

A Continuum of Hypnotherapeutic Interactions: From Formal Hypnosis to Hypnotic Conversation

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Hypnotherapeutic interactions can be mapped on a continuum from *formal hypnosis* to *hypnotic conversation*. Unlike the structured forms of formal hypnosis, hypnotic conversation relies upon utilizing the client's responses, both verbal and non-verbal, to facilitate therapeutic process. In this paper, we illustrate this continuum with a series of anecdotal clinical examples starting with formal hypnosis and moving incrementally towards hypnotic conversation. Finally, we offer an example similar in appearance to formal hypnosis, but now described in the context of hypnotic conversation. We are neither putting forth a theory nor offering a new perspective for those who research hypnosis as a phenomenon. Rather, these ideas and metaphors serve to broaden the framework of what constitutes hypnotic interaction so as to evoke new opportunities for increasing therapeutic efficiency and efficacy.

Hypnosis is art and science masquerading as conversation.

James Warnke (personal communication, September 22, 2000)

Introduction

In this paper, we wish to broaden (and ultimately deepen) the clinician's awareness of interactions in which the dynamics of hypnotherapy, induction, and trance are in play. To do this we will propose and describe a continuum in hypnotherapy from modes of interacting considered as *formal hypnosis* to one that we are calling *hypnotic conversation*. This continuum is a scaffold on which we will drape a set of ideas and metaphors regarding hypnotherapy, induction, and trance.

Zeig (1985) tells us that, although Erickson used formal hypnosis in only a fifth

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of his cases, he consistently used hypnotic technique even when he was not “doing hypnosis.” In our work we often do *not* use the terms “hypnosis,” “trance,” or “unconscious.” We may choose not to use formal induction or hypnosis. Nonetheless, our interactions with our clients are informed and organized by premises and components operative in formal hypnosis including: building rapport, assessing client responsivity, focusing attention, framing client responses in a way that promotes therapeutic outcome, indirect suggestion, and utilizing more of a client’s attitudes, understandings, and abilities on behalf of his or her desires and well-being (Erickson & Rossi, 1979; Zeig, 1984; Lankton & Lankton, 1983; Hammond, 1990).

We acknowledge the growing body of research generating data, facts, and measurements of trance and hypnosis as a phenomenon. This includes several generations of hypnotizability scales (Council, 2002). We are neither putting forth a theory nor trying to provide a new perspective for those who research hypnosis as a phenomenon. Rather, we offer these ideas and metaphors in order to increase therapeutic efficiency and efficacy through 1) the utilization of client responses during induction, 2) the use of the client’s natural response-tendencies as a tool for therapeutic interaction, 3) the utilization of the immediate therapist-client interaction for the initiation of trance instead of waiting for the opportunity for formal hypnosis to arise, and 4) the incorporation of hypnotherapeutic interaction into the conversation that arises between clinician and client.¹

Working Definitions

Trance

When asked to define trance, Erickson is reported to have replied, “whatever I say it is... will distract me from recognizing and utilizing the many possibilities that are” (Gilligan, 1987; p. 39). Despite the long history of dedicated scientific research, trance has, in our view, no stable referent. While there are enough significant differences among researchers and theorists to support this assertion (Weitzenhoffer, 2000), our point keeps with Erickson’s: any definition that proposes explanatory closure limits possibilities.²

Induction

In most varieties of clinical hypnosis and hypnotherapy, induction is seen as a means towards the establishment of a trance. In explicating our continuum of hypnotherapeutic practice, we will add to this definition. An induction is an interaction in which attention becomes focused or directed such that the person becomes absorbed in the details of his experiencing. A focus can be a very wide focus (to keep with the visual-spatial metaphor), a blurry or defocused focus, a multiply placed focus, and so forth. A direction (also a spatial metaphor) may be in any direction, even in the direction of not-knowing or not-having a direction.

¹ These four items—and this entire paper—are rooted in the Ericksonian concept of utilization: using the client’s beliefs, behavior, and personality on behalf of the desired therapeutic outcome (O’Hanlon, 1987).

