The Handbook of Contemporary Clinical Hypnosis is an up-to-date, authoritative resource designed to underpin the use of clinical hypnosis within the medical and psychological fields, and to support training and research in the area. Published in association with the British Society of Clinical and Academic Hypnosis (BSCAH), the book draws on the expertise and experience of a wide range of health professionals including doctors, dentists, nurses, psychologists and counsellors, all of whom use hypnosis techniques in their practice. Theoretical rigour is provided by contributions from academics currently conducting research into hypnosis and its applications.

This unique collection is an invaluable resource for those interested in acquiring the basic skills of hypnosis, as well as those exploring more advanced applications in specialized areas. Written by clinicians for clinicians, The Handbook of Contemporary Clinical Hypnosis is the definitive reference text for our current understanding of hypnosis and its application in clinical settings.

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Claudia Nielsen, Psychotherapist and Vice-President of the Scientific and Medical Network, UK

‘The Handbook of Contemporary Clinical Hypnosis highlighted for me what is often lacking in most hypnosis works: a truly integrative effort to enable the clinician to appreciate the theoretical and experimental underpinnings of the clinical techniques. Beginning with an outstanding introduction and continuing with an excellent series of chapters elucidating the different areas and techniques of hypnosis, the various authors share their approaches in a succinct yet comprehensive manner. I am delighted to recommend this contribution to the hypnosis literature. I am certain that the reader will share my satisfaction and enjoyment in reading Brann, Owens and Williamson’s excellent editing.’

Shaul Livnay PhD, Chairperson, The Committee for Educational Programs in Europe, European Society of Hypnosis, Israeli Society of Hypnosis
The Handbook of Contemporary Clinical Hypnosis

Theory and Practice

Edited by

Les Brann, Jacky Owens and Ann Williamson
## Contents

About the Editors xi  
About the Contributors xiii  
Foreword xvii  
Preface xix  

### Part One  Hypnosis: The Fundamentals  

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Author</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hypnosis: The Theory behind the Therapy</td>
<td><em>Dr Peter Naish</em></td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Hypnotic Phenomena and Hypnotizability</td>
<td><em>Dr Ann Williamson</em></td>
<td>19</td>
</tr>
<tr>
<td>3</td>
<td>History of Hypnosis</td>
<td><em>Dr Ann Williamson</em></td>
<td>31</td>
</tr>
<tr>
<td>4</td>
<td>Imagery and Visualization</td>
<td><em>Mrs Jacky Owens</em></td>
<td>41</td>
</tr>
<tr>
<td>5</td>
<td>Use of Language and Metaphor</td>
<td><em>Dr Ann Williamson</em></td>
<td>51</td>
</tr>
<tr>
<td>6</td>
<td>Safety</td>
<td><em>Mrs Jacky Owens</em></td>
<td>77</td>
</tr>
</tbody>
</table>
Contents

Part Two  The Stages of Therapy  
*Dr Les Brann with contributions from Dr Geoff Ibbotson, Mrs Jacky Owens and Dr Ann Williamson*

7. Initial Steps  89
9. Induction and Deepening  107
10. Establishing the Problem  123
11. Resolving the Problem  131
12. Ego Strengthening, Anchoring and Re-alerting  141
13. Self Hypnosis and Other Homework  151

Part Three  Specific Disorders  155

14. Self Esteem and Self Confidence  
*Dr Ann Williamson*

15. Anxiety and Panic Disorder  
*Dr Ann Williamson*

16. Depression  
*Dr Alastair Dobbin*

17. Phobias  
*Dr Les Brann*

18. Medically Unexplained Symptoms  
*Dr Michael E.Y. Capek*

19. Specific Psychosomatic Disorders  
*Dr Les Brann*

20. Dermatology  
*Dr Mhairi McKenna*

21. Pain  
*Dr Les Brann*
22. Anaesthesia, Surgery and Invasive Procedures  
*Dr David Rogerson, Mrs Jacky Owens and Dr Les Brann*  
315

