of epilepsy—after which the patient's health was restored (Gauld, 1992). This practice was referred to as *animal magnetism* and later as *mesmerism* (Gauld, 1992; Pintar & Lynn, 2008).

In 1784 the Marquis de Puységur, who was a French aristocrat and a former pupil of Mesmer, discovered that (animal) magnetism could be just as effectively employed without the patient having to undergo the traditional crisis (Pintar & Lynn, 2008). Instead of the crisis, Puységur produced a quiet slumber (Hilgard, 1980) or *magnetic sleep* (Pintar & Lynn, 2008). What was distinctive about this was that the patient often did not recall when awake what happened while asleep (Hilgard, 1980). He termed this *artificial somnambulism*, analogous to natural somnambulism or sleep-walking—wherein the individual similarly does not recall what happened while he or she was asleep (Hilgard, 1980). Puységur had, therefore, transformed the practice of magnetism: Magnetic sleep now replaced the crisis as the definitive quality of the mesmeric state (Pintar & Lynn, 2008).

In 1842, James Braid, a Scottish physician, reported that the mesmeric state could be induced merely by having the client stare at a shining object, that is, without the (magnetic) influence of the practitioner or operator (Crabtree, 1993; Gauld, 1992; Hughes & Rothovius, 1996; Pintar & Lynn, 2008). He reasoned that this state was a function of a particular physiological state of the brain and spinal cord—the “exhaustion of the sensory and nervous systems, which produces a feeling of ‘somnolency’ [or sleepiness] in which the mind ‘slips out of gear’” (Crabtree, 1993, p. 158). He thus argued that this state, which was related to, but different from ordinary sleep (Pintar and Lynn, 2008), was not caused by a magnetic or

mystical fluid but rather by a particular physiological process or state (Bernheim, 1887/1889; Carrer, 2002). In accordance with this, he coined the term *neurohypnotism*—and later, for the sake of simplicity, *hypnotism*—which was derived from the Greek words *neuron* meaning nerve and *hypnos* meaning sleep, that is, nervous sleep (Braid, 1843). Although it is now understood that this state bears no real relationship to sleep, ordinary sleep or otherwise (Elman, 1964/1984), Braid's ideas received strong acceptance at the time as did his term hypnotism, and its more common variant *hypnosis* (Hughes & Rothovius, 1996), which continues to be in use today.

Towards the end of that same century, a French physician in Nancy, Ambroise-Auguste Liébeault, claimed that hypnotism/hypnosis was not caused by a magnetic fluid or even a physiological process, but rather by a psychical or psychological one (Carrer, 2002). Specifically, he proposed that hypnosis was a function of *suggestion* (Liébeault 1889/2002). Repeated suggestions of sleep, followed by repeated suggestions of the disappearance of the ailment, could bring about healing (Carrer, 2002). In other words, he proposed that

Suggestion...is the key to Braidism [hypnosis]! There is no magnetic fluid, there is no hypnotic physical action, there is only one psychical action: the thought. It is the *pure psychic theory* that supersedes Mesmer's fluidic theory and Braid's psychophysiological theory. (Bernheim, 1906; cited in Carrer, 2002, pp. 17-18)

This approach then constituted the basis of the School of Nancy. This school, which was established, in part, by Liébeault and Hippolyte Bernheim, a renowned professor at the Medical School in Nancy, advocated the practice of hypnosis as a form of *suggestive therapeutics*—the use of suggestion in the treatment of psychological and medical disorders (Carrer, 2002). The school's strong assertion that suggestion was the force underlying the induction and the beneficial effects of hypnosis brought it into conflict, however, with the then-popular and influential views of Jean-Martin Charcot—the founder of, and legendary professor at, the Salpêtrière School in Paris (Gravitz, 2002).

In contrast to the Nancy School's approach, Charcot and the Paris School argued that hypnosis was linked to hysteria¹: It was a state similar to an hysterical fit and, thus, had no therapeutic power and could even be detrimental if practised on normal people (Carrer, 2002). Ultimately, though, the Nancy School was able to demonstrate that even hysteria was a function of suggestion and, therefore, its views prevailed and subsequently spread throughout Europe and America (Carrer, 2002). Against this background, one of Charcot's former students went to Nancy to learn more about hypnosis and its induction—Sigmund Freud.