² In his *Conversations with Milton Erickson* series (1985), Jay Haley frequently tried to pin Erickson down to a theoretical explanation for his work. Erickson typically responded to these requests by telling another story.

Hypnotherapy (Including Formal)

Broadly defined, hypnotherapy is a form of interaction in which attention becomes focused in a way that brings forth an experiential context that is therapeutic. Most traditional descriptions of hypnotherapy favor a container schema (Lakoff & Johnson, 1980/1999) to describe the actual practice of the work. For example: a person, by means of an induction, goes *into* a trance (Trance as Container). Once *inside*, therapeutic suggestions are received that *go into* the person's unconscious (another Container). This flowchart neatness belies the complexity of the process and conceals rather more than it reveals.³ Hypnotherapy, and therapy in general, takes place in an alive, richly thick, experiential context, a system, that is not reducible to the sum of its individual components. We will illustrate what we mean by hypnotherapy in the examples that follow.

Unconscious

Erickson frequently prefaced his use of this term by saying, “for convenience sake I speak about the conscious mind and unconscious mind,” (Zeig, 1980; p. 33) creating a distinction that, for him, had therapeutic utility. Presupposing a “more of you than you can ever be aware” is a powerful framework for organizing a person's expectancy about therapy. It usefully proposes that there are always more resources, more flexibility, more range and capacity, than a person generally knows or believes. Bateson's (1972, 1979) version of what is meant by unconscious is in accord with how we think of it: as the complex array of processes operating to keep the organism alive and functioning, that orient the organism in relation to its world. He also referred to it as that set of presuppositions that organize experience and perception, of which we are largely unaware.

Like Erickson, we frequently refer to the unconscious in reified form. The reification stands in for *unconscious process*, a more cumbersome term. We invite our clients to accept this reification but do not propose, ontologically, that there is a thing called the unconscious. However we do make use of the relatively well-accepted idea that much of who we are is outside the range of awareness.⁴ In trance induction, the therapist can use this conscious/unconscious distinction (Erickson, Rossi, & Rossi, 1976; Lankton & Lankton, 1983) to construct a model of therapeutic dissociation. For example: “while your conscious mind continues to doubt and question, your unconscious can facilitate a sufficient sense of confidence in the certainty of your ongoing experience.”

Conversation

For us, conversation refers to all forms of interaction, not just verbal, in which interacting components enact a process of mutual perturbation and response. Maturana and Varela (1987) refer to this as structural coupling: the coming together of two or more unities to form a network of viable connection. In keeping with our definition of an

³ For instance, the largely unpredictable nature of the enterprise of suggestion giving and communication in general. We believe it is the receiver rather than the sender who determines the meaning of a message. We also reject the “myth of instructive interaction” (Efran, Lukens, & Lukens, 1991) that is often presupposed by the traditional framework for hypnosis.

⁴ Lakoff and Johnson (1999) refer to this as the cognitive unconscious, and estimate that it constitutes over 95% of actual cognitive activity.

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unconscious, conversational processes take place on multiple levels, in multiple domains, both within and without conscious awareness. These domains include, for example, ideomotor signaling, body motions, breathing, sighing, attitudes, behaviors, language choice and syntax, and emotional responses.