23. Oncology  
*Mrs Jacky Owens and Dr Leslie Walker*  
333

24. Cancer Care  
*Mrs Phyllis Alden and Mrs Jacky Owens*  
351

25. Death, Dying and Loss  
*Dr K K Aravind, Mrs Jacky Owens and Dr Ann Williamson*  
375

26. Post-traumatic Stress Disorder (PTSD)  
*Dr Geoff Ibbotson*  
389

27. Adjustment Disorders  
*Peter J Hawkins*  
413

28. Eating Disorders  
*Dr David Kraft and Dr Peter J Hawkins*  
425

29. Habit Disorder and Addiction  
*Dr David Medd and Dr Ann Williamson*  
441

30. Obsessive Compulsive Disorder  
*Mrs Phyllis Alden and Dr Ann Williamson*  
457

31. Obstetrics  
*Mrs Diana Tibble and Dr Les Brann*  
463

32. Infertility  
*Dr Les Brann*  
483

33. Psychosexual Problems  
*Dr Peter J Hawkins and Dr Les Brann*  
493

34. Children  
*Dr David Byron and Dr Sobharani R Sungum-Paliwal*  
507

35. Learning Disability and Autistic Spectrum Disorder  
*Mr Cliff Robins*  
525

36. Sleep Disorders  
*Dr Les Brann*  
537
Contents

37. Performance Enhancement
   Dr Barry Cripps
   547

38. Informal Hypnotic Techniques
    Dr Caron Moores, Dr Grahame Smith and Mr Martin Wall
    567

39. Working Transculturally
    Dr Geoff Ibbotson
    575

40. Commissioning, Providing and Auditing a Hypnotherapy Service
    Dr Les Brann
    583

Appendix 1: Life History Inventory
    591
Appendix 2: What Goes in Must Come Out
    593
Glossary
    595
Author Index
    599
Subject Index
    621
This book has been written by members of the British Society of Clinical & Academic Hypnosis (BSCAH).

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Foreword

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November 21, 2010

Hypnosis is the oldest Western conception of a psychotherapy, yet generation after generation forgets and then rediscovers it. Hypnotic techniques have been oddly disassociated from the canon of mainstream medicine, despite their efficiency and effectiveness. The aura of purple capes and dangling watches haunts hypnotic history and daunts practitioners. Yet the phenomenon of hypnosis touches on something central in the healing arts: getting the patient’s full attention, mobilizing an alteration in awareness, sensitizing the patient and doctor to the importance of clear and empathic communication and honing therapeutic strategies. Hypnosis is not a treatment, but rather a mental state that can facilitate a variety of treatment strategies. It is a form of highly focused attention coupled with an ability to dissociate – put outside of conscious awareness – things that would ordinarily be in consciousness. Hypnosis is to consciousness what a telephoto lens is to a camera – what you see you observe in great detail, but you are less aware of the context. This means a reduction in critical scrutiny and an emphasis on doing rather than thinking about what you are doing. Such a state of mind offers special therapeutic opportunities – the patient is really paying attention. But it also confers special responsibilities on the clinician using it – to assess the problem well, think through therapeutic strategies carefully, evaluate the patient’s response, be clear when the hypnotic experience is over and teach the patient how to mobilize and make good use of their own hypnotic abilities.

Thus the material in this book, written by leading clinicians and practitioners of hypnosis, is important to clinicians entering into and practicing with the uses of hypnosis in medicine and related disciplines. Hypnosis involves trust, and that trust is rewarded by
clinicians who understand the phenomenon, along with its assets and limitations, and who use it artfully to help patients master problems. There is widespread misapprehension that hypnosis poses a threat of losing control. Practiced appropriately, it is a powerful means of helping patients enhance control over symptoms like pain and anxiety, aspects of somatic function and psychological distress. The chapters in this book provide a firm clinical basis for helping patients to help themselves.