In talking about his visit to the School of Nancy, Freud (1920/1989) wrote:

With the idea of perfecting my hypnotic technique, I made a journey to Nancy in the summer of 1889 and spent several weeks there. I witnessed the moving spectacle of old Liébeault...I was a spectator of Bernheim's astonishing experiments... and I received the profoundest impression of the possibility that there could be powerful mental processes which nevertheless remained hidden from the consciousness of men. (p. 10)

It would thus appear that Freud's visit to Nancy inspired him to develop further his concept of the *unconscious mind* (Carrer, 2002) and ultimately—what was arguably the first modern (i.e., comprehensive and systematic) application of the (School of Nancy's) principle of suggestive therapeutics—his theory of psychoanalysis; the founding approach in clinical psychology and psychotherapy. As brilliant as Freud was, he did not seem to possess the same skill for inducing hypnosis as Liébeault and Bernheim (Hughes & Rothovius, 1996) and, as a result, he developed the technique of *free association* as an alternative means of investigating unconscious processes. In the end, Freud would forego hypnosis entirely for free association (Freud, 1920/1989) and this development, along with the rapid spread of psychoanalysis, seems to have been associated with the subsequent—albeit temporary—decline in the development and application of hypnosis (Pintar & Lynn, 2008).

It was only around the middle of the 20th century that the practice of hypnosis underwent a resurgence in

popularity, which coincided with the work of Milton H. Erickson (Hughes & Rothovius, 1996; Pintar & Lynn, 2008) and the somewhat lesser known Dave Elman.

Milton H. Erickson's Approach

Given that a great deal has already been written about this celebrated 20th century figure of hypnosis and that the focus of this work is directed more towards Dave Elman and his formal elucidation of waking hypnosis, the following serves as a mere overview. Milton H. Erickson—who was born in 1901 in Aurum, Nevada and who died in 1980 in Phoenix, Arizona—was a psychiatrist with a special interest in medical hypnosis and family therapy. He is considered to have been a genius in the practice of hypnosis as well as in its therapeutic application (Haley, 1993; Hughes & Rothovius, 1996; Rosen, 1982; Rossi & Ryan, 1985).

Erickson (1980) defined hypnosis as "A state of intensified attention and receptiveness and an increased responsiveness to an idea or to a set of ideas" (p.1352). More particularly, he considered hypnosis to be a special psychological state in which the individual functions at a level of awareness other than the ordinary conscious state, that is, unconscious or subconscious awareness (Erickson, 1980). This awareness is characterised by heightened receptiveness and responsiveness; deriving from the intensity and restriction of attention to the task in hand and the consequent freedom from the conscious tendency to orient constantly to distracting reality considerations (Erickson, 1980). The hypnotist or operator progressively, persuasively, and repetitiously suggests tiredness, relaxation, eye closure, loss of interest in externalities, and an increasing interest in inner experiential processes, until the client functions with increasing adequacy at the level of unconscious awareness (Erickson, 1980). Central to Erickson's (1980) understanding of hypnosis is that the client's conscious awareness is bypassed: usually by focussing attention and subsequently re-directing it towards inner experiential processes or unconscious awareness. One of Erickson's favourite ways of accomplishing this involved the use of confusion.

Erickson acknowledged that (the use of) confusion often featured in his induction of hypnosis (Erickson,

Rossi, & Rossi, 1976). Using, for example, what he termed the *confusion technique*, Erickson would confuse the client, using a verbal and/or nonverbal non-sequitur, and then abruptly re-direct the client's attention away from typical reality considerations to inner experiential processes—by issuing clear and direct suggestions to that effect (Erickson, 1980; Erickson et al., 1976). Erickson's explanation for this phenomenon was that when a client becomes confused (about reality), he or she is more likely, with the aid of suggestion, to withdraw to inner experiential processes and learnings, thereby precipitating hypnosis. Put differently, confusion effects a bypass of conscious awareness and, with suggestion, leads to increasing unconscious awareness.

In addition to the use of confusion, Erickson also pioneered indirect or conversational approaches to induction. In an apparently casual, informal conversation Erickson would utilise indirect suggestions, including, puns, jokes, metaphors, analogies, truisms, and questions, to elicit hypnosis or trance (Erickson, 1976). Going beyond his work relating to the induction of hypnosis, Erickson also developed highly innovative ways of utilising hypnosis and hypnotic techniques for psychotherapeutic purposes (Rosen, 1982).

In fact, when it came to the application of hypnosis or hypnotic techniques for psychotherapeutic purposes, Erickson was so adroit that, according to Rosen (1979), "He tends not to distinguish between induction of trance or hypnotic techniques and therapeutic techniques or manoeuvres..." (p. 12) Thus, in studying Erickson's work and its application to psychotherapy, it is often difficult to distinguish where his use of hypnosis begins and ends.