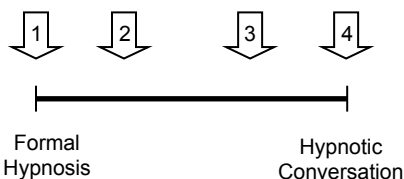
Hypnotic Conversation

Hypnotherapy, and therapy generally, is a form of conversation that carries forth some purpose. Usually a client has an interest, a problem, a goal, or a yet to be articulated distress that triggers his seeking a relationship with a therapist. Together client and therapist negotiate meaning around this *something* and agree upon a framework for action. A hypnotic conversation falls within this domain, only it is further specified by the utilization of trance, formally or informally induced, or spontaneously utilized as it arises. Hypnotic conversation makes use of a systemic and interactional frame regarding trance (Gilligan, 1987; Haley, 1963/1990) that emphasizes the interactional process of trance rather than the individual state of the subject. Unlike versions of hypnosis in which suggestions are presumed to be taken in and acted upon by the client, hypnotic conversation is a matter of perturbation and response operating in recursive patterns of increasing complexity (Rossi, 1992; p. 231, 238-239). In systems terms, increased complexity (up to a certain threshold) affords the organism with more options for viability and fit in relation to its world.⁵ The therapist's job is to "direct spontaneity" (Lounsbury & Winston, personal communication, September 26, 1997) through a continual folding in of the client's responses into the ongoing emergence of the trance. This idea builds on the long history of circular patterns of suggestion and psychobiological signaling (e.g., non-conscious movement, changes in respiration, skin color, heart rate, eye blinking, body posture, facial expression, muscle tonicity) in clinical hypnosis (Bernheim, 1886/1957; Erickson, 1980; Erickson & Rossi, 1981; Rossi & Cheek, 1988; Rossi, 1996). Brown (1991; p. 45-46) describes this as the development of interactional synchrony. This will be illustrated in the clinical examples to follow. Hypnotic conversation is a means for therapist and client to embark upon "a path that does not exist but is laid down in walking" (Varela, 1992; p. 255).

A Continuum of Hypnotherapeutic Interaction

As stated, we are offering a continuum of hypnotherapeutic interactions from formal hypnosis to hypnotic conversation. Graphically, this continuum can be represented as follows:

Continuum of Hypnotherapeutic Interactions



⁵ See Ashby's (1965) law of requisite variety.

At our starting point (arrow 1), formal hypnosis frames induction as a means to trance, with interventive suggestions offered during the trance state. In its extreme, this is hypnosis as might be taught to beginning students in an introductory hypnosis workshop. Between arrows 2 and 3 the distinction between induction, trance, and therapy begins to blur. The clinician increasingly weaves the client's unconscious responses into the induction, while framing those responses on behalf of the therapeutic outcome. What had been, in the frame of formal hypnosis, the induction, now in itself becomes therapeutically interventive (Zeig, 1988).

Continuing toward arrow 4, the interaction increasingly looks like conversation: no identifiable induction, no formal trance. The distinctions between induction-and-trance and conversation blur even as the opportunity for the client's unconscious engagement and learning are amplified.

We will illustrate this continuum using a series of anecdotal examples starting with formal hypnosis and incrementally moving toward hypnotic conversation. With the exception of the fictional example 1.1, all examples are reconstructed paraphrasings taken from the authors' practices (AR or JT). We will roughly position each example on the Continuum of Hypnotherapeutic Interactions graphic and offer commentary as we move from formal hypnosis to hypnotic conversation.

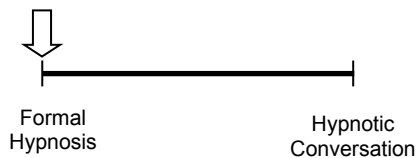
As an afterword, we will offer an example of what looks like formal hypnosis, but includes elements of hypnotic conversation. This example will illustrate that our proposed continuum of hypnotherapeutic interaction is circular and recursive rather than linear.

Formal Hypnosis

Typically, hypnosis in therapy is taught to beginners as a series of stages, analogous to stages in therapy generally. First comes gaining rapport, then an induction, perhaps a deepening, then suggestions followed by a reorientation. In formal hypnosis the induction, ranging from a scripted standardized protocol to a more improvised conversational mode, is intended to induce a particular state in the client such that he or she becomes, as Erickson frequently put it, responsive to new ideas and learning. In the following fictional example of what we are here calling formal hypnosis (as might be taught in an introductory workshop), induction is seen as a means to induce trance. Therapeutically interventive suggestions are offered when the client is adjudged to be in a trance state.

This and two others of our six examples use one of the many forms of ideomotor signaling—what we call a hands-coming-together induction. Variations are described by Weitzenhoffer (1957) (a stage hypnotist's version), provided in a more permissive form by Rossi and Cheek (1988), and subsequently developed by Rossi (2002) and others (Lounsbury & Winston, 1997).