There is a growing evidence base, including sizeable randomized clinical trials, demonstrating effects of hypnosis on problems such as chronic pain, procedural anxiety and pain, irritable bowel syndrome, migraine headaches and asthma. The side effect profile for hypnosis is favourable compared to that of virtually any medication. So the risk-benefit profile is favourable. Despite this, there remains concern that hypnosis is either ineffective or dangerous. We are accumulating more evidence that it works and how it works, with neuroimaging studies using event related potentials, PET and fMRI demonstrating changes in brain function associated with hypnotic instructions and symptom reduction. We have plenty of evidence, and should and will accumulate more. What is needed now is educated use of hypnosis to help people suffering from pain, anxiety, smoking and other medical and psychiatric problems. Read this book and enhance your ability to help your patients. They will thank you. And remember, it is a smart hypnotist who knows who is hypnotizing whom.
Preface

This book is the culmination of a decision made at the BSCAH Council meeting in February 2008 to produce a definitive textbook to assist in our teaching programme and as a basic reference for all health professionals and academics interested in hypnosis. The decision was easy, but producing the text has been hard work, not only for the contributors and for ourselves as authors and editors, but also for our families and colleagues who have had to endure our focused attention on this mammoth task over the last 18 months.

There was a need for the book to be so much more than a comprehensive trawl of the literature and a subsequent regurgitation of what, in reality, is already in the professional domain. Notwithstanding the above, research findings are included, but the student is reminded that, by its very nature, hypnotherapy does not fit easily into the ‘controlled trial’ model of clinical evaluation. Consent and co-operation of the patient, the development of rapport and the skill and experience of the therapists are prerequisites of hypnotherapy, and this cannot be reproduced with the use of set scripts or videoed programmes. Also, during therapy, the very nature of the diagnosis may change (e.g. from irritable bowel syndrome [IBS] to victim of childhood abuse), and this underlying problem may never have been uncovered in the control arm of a trial. Randomization, therefore, is likely to be at best speculative. It is reassuring, however, that despite the above reservations, research evidence does exist and is of huge importance, especially in the area of neurophysiology, but in clinical trials it is likely to significantly undervalue the hypnotherapeutic intervention. Thus results of clinical outcome audits will be a better guide for health service commissioners.

The current obsession with evidence based medicine has inevitably led to the commissioning of restrictive, protocol driven services in the mistaken belief that this will provide ‘cost-effectiveness’ for the health economy. As a consequence of this approach, there has been a decline in the practice of treating a patient as an individual exhibiting a set of problems unique to their own genetic make-up and its interaction with the environment in which they grew up. We hope that this book will become a resource for commissioners who
will be required to take a more holistic approach to service provision. It is eminently suited to integration with other aspects of health care being compatible with pharmacological, surgical, medical and psychological programmes of therapy in a time efficient manner.

Some sections are unashamedly clinical where the content is based on years of experience and observation in the clinical setting. Much learning of hypnotherapy, however, goes on from a mixture of formal study and clinical discussion such that the experienced therapist evolves a methodology that is an amalgam of techniques and styles absorbed from a variety of often forgotten sources, which have been adapted to suit the specific personality and clinical orientation of that therapist. The text, therefore, will not be interrupted unnecessarily with a plethora of references, and we hope our colleagues in the Society and worldwide will forgive us if they recognize their own ideas but without any due acknowledgement.

Throughout the book we have made repeated reference to the need for therapists to work within their field of competence, and this competence relates to their background health professional status as much as it does to their hypnotherapy expertise.

Techniques, treatment regimes and verbatim scripts are included to give the student ideas and confidence to begin. They are not intended to imply that this is the ‘must do’ approach. There is no such thing as ‘the’ technique for any particular problem, and the student must follow the ‘learn it, try it, adapt it’ approach to these different methodologies. Outcome audit and personal development are fundamentals of best practice.

What to include or exclude in a book on hypnosis has been difficult. The chapter on informal techniques demonstrates the usefulness of the hypnotic approach without formal induction and is a reminder for us all to think ‘hypnotically’ in our ordinary consultations. Similarly, utilization of the broader concept of ‘trance’ has enabled the inclusion of reference to areas such as dance and art therapy. Overlap with other therapeutic areas is obvious, and the student new to hypnosis will soon recognize that many of the ‘active ingredients’ of treatments have their true origins in hypnotherapy.