Erickson's concept of the *general waking trance* (Baker, 2009, p. 18) seems to come closest to that of Dave Elman's waking hypnosis, that is, hypnosis without the classical or typical eye-closure and accompanying increase in self-awareness and relaxation—the subject of the next section. Although Erickson apparently never wrote about this, Ernest L. Rossi, a former student and biographer of Erickson, stated that, just months before Erickson's death, Erickson explained to him, for the first time ever, his concept of the general waking trance (Baker, 2009). According to Rossi (Baker, 2009), Erickson reserved the

term general waking trance for those situations wherein the individual enters a trance even though he or she is apparently awake, such as, for example, developing a fixed stare in a seemingly awake state. Rossi (Baker, 2009) explains further, "[When you have] such an attention grabbing impact.... [the] person is looking at you with that intense...'Response Attentiveness'...they are in a trance even though they are apparently awake" (p. 18).

It would therefore seem that, although Erickson did not refer directly to the concept of waking hypnosis in his writing, his notion of the general waking trance not only shows that he was clearly familiar with it, but also, as will be explained later, it may have informed much of his approach to psychotherapy. Whilst Erickson only alluded to this concept in his work, Dave Elman dealt with it explicitly.

Dave Elman's Approach

Dave Elman, who was born Dave Kopelman in 1900 in Park River, North Dakota and who died in 1967 in Clifton, New Jersey, was a practising hypnotist and a contemporary of Erickson (Elman, 2009). His inductions were extremely rapid and his capacity to facilitate deep hypnosis—somnambulism (i.e., partial or complete amnesia in the hypnotic state)—was profound (Boyne, 1984; Phipps, 2012, March). From 1949 onwards, and having long since given up stage hypnosis, Elman dedicated the rest of his life to teaching hypnosis and hypnotherapy to doctors throughout the United States. In fact, it was during this period that Elman, with one of his students in attendance, is credited as having overseen the first open heart surgery performed with the use of hypnosis alone, that is, without anaesthesia. More importantly, however, in 1964, a few years before his death, he produced his eminent work "Findings in Hypnosis," which was later re-published as "Explorations in Hypnosis" and, finally, "Hypnotherapy" (Boyne, 1984). This work is a summation of his theories and techniques and it highlights how his detailed attention to semantics and his unique ability to generate mental expectancy formed the background for his effectiveness with so many of his clients (Boyne, 1984). Against this setting, Elman's approach to hypnosis and more particularly waking hypnosis will now be explored.

Elman's definition of hypnosis.

In defining hypnosis, Elman (1964/1984) stated "Hypnosis is a state of mind in which the critical faculty of the human is bypassed, and selective thinking established" (p. 26). In respect of this definition, there are several points that require explication. First, hypnosis is a state of mind rather than a (fixed or immutable) condition. A state of mind is much like a mood and, thus, hypnosis can be obtained instantaneously (Elman 1964/1984).

Secondly, the *critical faculty*—not completely unlike Erickson's concept of conscious awareness and its reality-orienting function—is that part of the mind that passes (reality) judgement (Elman 1964/1984). It distinguishes between the concepts of, for example, hot and cold, sweet and sour, large and small, dark and light. Consequently, if it is bypassed—in such a way that hot and cold, and so forth, can no longer be distinguished—conventional judgement making can be substituted for selective thinking (Elman 1964/1984).

Thirdly, *selective thinking* is anything that you believe wholeheartedly (Elman 1964/1984). For instance, if you are led to believe that you will feel no pain, and you believe it wholeheartedly or completely, you will have no pain (Elman, 1964/1984). However, let the slightest doubt enter and the selective thinking disappears; the critical faculty is no longer bypassed and you will feel pain at the normal level (Elman, 1964/1984). Selective thinking disappears not only with doubt, but also with fear (Elman, 1964/1984). Elman was therefore at pains to explain that bypassing the critical faculty is not hypnosis: It is merely the entering wedge (Elman, 1964/1984). Put differently, hypnosis is only achieved when the critical faculty is bypassed *and* selective thinking is firmly established. Elman believed that in every instance of hypnosis this axiomatic definition is upheld and, furthermore, that there are different states of hypnosis.

States of hypnosis.

Elman (1964/1984) identified that, in addition to the waking state, there are four trance states of hypnosis, including the light or superficial state, the somnambulistic state, the coma or Esdaile state, and hypnosis attached to sleep—hypnosleep (Elman, 1956). In the light or

superficial state of hypnosis the critical factor of the human mind is sufficiently bypassed for selective thinking to be established (Elman, 1956). This usually occurs when the client's body is (physically) relaxed (Elman, 1964/1984).