Example 1.1: Smoking Cessation



K. wishes to stop smoking. We would discuss K.'s motivation and take a relevant history, then set about inducing a trance using a template such as this hands-coming-together script:

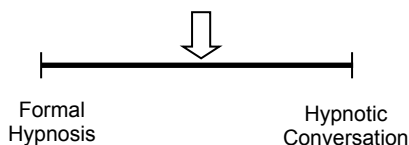
Hold your hands 8 to 10 inches apart. That's right. Now, if your unconscious is willing to assist you in going into trance, then you will find those hands moving together. If your unconscious has some objection to this task, then you will find those hands moving apart as you give voice to the objection. So, now you can be consciously curious as to when you will notice your unconscious response: whether those hands move toward each other or away from each other.

We would notice and respond to motions of the client's hands while offering suggestions for comfort and relaxation in a cadence matching the client's exhalations. We would associate the hands actually touching with a deepening of the trance state. Once the client is in a trance state we would offer interventive suggestions.

The Hypnotic Middle Ground

In examples 2.1 and 2.2, below, the distinction between conversation, induction, trance, and therapeutic intervention increasingly blur. Judging by the outcomes, some therapeutic transaction took place. This transaction is still informed by the same human capabilities that the methods of formal hypnosis seek to engage.

Example 2.1: Gaining Relief from Headache and Left-sided Temporomandibular Joint (TMJ) Dysfunction [JT]



C. wished to gain relief from her headaches which she thought were caused by the jaw clenching/muscle-cramping/pain cycle of TMJ dysfunction (previously diagnosed by her dentist). I suggested it might be useful for C. to learn self-hypnosis. She agreed.

We started with a hands-coming-together induction (see example 1.1, above). After a few minutes C.'s left hand started to oscillate back and forth. Assuming the response was relevant I encouraged it:

That's exactly right. And without conscious effort on your part, your unconscious can continue exploring and learning this way... exactly what is important for you to learn to gain relief from those headaches.

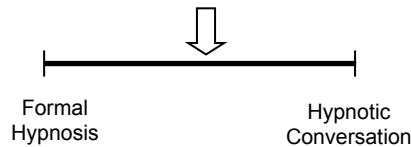
The motion became more erratic and violent-looking, as if the left hand was fighting off being held. The right hand was still. I continued:

Your unconscious continues to make use of this task in its own way... in a way that is exactly right for your learning....

And after about 10 minutes, when the left hand motion was subsiding I suggested that when her unconscious had done enough for now to make a difference, she'd find herself coming back to the room. The left hand stopped moving, both hands dropped to the lap, she opened her eyes, and then said, "I started out as a lefty and my first grade teacher forced me to write with my right hand. I've carried the tension of that on my left side for years!" The headaches and the left-sided TMJ symptoms abated over the next two weeks.

The induction evolved into a therapeutic learning experience. The client's left-hand oscillations, rather than construed as resistance to the induction, became the embodiment of the learning being done. The clinician's folding in of the client's unconscious responses during the induction—*while holding the assumption of the relevance of the client's left-hand motion to the therapeutic outcome*—was a suggestion to the client: "How will you make useful meaning of this experience?"

Example 2.2: Investigating Controls [AR]



This example uses the individual's natural proclivities to promote a therapeutic experience. What might be called the induction in formal hypnosis emerged quite naturally out of my interaction with the client.

A woman I had seen for several months initially became quite anxious at the suggestion I made of hypnosis. She was concerned about giving up control to me, a man. Despite her trust in me, it scared her to consider the possibility that I could make her do something she would not want to do. I suggested that we set up an experiment to demonstrate her ability to stay *out* of trance to ensure a confidence in her ability to take care of herself if she were to go into trance. I described what I would do if I induced a trance. She stiffened her muscles. "So, tensing your muscles would be one way to stay out of trance. What else?" She replied that she would probably keep some part of her body moving. "Mmmhmm, some part of your body moving... like those feet? What else?" As I verbally noticed her movements, she increasingly became still, though always maintaining movement somewhere. "Eyelids blinking. Good. What else?" Finally, her eyes closed and her body became completely still. Or so it seemed until I noticed a tiny twitching in her upper lip. "And that barely perceptible twitching of the upper lip. No more movement than necessary to let you know what is important for you to know... that you have control... even as you get relaxed and comfortable. In control, and really taking advantage of the opportunity to go into trance."