Permission has been obtained to use various case examples; all have been anonymized to avoid identification and all names given are fictitious.

Whilst we appreciate that there is a lot of academic debate about the exact definition of certain terms and concepts, throughout this book we have used the terms ‘unconscious’ and ‘subconscious’ synonymously and interchangeably. In the clinical sections this interchange equally applies to ‘hypnosis’ and ‘hypnotherapy’. We have chosen to use ‘patient’ rather than ‘client’ and have used the masculine form where the gender could be either. Similarly where we have used the terms ‘medical’ and ‘clinical’, we intend these to refer to the wide ranging disciplines encompassed by medicine, psychology and allied health professions.

We have been privileged to have been entrusted by BSCAH to produce this work and thank the Council members for their support and encouragement. We would like to thank, of course, all our contributors and apologize if at times we have been difficult to satisfy. Particular thanks are due to Karen Mackrodt and others who have helped with the proof reading. There are many others who, perhaps even unknowingly, have given help with this project and who deserve thanks – it would be impossible to list them all but we hope they will accept this global message of gratitude.

Les Brann, Jacky Owens and Ann Williamson
October 2010
Part One

Hypnosis: The Fundamentals
Hypnosis: The Theory behind the Therapy

Dr Peter Naish

Introduction

There seems to be a tendency for people using hypnosis therapeutically to be surprisingly uninformed about the science behind the process. There are doubtless a number of reasons for this, not least that a busy therapist will feel there is little time for keeping up to date with the latest research. This may be so, but imagine consulting a surgeon who said, “Yes, I’ve got a vague idea of how the body works and I gather they have scanning and so on nowadays, but I just do what I picked up when I first started this. It seems to work for me!” One would have to ask, “But does it work for the patient; could it be made to work better?”

Therapists who have ‘been around a while’ do actually have a reason for turning their backs on hypnosis research in the past; a few decades ago, that research appeared to be investigating a very different phenomenon from the one they used every day in their practices. As will be explained, the message coming from the laboratory seemed, in effect, to be that hypnosis was not ‘real’. Meanwhile the therapists were using these ‘unreal’ procedures and getting very real therapeutic effects – something was wrong somewhere!

Nevertheless, even from the seemingly uninviting scientific landscape of that era there were gems to be mined. For example, it was shown that merely instructing people to relax and imagine could produce quite convincing hypnotic effects. However, giving precisely the same instructions, but preceding them with the information that this was hypnosis, produced stronger effects (Kirsch, 1997). It was possible to draw a number of conclusions
from this, including the observation that since simply speaking the word ‘hypnosis’ can hardly do anything very dramatic, the enhanced performance seemed unlikely to have involved any impressive change in brain state. A therapist may not be very concerned whether there is a change in brain state or not, but he or she should note that an important element in getting people to behave ‘hypnotically’ seems to lie in defining the situation as ‘doing hypnosis’, rather than in the precise instructions spoken. Many people starting to use hypnosis therapeutically try to learn so-called induction scripts verbatim, as if, like some necromancer’s conjuration, a single wrong word will bring catastrophe. Clearly this is untrue; whatever words work for the hypnotist should work for the clients – as long as they believe it is all in the cause of hypnotizing them. Even better of course is to choose words that are well suited to the particular client; that is where the skill lies, not in remembering a script.