In respect of the somnambulistic state the human mind is bypassed to such a degree that the selective thinking encompasses amnesia, either automatically on the part of the client, or through suggestion from the operator (Elman, 1956). This takes place when the client is both physically and mentally relaxed—"the mind becomes a complete blank" (Elman, 1964/1984, p. 95).

In the coma or Esdaile state—named after the English surgeon, James Esdaile, who went to India in 1845 and is said to have performed numerous surgeries using (this state of) hypnosis alone (Elman, 1964/1984)—the client reaches such a great state of relaxation and euphoria, that he or she does not wish to be aroused, anaesthetises himself or herself, becomes completely immobilised and catatonic (Elman, 1956).

With hypnosis attached to sleep or hypnosleep, this is the greatest depth of all (Elman, 1956). In the light state the client is perfectly conscious; this is true for somnambulism too, because the client's awareness in this state is infinitely increased; in the coma or Esdaile state, the client has complete awareness—but when the client is hypnotised in his or her sleep and a complete hypnotic state is obtained, the operator often finds himself or herself communicating with the unconscious mind of the client (Elman, 1956). When the client wakes up, he or she has no recollection whatsoever of that experience and, occasionally, the amnesia cannot be completely removed (Elman, 1956). Hypnosleep is attained by hypnotising a client who is sound asleep (Elman, 1964/1984). Having reviewed these four trance states of hypnosis, it is now possible to examine Elman's identification of the fifth state, that is, waking hypnosis.

Waking Hypnosis

Elman (1964/1984) observed that when hypnotic effects are achieved without the use of the trance state, such hypnotic effects are referred to as waking hypnosis: In every instance, it involves a bypass of the critical faculty

and the implanting of selective thinking. To explain this further, Elman (1964/1984) cited the following experiment:

In the presence of a number of people crack and break open a perfectly fresh egg. Make a wry face and exclaim, "Phew, that egg smells rotten. I wouldn't eat that for a million dollars. Oh boy, is that terrible. Smell that, will you somebody?" Now pass that egg around for the people to smell. Person after person will say, "That egg smells terrible." And some will say, "Why, it even looks bad." These people have been hallucinated into believing that the fresh egg is bad. To all intents and purposes they have been completely hypnotized. (p. 72)

Elman (1964/1984) highlighted that, although at first glance it may appear that the people in this experiment have not been hypnotised—as they were not in a trance state at all—the application of his axiomatic definition of hypnosis, as a state of mind in which the critical faculty is bypassed and selective thinking therefore made possible, shows, in fact, that they have been. Elman (1964/1984) explained:

When you made the exclamation, "Phew, that egg smells rotten. I wouldn't eat it for a million dollars," you made a positive statement of apparent fact, which your hearers accepted at face value. Respect for your judgement caused them to believe what you said, even before they smelled the egg. Having minimized their ability to judge the egg fairly, you asked them to judge it, and they did so—not with their critical faculties, but with yours. You accomplished hypnosis. You hallucinated two of their senses—that of sight and that of smell. You accomplished hypnosis as effectively as a trance can render it. If subsequently the hallucination were not exposed, your hearers would remain convinced to the end of their days that the egg was in an advanced state of putrefaction. (pp. 72–73)

From the foregoing, it is apparent that Elman (1964/1984) considered this experiment to be an example of waking hypnosis because: (a) hypnotic effects

were achieved, including olfactory (i.e., smell) and visual hallucinations; and (b) they were achieved without the use of the trance state, that is, the individuals were awake or in the waking state.

It is also on this basis that Elman (1964/1984) drew a clear distinction between waking hypnosis and another state of hypnosis—somnambulism with the eyes open. More particularly, as noted earlier, somnambulism is a deeper state of hypnosis wherein the client displays amnesia, either automatically, or through suggestion from the operator. One of the characteristics of this state is that it is possible for the client to open his or her eyes and, simultaneously, maintain the trance or sleep-like state. Therefore, although in both somnambulism and waking hypnosis the client's eyes may be open, the former state is function of trance, whereas the latter is not.

According to Elman (1964/1984), the key to achieving waking hypnosis is that "The mind of the subject must lock itself around a given idea" (p. 77). Put differently, selective thinking should be firmly, if not completely, established. Therefore, suggestions in the waking state should be given with absolute confidence and assurance, that is, leaving no room for doubt, because if this happens the suggestion usually becomes ineffective (Elman, 1964/1984). Consequently, suggestions should be given in a manner which implies that "What you have said is as certain of happening as the dawn" (p. 78). In addition to the mind of the client having to lock itself around a given idea, waking hypnosis—as with all states of hypnosis—requires that the suggestion should be one that the client wants (Elman, 1964/1984).