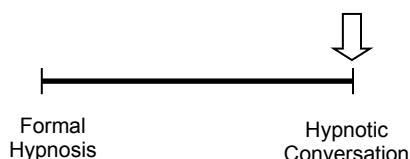
This client began this transaction believing that being in control and letting go were separate states/activities. During this trance-inducing exchange, a frame was co-created by client and therapist that *embraced at once the connection and separation* (Flemons, 1991) of letting go and staying in control.

Hypnotic Conversation

Within this framework, there may be no identifiable induction and no formal trance. The client's experience of the interaction provides the opportunity for therapeutic learning, conscious and unconscious.

Examples 3.1 and 3.2 of hypnotic conversation, below, may appear less precise and directive than the examples of formal hypnosis and hypnotic middle ground offered above. More than what was said, the unspoken interaction evoked a learning experience for the client homologous to the domain of therapeutic interest.

Example 3.1: Interrupting the Story [JT]

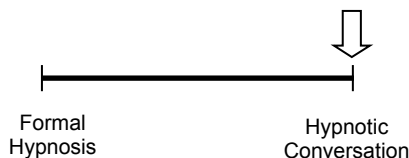


After four sessions, G. announced it was time for her to tell me her story so I could understand who she was. I told her that was OK with me insofar as recounting her story provided her an experience that furthered her enlivening interests. She looked at me blankly for a few moments, agreed, then started. Every time I noticed some shift—emotional, voice tone, postural, breathing—I would interrupt and ask her about her experience “right now.” This cycle continued. Finally, with some emotional charge, she told me that with all the interruptions she was not sure she would get to finish the story. I asked if that was OK. “Yes, somehow it is.” I suggested,

Any learning that is useful to you will happen now, not in the past of the story.
Maybe a learning evoked by a recollection.... But the learning happens here and now.
So, I keep interrupting your story to check with you now.

By session's end, although she had not finished her story, she said she felt “strangely good” about it, and “altered in a good way” that she did not understand. I propose that my interruptions served as wedges into her familiar and heretofore seamless self-narrative, opening up cracks, creating spaces for new experience.

Example 3.2: Learning Self-hypnosis [JT]



P. wanted to spend only one session with me to learn self-hypnosis in order to control his mood swings. We spent the session exploring the following:

Explorative Task	Hypothesized Purpose
How P. came to imagine that self- hypnosis was what he wanted to learn.	Allow P. to clarify what he wanted to accomplish with self-hypnosis.
What P. already knew about self-hypnosis.	Collect P’s internal resources consisting of hypnotic states he already knew how to experience.
What P. imagined he would experience in order to know he had learned self- hypnosis.	Evoke and initiate the internal processes by which P. would learn self-hypnosis by doing the work of imagining his experience from the perspective of already having learned self-hypnosis.

Toward the end of our time P. became angry, saying we had not done any hypnosis. I asked him to call in five days and, “...let me know what happens, because I learn as much from my failures as my successes.” Five days later he called and said, “After our session, I realized nobody was going to help me. I had to do what I could myself. Besides, I must have known self-hypnosis all along because I made a tape recording that I’ve used the past four days to do hypnosis by myself.” He showed no conscious awareness of the possible link between our work together and what he had accomplished.

Full Circle: Formal Hypnosis Informing Hypnotic Conversation Informing Formal Hypnosis Informing...