**Magic or Medicine?**

It has been mentioned above that hypnosis produces very real therapeutic effects – but does it? Many members of the general public attribute almost magical powers to hypnosis, and with expectation of that sort there is bound to be a significant placebo effect. Could it be the only effect? A conspiracy theorist might postulate that therapists deliberately ignore the science, because they believe that if simply saying ‘hypnosis’ makes things work better, then it is clearly a placebo. If that truth leaked out it would be like GP patients learning that a pill was only sugar; the magic would evaporate and the cure would cease to work. In fact therapists need have no fear, because good, laboratory based research has shown that hypnosis is more than just a placebo. One of the most impressive and effective uses of hypnosis is in the treatment of pain. Non-harmful pain can be produced in the laboratory, making it possible to research the impact of various forms of analgesic. One thing that can be done is to apply a pharmaceutically inactive cream, along with the message that it will help the pain: it does – clearly a placebo effect. The pain relief is due to the release of endorphins, which are endogenous morphine-like substances that block the neural pain signals. Naloxone is a morphine antagonist – a compound that prevents the action of morphine and thus permits pain to resurface. It has exactly the same effect on endorphins, so that the administration of Naloxone undermines the pain reducing qualities of a placebo cream. So much for placebos; what of hypnosis? Well, it turns out that Naloxone does not block the analgesic effects of hypnosis (Spiegel & Albert, 1983). Hypnosis must be something more than just a placebo.

Hopefully this brief introduction has convinced you that anyone intending to use hypnosis in a therapeutic setting should understand something of the science behind it. Theory should inform practice, just as clinical observation should be part of the seed-corn of research. It is hoped too that the preceding paragraphs offer a sufficient taster for you to see that the science need not be dry and dull; it offers the tantalizing promise of explaining the paradox that while hypnosis has none of the magic that many people imagine, in fact it seems capable of far more than many trained scientists once believed. So, now we must
make a very brief exploration of the path science has trodden and consider the vistas that
have only recently started to unfold.

A Quick Look Backwards

It is something of a tradition in books on hypnosis to begin with Franz Anton Mesmer
(1734–1815); one could say that was when science first took an interest in hypnosis like
processes. Mesmer practiced in Paris in the days before the French Revolution, and also the
days before it was called hypnosis or even (subsequently in his honour) Mesmerism – it was
then called magnetism. This episode of history is instructive because it picks up two themes
raised in the introduction of this chapter. We need not be concerned with the finer details
of Mesmer’s theories; it is sufficient to say that he believed cures could be effected by
correcting the flow of a kind of magnetic fluid through the body. Even in those days theory
influenced therapy. Thus, when Mesmer became too popular to deal with so many people
on a one to one basis, he devised a table-like drum called the Baquet, filled with iron and
appropriate magnetic paraphernalia. A whole group of people could sit around this and
receive the healing power simultaneously. Of course Mesmer’s beliefs were wrong, as
demonstrated very effectively and scientifically by a French royal commission, so eventually
the theories as to what was going on evolved, as did the way in which they were
implemented in therapeutic practice. That is as it should be: no one claiming that the
final, ‘right’ answer has been found, but practitioners keeping up with current thinking.
Unfortunately, even then the signs of a disconnection between science and practice were
apparent. The French scientific team showed convincingly that magnetism was in no way
involved in whatever was going on in these mesmeric sessions. Nevertheless, many people
clung to the idea that the wonderful effects (that we would recognize today and call
‘hypnotic’) could all be attributed to the power of magnets. It was Thomas Wakley,
founder of the journal *The Lancet*, who made a dummy magnet from wood (that could not
be magnetic, of course) and showed that it was just as effective.

Wooden ‘magnets’ seem to be getting us back to the realm of placebos again – it is what
you believe that counts. In Mesmer’s day it was believed that recovery could not be
attained without passing through a kind of internal struggle, referred to as the crisis.
Mesmer’s patients expected to have this experience, and they duly exhibited it. Fortunately
for today’s patients there is no such expectation, so they are spared that little episode.
Nevertheless they still tend to follow expectations, and the fact that they do so, rather than
just sticking to ‘basic hypnotic behaviour’, is something that science must explain. In fact,
truth be told, there is little that could count as a basic behavioural hallmark of hypnosis.
People simply do what they are told to do, so that a hypnotic induction involving relaxation
just makes them look relaxed. Nothing much happens after that, unless a specific
suggestion is given for a particular behaviour. This absence of a clear hypnotic hallmark
was one of the factors which made it difficult for researchers to accept that hypnosis was
in any sense a ‘thing apart’; the brain, it was concluded, must be doing much the same as in
many other situations.
Scepticism and Social Effects