Applied in this way, many of the effects obtainable with the trance state of hypnosis are obtainable with waking hypnosis (Elman, 1956). It can be achieved with clients who have never known the trance state and it can be used again and again as a lever or wedge to enter the deep state of hypnosis (Elman, 1956). In fact, Elman (1964/1984) ascribed such value to waking hypnosis that it prompted him to assert that, "No one can know hypnosis without knowing waking hypnosis" (p. 69).

Having reviewed the conceptual underpinnings of waking hypnosis, a brief illustration of it in practice will now be considered.

Case Study

Particulars of this case have been mixed with those of other cases and the trainee's name and identifying information are not mentioned to safeguard confidentiality. What follows is a transcription from an encounter between the author, in his capacity as a trainer, and a trainee whereby a hypnotic effect—temporary amnesia—was effected in the trainee's normal or awake state. The trainee was a 30-year old man attending group training for an integrative psychotherapeutic approach, which draws on the various, major theoretical orientations in clinical psychology and psychotherapy, including—where indicated—hypnosis or hypnotherapy. Neither the trainee nor the group had yet developed a working knowledge of either hypnosis or waking hypnosis. During the session, when the trainee was just about to get up from his chair the author precipitated a waking hypnotic effect by—assuredly and confidently—remarking:

Trainer (T): James, uhm, an odd thing just happened. (1s pause)

T: You're unable to tell me your address. (1s pause)

T: When you try to think of it, it just... (1s pause) isn't there. (6s pause)

Trainee (t): (Look of shock and confusion; shakes his head; giggles)

T: What is it? (3s pause)

T: It's gone, isn't it? (3s pause)

t: (Laughs; nods his head)

T: It's gone, isn't it? (2s pause)

t: Yes. (2s pause)

t: (Nods his head in agreement)

T: Now, when I snap my fingers that address will come right back and you'll be able to remember it. (Finger snap) There we go. What's your address?

(1s pause)

t: 210 Gerard Street...Vorna Valley...Midrand
(Takes a breath)

T: Uh.

t: 'Kay! (Giggles)

T: What do you make of that experience?

t: (Laughs)

t: Pfew! Okay.

T: Mmm.

t: [Giggles] It was like you are in my mind...

T: Ah huh.

t: I couldn't think of it.

T: You couldn't...

t: I could only hear your voice...

T: Ah huh, ah huh.

t: Saying you remember right now.

T: Ah huh, mmm, it was if I was in your mind?

t: Yes!

T: Uh.

t: And I couldn't remember.

T: You couldn't remember?

t: At all.

T: ah huh, huh.

t: And I've been staying there for five years now.
(Laughs)

T: So it comes as quite a surprise.

t: (Laughs)

T: Uh, uh.

t: Pfew! (Laughs) Okay.

T: Uh, okay.

Immediately after this—and before a complete training debriefing was undertaken—the trainee was asked whether he would be willing to write a brief account of the experience. This is what he wrote:

When Warwick [the author] said "James you will not remember your address" it was quite weird. I thought how could I forget as I have known it for 5 years now. When he asked me to tell him, I could not remember my address, at all. The only thing I could remember was him telling me that I will not remember my address. No matter how hard I tried to remember, the only thing I could hear was his voice telling me that I will not remember. It was as if my address was replaced by his voice. I could not remember.

However, when he said when I snap my finger, you will remember, I began to remember it that moment. His voice was erased and my address was back. It's as if I was sleeping or not attentive but I actually remember everything that happened, actually felt my emotions (confusion) but I was unable to remember my address.

Similarly to Elman's (1964/1984) explanation of the putrid eggs experiment, as set out earlier, the above case can be understood in the following manner: When the trainer made the remark, "James, uhm, an odd thing just happened. You're unable to tell me your address. When you try to think of it, it just isn't there....It's gone, isn't it?" the trainer made a positive statement of seeming fact, which the trainee accepted at face value. Respect for the trainer's judgement caused the trainee to believe what the trainer said: He was unable to tell the trainer his address. Having reduced the trainee's ability to judge his own memory fairly, the trainer asked him to judge it, and the trainee did so—not with his critical faculties, but with those of the trainer. The trainer thus effected hypnosis in the normal or waking state and produced temporary amnesia.