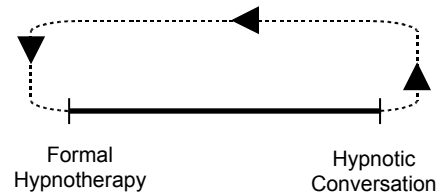
We suggest that what we here call hypnotic conversation, while it may look like normal conversation, is informed by our experience of formal hypnosis and contains many of the components of formal hypnosis. Parsing therapeutic interactions in terms of our experiences of formal hypnosis broadens our sense of interventive options. Depending on the clinician’s abilities, any of the client’s beliefs and behaviors—including verbal, physical, attitudinal, and manner—may be engaged to involve the unconscious intelligence to which those beliefs and behaviors are connected. Rather than formal trance, the therapist:

- 1) develops sensitivity to the client’s state changes and utilizes them,
- 2) convincingly and compellingly frames the client’s experience as on behalf of the desired therapeutic outcome,
- 3) consistently and precisely uses language harboring assumptions in support of the client’s therapeutic outcome, and
- 4) recognizes and allows space for the spontaneously occurring states in which the client comes to a new distinction.

Coming full circle: placing formal hypnosis in the larger context of hypnotic conversation also broadens our sense of interventive options. Consider the following example:

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Example 4.1: Expectant Mother Gaining Confidence in Her Unconscious Competence



S., a first-time expectant mother, was anxious about giving birth and wanted to learn self-hypnosis to be comfortable in anticipation of and during her birth experience. I used the hands-coming-together template (described in example 1.1, above) to provide S. the experience of her unconscious competence for physiological response. I framed the learning of self-hypnosis as S. becoming more comfortable with allowing her unconscious to do something it already knows how to do. I offered her examples of this (breathing, conceiving a baby, and gestation), then said:

You can consciously move your hands together, you know that. You also move your hands expressively and unconsciously as a normal part of your body language when you speak. So, let's start your learning of self-hypnosis by allowing your unconscious to move your hands together as you consciously learn to notice and rely even more on your unconscious abilities.

Intending to highlight the competence of S.'s unconscious physiological responses, I commented on the movements I thought she was not consciously controlling. Gradually her eyes closed and her breath became even.

By the time you and your baby are ready for birth, you have already accomplished most of the birth process, growing your baby until he is ready to be held in your hands. [S.'s right hand index finger twitches.] And as those hands move closer, you don't know consciously exactly when they will touch... [S. inhales and exhales fully, and her left forearm jerks, moving her left hand a bit closer to her right hand.] . . . just as you don't know consciously when you and your baby will decide the best time for the healthiest most comfortable birth possible for both of you. But your unconscious knows... when... those hands will touch. And your unconscious may have already chosen... which points on those hands will first touch. And as movement continues... together... with each exhalation your unconscious can provide you a deepening confidence... rooted in your unconscious competence to move this way... [I notice an in-utero motion] that's right... both of you... to learn this way... to grow and nurture your baby this way... [S. exhales] to breath this way... to confidently give birth this way. And when those hands touch... your unconscious can provide you the direct experience of the pleasure of your own competence... your own unconscious intelligence and responsivity on behalf of the most

healthy and comfortable birth possible for you and your baby.

In my cadence and tone I was responding to S.'s nonverbal responses—including breathing, hand and finger movements, and even a visible motion of her baby in utero. In the framework of formal hypnosis, this hands-coming-together induction produced a trance state in which I offered S. suggestions in support of a healthy, comfortable birth. In the framework of hypnotic conversations, S.'s experience of her hands moving together *with no conscious effort on her part* allowed her to gain confidence in her unconscious (and analogous) physiological abilities to give birth. She also learned to enter a state in which she can be comfortably available to her unconscious abilities.

Conclusion

It appears, then, that the continuum we originally proposed has turned into a creative circle (Varela, 1984; Rossi, 1968) with the original poles of formal hypnosis and hypnotic conversation as punctuation points on opposite sides, leading to and from each other. The circle makes moot the question of which contextualizes which. As therapists our primary concern is the emergence of new experiential domains more viable than those from which we and our clients start. Ultimately our bias is that the realm of hypnotic conversation offers a more capacious framework for us to enact a wider range of therapeutic interactions with our clients, including more formal and ritualized hypnotic work.

Acknowledgement

We wish to thank the Advanced Training Group of the Forum for Psychotherapy Cybernetics, its founders and facilitators Nancy Winston and Paul Lounsbury, and its participants throughout the past decade. Within the crucible of this group we, as people and clinicians, continually discover and experience how to participate in therapeutic hypnotic conversation.

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