Before considering explanations for hypnotic behaviour, we must note that some of us do not exhibit any such behaviour at all. People vary in their responsiveness to hypnosis; some seem untouched by it, while others respond dramatically; most lie between the extremes. In research it is common to assess experimental participants, to get a measure of their responsiveness; to do this, hypnotic susceptibility scales are used. These comprise a series of graded suggestions that may or may not produce effects in the person being tested. The suggestions cover a range of potential experiences, for example motor effects such as “Your arm is getting lighter and will begin to lift” or sensory ones such as “There is sugar dissolving on your tongue and it tastes sweet”. People are rated by the proportion of the test items that ‘work’ for them. In the clinical field it is often considered a waste of valuable time to carry out a test on someone who is to be treated anyway, whether of high or low susceptibility. However, while a complete formal assessment may be inappropriate, using just one of the test items can give a helpful hint as to the sort of person being treated. Moreover, if there is any degree of ‘working’ this can be fed back to the patient as indicating that hypnosis really can ‘do things’; never miss the chance of enhancing the hypnosis with a good placebo effect! At the same time, note that the experienced practitioner does not permit the absence of an effect in the test to undermine the effectiveness of the treatment.

It will be observed that both the examples of test items given above could be faked; someone could lift their arm and say that it felt light, and they could claim to taste sugar when in truth they did not. This applies to all test items – if a non-susceptible subject wished, they could behave as if they were responsive to everything. We assume that they do not wish to fake it, and as with so many situations of human interaction, we take their responses at face value. However, this is a little unsatisfactory for science, where it is considered better to be sure. Psychology is the science most familiar with trying to research the hidden, subjective experience and finding objective handles by which we can gain some grasp of what is going on. An early researcher in this field was the American T. X. Barber (see e.g. Barber et al., 1974) who used a hypnotic susceptibility test with two groups of people. One group had been conventionally hypnotized, but the other had not. Instead they had been exhorted to do the best they could in the series of tests they were about to be given; they were told that the tests were not hard, and if they didn’t make an effort the experiment would be a failure, which would be an embarrassment to the researcher. Clearly, this was rather pressuring (as was intended) and it may not be surprising to learn that the non-hypnotized group passed more of the hypnotic tests than the hypnotized group!

We have a good explanation for the pressured group’s performance – they faked it, because they thought they should. Now, science prefers parsimony; it does not like multiple, complicated explanations when one will do. So why postulate some invisible process called hypnosis, when we know that people raise arms and taste sugar if they feel social pressures to do so? Well, this ‘social’ explanation might serve for the hypnosis group too, but only if we could identify social pressures acting upon them also; it turns out that pressures are easy to find. We are a social animal and behave very much like other
group-living primates. Most of us do not like to stand out as too different or awkward, and we tend to want to please someone perceived to be of higher status. A university professor carrying out experiments on the students (the situation for much psychological research) is of higher status. The students know what is expected of them, because we all have a broad idea of what hypnosis is supposed to be like; what they do not know is supplemented by what is implicit in the suggestions given. If a participant finds to their concern that nothing seems to be happening they may think something along the lines of “Oh dear, what’s wrong with me? I bet everyone else gets hypnotized properly.” The only solution is to act the part. Not everyone would be so compliant as to respond in that way, but then not everyone scores high on the tests.