Having set out a practical illustration of waking hypnosis, it is feasible to consider some examples of this phenomenon in daily life and its (purposeful) application in other fields.

Waking Hypnosis in Daily Life

There are many instances of this phenomenon occurring spontaneously in daily life. Consider, for example, the crying child who is certain that if the mother should kiss him or her (i.e., "kiss it better"), the pain will disappear (Elman, 1964/1984). In this respect, the child's mind is locked around the idea that the mother's kiss will alleviate or even remove the pain. Thus, the child's critical faculty is bypassed (i.e., illogical premise that mother's kiss *can* alleviate the pain) and selective thinking is established (i.e., mother's kiss *will* alleviate the pain), which precipitates a hypnotic effect (i.e., mother's kiss *has* alleviated the pain—referred to as hypnotic analgesia or anaesthesia) achieved without the use of the trance state (i.e., waking hypnosis).

Here is another example: It is summer-time, the man is very comfortable, and he is enjoying the weather immensely (Elman, 1956). Suddenly someone says, "Wow! It's hot" and, in a short while, the man notices that he is perspiring profusely. In this respect, and similarly to the previous example, the individual's critical faculty is bypassed (i.e., the false premise that it may be hot) and

selective thinking is established (i.e., it is hot), which precipitates a hypnotic effect (i.e., he becomes hot and starts to perspire—control over autonomic processes, such as, body temperature and perspiration) achieved without the use of the trance state (i.e., waking hypnosis).

It is thus apparent, from these examples, that the phenomenon of waking hypnosis is part and parcel of daily life. What remains to be determined is the explicit application of this phenomenon in other areas, such as medicine and dentistry.

Waking Hypnosis in Medicine and Dentistry

Waking hypnosis seems to feature prominently in the fields of medicine and dentistry. A few examples of this may suffice. Physicians and dentists at times administer a placebo injection—using sterile water or saline only—for a myriad of somatic complaints (Elman, 1956; Hall, 2008, August). Consider the doctor who tells the patient that the injection will alleviate his or her symptoms. Provided that the patient wants the suggestion and his or her mind is locked around the idea that the injection will alleviate the symptoms, a hypnotic effect (i.e., control over involuntary systems and processes in the body) may be achieved.

Similarly, a doctor or dentist who informs the patient that the (sterile) jelly, which has just been applied, will cause the area to go numb, may—provided the conditions are satisfied—precipitate a waking hypnotic effect, namely an hypnotic anaesthesia (Elman, 1964/1984). In fact, any time a doctor or dentist gives or prescribes a placebo, he or she is using waking hypnosis (Elman, 1956).

Another example is the dentist who treats a patient with an overdeveloped gag reflex—that is, a patient who gags every time an instrument is inserted into the back of the mouth—by saying, "Here's a pencil. Hold onto it with both hands. So long as you hold onto it, you won't be able to gag" (Elman, 1956, p. 21). The patient grasps the pencil and is surprised to find that he or she doesn't gag anymore. Here, the patient has achieved a waking hypnotic effect—control over an involuntary reflex.

Having reviewed several instances in which waking hypnosis is used in medicine and dentistry, the attention can now shift to the field of psychotherapy.

Waking Hypnosis in Psychotherapy

Although waking hypnosis is applied in other fields, it appears that there is less clarity about the purposeful application of it in the field of psychotherapy. As discussed previously while Erickson was clearly aware of the phenomenon of waking hypnosis—and had, in his last meeting or supervision with Rossi, referred to it as the general waking trance—he did not seem to address it clearly, directly, and plainly in his writing on psychotherapy. Therefore, whereas he was explicit, in hypnosis, about the necessity for bypassing the critical factor or, in his words, conscious awareness, and the role of confusion—his confusion technique—in accomplishing this, the same cannot be said for the delineation of his psychotherapeutic approach.

That Erickson was not explicit about the use of waking hypnosis in his writing does not, however, mean that he was not using it in the practice of psychotherapy. In fact, closer examination suggests that, given his penchant for confusion, indirect suggestion, puzzlement, and metaphor in his psychotherapeutic work (Hughes & Rothovius, 1996), he may have been using these devices, in the waking state, to deliberately bypass the critical faculty and to establish selective thinking—that is, waking hypnosis or, what he termed, the general waking trance. If this is so, it may be that much of his psychotherapeutic work was informed by the application of waking hypnosis.

It is interesting to note that Rossi—completely independently of the present author's views—seems to have arrived at a similar conclusion about Erickson's work (Baker, 2009). In explaining the potential significance of Erickson's notion of the general waking trance, Rossi states, "In this video Milton explains his concept of 'the general waking trance' that I now believe is the natural bridge between therapeutic hypnosis and psychotherapy as we practice it today" (Baker, 2009, p. 18). Further on, Rossi, in referring to the general waking trance as a *naturalistic trance* articulates:

This [general waking trance]...is a so-called "naturalistic trance" because it engages the person's intense interest, motivation, and "fixed attention" without the use of any formal hypnotic induction technique. I now believe this is the essence of

Erickson's "naturalistic" and "utilization" approach to therapeutic hypnosis, which many excellent psychotherapists actually use without labelling as such. (Baker, 2009, p. 18)

Rossi's conclusion, thus, seems consistent with that put forward in this paper: Erickson's psychotherapeutic approach was possibly informed by the undisclosed use of waking hypnosis or, in Erickson's words, the general waking trance. Rossi also makes the pertinent observation that it is likely that many effective psychotherapists are using waking hypnosis/the general waking trance without labelling it as such (Baker, 2009)—or worse, from the perspective in this paper, without knowing it.

The final step in this paper is to consider, using the REACH technique as an example, how waking hypnosis may be applied as an adjunct in psychotherapy.

REACH Technique

The *REACH technique* was developed by the author in conjunction with the renowned South African clinical psychologist and psychotherapist, Charl Vorster (1946-2014; personal communication, April 2, 2010). It was devised for application in the *interactional* approach or, for want of a better term, the *integrative interactional* approach. The interactional approach, itself, is a major theoretical approach in clinical psychology and psychotherapy. It is based on the premise that how individuals interact with one another determines the nature and quality of their (psychological and mental) wellbeing (Vorster, 2011). Thus, when their interaction is ineffective, they tend to exhibit psychological distress or psychopathology. Consequently, the aim within this approach is to help clients develop more effective patterns of interaction. The integrative interactional approach, is a more recent development of the interactional approach that incorporates additional theoretical orientations in clinical psychology—including hypnosis and hypnotherapy where indicated—to further contextualise interaction and enhance treatment (Beyers et al., 2017; Green & Phipps, 2015; Phipps, 2014; Phipps & Vorster, 2015; Vorster, 2003; Vorster, 2011; Vorster et al., 2013). The REACH technique is suitable for use in psychotherapeutic settings employing an integrative

interactional approach, where the application of hypnosis and/or its principles is an established norm.

Specifically, the technique entails the explicit and purposeful application of waking hypnosis in a psychotherapeutic relationship to effect a rapid, powerful change in that part of the client's interaction that is maintaining his or her psychological distress. It was initially devised as a technique for helping the client who reports feeling alone and unsupported and who simultaneously exhibits, for lack of a better term, an overly-independent, self-isolating interactional style: The individual is so independent that he or she has become isolated and is unable to effectively request and/or accept help from those around. In this instance, although the client requires psychotherapeutic help and support to overcome an overly-independent, self-isolating interactional style, he or she is unable to accept the psychotherapeutic help in the first instance because of an excessive level of independence. Thus, a *Catch 22* is precipitated.

The aim of the REACH technique is to bring about a powerful change in the client's overly-independent, self-isolating interactional style by facilitating the development of a more interdependent, engaging one—one in which he or she is more receptive, accepting of empathy, accepting of acknowledgement or recognition, emotionally close, and open to the instillation of hope—first in the psychotherapeutic relationship and subsequently in one or more of the relationships in the family or broader system. The term "REACH" is an acronym highlighting the main interactional qualities during the psychotherapeutic encounter, including increased receptivity, empathy, acknowledgement/recognition, (emotional) closeness, and (openness to the instillation of) hope (i.e., R-E-A-C-H).

The procedure is performed as follows:

1. Establish a person-centred psychotherapeutic relationship characterised by genuineness, understanding, and unconditional acceptance.
2. At the point of intervention, the therapist expresses accurate empathy—the reflection of a feeling/s—to the client.
3. As soon as the client accepts the reflection of a feeling(s), he or she is asked where in the body he or

she is experiencing this.

Note: The intensified attention and focus on emotion/s and the somewhat unexpected—if not unusual—question asked, as to where in the body this feeling is occurring, results in a bypass of the critical factor—the first element in waking hypnosis.