One may well wonder how the above picture was supposed to map onto clinical experience. Did ‘cured’ patients fake their recoveries? The title of Wagstaff’s (1981) book Hypnosis, Compliance and Belief gives a hint of his sceptical stance, but others adopted more of a compromise position. They still emphasized the social aspects of the situation that led people to behave ‘hypnotically’ (and the inverted commas were often used) but acknowledged that some people actually went on to convince themselves that they were having the experience – they were not deliberately lying. Spanos was a Canadian researcher who seemed to spend much of his research career (sadly cut short in a flying accident) devising experiments to show that hypnotized people did only what they believed hypnotized people do. He used the term ‘socio-cognitive’ to label these ‘middle-ground’ theories; the label derives from two fields within psychology: social and cognitive. Where social psychology is concerned with the interactions between people (including between hypnotist and hypnotized), cognitive psychology is a branch of the discipline seeking to understand the hidden mental processes giving rise to conscious experiences within the individual. Spanos (1991) did not expand greatly upon the nature of the cognitive processes that might enable a person to alter their conscious experience. That it did alter was taken by some to justify referring to hypnosis as an ‘altered state of consciousness’, but for the socio-cognitive school that was to go too far; they saw no evidence for a significant change in brain state. The ensuing controversy became known as the ‘state versus non-state debate’ (see chapter 2), and it is only quite recently that the arguments have become more muted (see Kirsch & Lynn, 1995 for a helpful review).

**Cognitive Processes**

Whether or not social factors are especially important in hypnosis, if people’s experiences are genuine (i.e. they are not faking) it is indisputable that rather unusual cognitive processes are taking place. Take moving an arm for example. As I pause in the typing of this chapter I reach for a cup of tea. Because I am concentrating on what I want to say I am only half aware of wanting to take another sip; I am not at all aware of the arm movement that makes that sip possible. So, there is nothing unusual in having an arm move without knowing that one is doing it. However, now that I have chosen arm moving as my example, I have become entirely aware of it. Not only that, but I am aware of intending to cause that
movement. That is all exactly as one would expect; it would only become odd if I was aware of my arm moving, but had no sense of being the agent of that movement. That is the experience of people who pass the arm levitation test of a hypnotic susceptibility scale. The work of Spanos showed that people get the effects that they expect, so it cannot be claimed that the hypnotist’s suggestions are somehow acting directly on some part of the participant’s brain and bypassing conscious control processes. Clearly the hypnotized person hears the suggestion, then presumably uses fairly normal channels to set things in motion. The unusual element of this must be in the failure to recognize that they are using those ‘channels’.

**Intention and awareness**

A number of theories have suggested that there must be some kind of disconnection between intention and awareness (e.g. Bowers, 1992; Brown & Oakley, 2004; Woody & Sadler, 2008), and they draw to a greater or lesser extent upon the idea that our monitoring and control systems are hierarchical in nature. Thus with my cup it is sufficient to wish to pick it up; I do not need to know anything about the precise movements of arm, hand and fingers to achieve this. Nevertheless, I can attend to those if I wish, for example if trying to extricate a very full cup from a cluttered desk, without spilling tea on the other things. Usually our level of awareness is at the same level as that at which intentions are made, but it is conceivable that one might issue commands at a high level (e.g. ‘Have another sip’) while monitoring at a lower (‘I can feel my arm moving’).

A variation on this theme has been proposed by Dienes and Perner (2007), who based their ideas upon the concept of higher order thought (i.e. self-awareness of awareness). Our human consciousness, it is suggested, derives from our ability to think about our experiences and even to think about that thinking (I feel the cup; I am aware that I am feeling the cup; I notice that I am having that awareness about the sensation of holding the cup). Dienes and Perner suggest that in hypnosis we abandon those higher order thoughts that have to do with the intention to act, and hence simply have conscious awareness of the result. Brain scanning had previously identified a frontal region of the left hemisphere that appeared to be involved in the higher order thinking process. Hence, Dienes and Perner reasoned that if this region were unable to work effectively, a person would be more likely to experience hypnotic behaviour as happening by itself. Sure enough, after using a technique known as transcranial magnetic stimulation to disrupt the region, they found that people rated their hypnotic responses as feeling more automatic.

**Time distortion**

It is possible to approach the notion of disconnection (or at least some form of neural disruption) from a different perspective: that of its impact upon time judgements. It is a common observation that a person who has just had a session of hypnosis will produce