4. The therapist repeats the reflection of the feeling and its location or placement in the body.
5. If the client begins to talk, then the therapist immediately: (a) refocuses him or her on the feeling, its location, and the experience of it in the moment or here-and-now; and/or (b) encourages him or her not to talk, but rather to "stay with the feeling" in conjunction with the reassurance from the therapist, "It won't overwhelm you, it won't consume you, just stay with it."
6. This process is repeated, for any emerging feelings, without interruption until the client becomes: (a) silent or quiet; (b) significantly less talkative; (c) accepting of empathy; and/or (d) receptive, open, transparent, and emotionally close.

Note: The effect of steps 4, 5, and 6 is to further establish and maintain the bypass of the critical factor.

7. The therapist communicates selective or desired inputs in a clear, direct, and assured manner. These inputs, which include further empathy, acknowledgement/recognition, reassurance, hope, and/or feedback, bring about a new experience and way of relating for the client that are consistent with a more effective, interdependent, engaging interactional style. Thus, in that the therapist has reached out and established (emotional) contact with the client, the client frequently experiences a powerful corrective emotional experience, feeling connected, supported, hopeful, and encouraged.

Note: Selective thinking is established—this is the second element that precipitates waking hypnosis.

8. Complete the procedure by asking the client to reflect on the experience and then explore this together in a person-centred way.

Note: This has the effect of terminating the waking hypnosis and helps the client to reinforce the new and more appropriate behaviour or pattern of interaction.

It should be apparent from the foregoing that the use of the REACH technique is not necessarily limited to the client who presents with an overly-independent, self-isolating interactional style. It can be used with any pattern of interaction that requires change. Moreover, although it has been devised for use in integrative interactional therapy, the REACH technique can be used in other psychotherapeutic approaches too. The reason for this is that the application of empathy in this way results in a bypass of the critical factor, upon which selective inputs—from any therapeutic orientation—can be applied, thereby precipitating a waking hypnosis effect.

As with any psychotherapeutic application, however—especially one that precipitates rapid change in (emotional) distance/closeness, independence/interdependence, and/or isolation/engagement—the use of waking hypnosis and, in this case, the REACH technique, *requires very careful and thorough consideration* of the possible impact and effect of such change/s in respect of the individual's functioning within his or her different relational contexts, the therapeutic relationship included.

Implications for Psychotherapy

The aim in the paper has been to illuminate the phenomenon of waking hypnosis and to consider how it may be purposefully and explicitly applied in psychotherapy. It is evident that waking hypnosis represents a powerful psychotherapeutic technique that enables the psychotherapist to forego the traditional trance state when indicated. Effectively applied, waking hypnosis can effect rapid and effective psychotherapeutic relief; thereby providing the client with a strong, corrective emotional experience in the here-and-now, together with incisive changes in his or her pattern of interaction.

Perhaps even more importantly, the paper has shown how developments in the field of hypnosis and hypnotherapy have had a strong bearing on clinical psychology and psychotherapy. Specifically, Sigmund Freud's psychoanalysis, which served as the founding approach in the latter fields, was initially inspired by the work of (Ambroise-Auguste Liébeault and Hippolyte Bernheim at) the School of Nancy on *suggestive therapeutics*—the use of suggestion in the treatment of

psychological and medical disorders. Put differently, clinical psychology and psychotherapy have evolved, in part, as the advanced practice of modern suggestive therapeutics or hypnosis. It is for this reason that today all psychotherapeutic approaches rely, in one way or another, on the application of suggestion, directly or indirectly, in various (altered) states of consciousness. Ultimately, therefore, the challenge for psychotherapists is not to identify whether they are applying hypnosis and hypnotic principles in their day-to-day treatment, but rather how they are doing so and learning to apply this with increased awareness, responsibility, and effectiveness.

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Footnotes

¹The term waking hypnosis is really a misnomer because the client in the hypnotic state is not in a state of sleep. Conversely, then, the hypnotized client cannot be designated as being in a "waking" or "awake" state. The issue relates directly to the terms hypnosis and artificial somnambulism, themselves. These two terms similarly, erroneously designate states of sleep and sleep-walking, respectively. Although these terms, strictly speaking, should be replaced by words with more accurate designations, they are retained in the field for the sake of tradition and convention. Thus, the term waking hypnosis does not designate a true awake (i.e., as distinct from a sleep) state, but rather an altered or hypnotic state that

was precipitated without undergoing a trance in the usual or typical sense.

²Hysteria, which is today referred to as functional neurological symptom disorder (formerly conversion disorder; American Psychiatric Association, 2013),

involves neurological symptoms, such as numbness, blindness, paralysis, or fits, thought to be due to psychological dysfunction (i.e., triggered by emotional distress) rather than an underlying neurological disorder.

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