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AN INTERVIEW WITH PETER BLOOM

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ABSTRACT

This article summarizes the key points of a conversation between Peter B. Bloom and Mark P. Jensen, during which Dr Bloom discussed his views of hypnosis and what he has learned to be most important and effective as a clinician using hypnosis for 40-plus years in his psychiatric practice. Dr Bloom views hypnosis as a type of altered state of consciousness that involves absorption and focusing on inward experiences, use of imagery, and focus on subjective feelings. He understands that this state is not unique to hypnosis; there are other routes to achieve this state, such as meditation and yoga. However, in the context of an intense therapeutic relationship, hypnosis can facilitate his and his patients' abilities to follow through with creative ideas that emerge in the process of therapy. In order for hypnosis to be most effective, Dr Bloom believes that (1) the patient must be an active and equal partner, (2) there must be a solid connection between the therapist and patient, and (3) the clinician should be open to and encourage the creative solutions that often emerge from the patient and clinician during hypnosis. Dr Bloom finishes the interview by describing in detail a formal induction and ego strengthening technique that he adapted from one he learned from Erika Fromm, and that he has found to be very effective for many of his patients over the years.

Key words: hypnosis techniques, hypnotherapy, creativity

INTRODUCTION

Dr Peter Bloom became interested in learning more formally about hypnosis when he discovered a good match between what he was doing naturally in his work with patients, and what he later learned about Milton Erickson's approach. One example was with a patient who, in the mid-1960s, was facing open-heart surgery and was convinced that he was going to die during the operation. The patient told Dr Bloom, 'I feel like there's a fence around me, and I can't get out.' Dr. Bloom said, 'You know, don't you, that the surgery is going to put a gate in that fence?' With this positive image, the patient calmed right down. After the surgery, he told Dr Bloom that it was the image of the gate that helped him to keep calm throughout the procedure.

Bill Webb, who was the head of consultative liaison psychiatry at the Hospital University of Pennsylvania at the time, gave Dr Bloom a recorded tape of Jay Haley discussing some of the cases of Milton Erickson. When Dr Bloom listened to the tape, he immediately experienced a feeling of no longer being alone in his approach to patients. At that time, a course on hypnosis was taught at the Graduate School of Medicine at Penn, directed by Sidney Pulver. Dr Bloom took the course, and over time became deeply involved in various hypnosis societies: the American Society of Clinical Hypnosis, the Society of Clinical and Experimental Hypnosis,

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and later serving as secretary-treasurer and then president of the International Society of Hypnosis. He soon began teaching others in basic and advanced applications of hypnosis.

Dr Bloom is an incredibly creative clinician, and has a unique approach in forming creative healing relationships with his patients and with those he teaches (Bloom, 1990, 1991, 2001). Anyone who is lucky enough to interact with him immediately becomes aware of his ability to facilitate constructive growth. Dr Bloom is alert to the fact that an appropriate goal of therapy is not just to have a happy life, but to have a satisfied and worthwhile life. He is particularly effective in helping his patients achieve this goal.

Mark Jensen: *How do you view hypnosis?*

Peter Bloom: Theorists share different perspectives on what is involved in hypnosis. A comprehensive review of these perspectives is beyond the parameters of this interview; however, I remember a nice series of articles on this topic in the October 2005/January 2006 issue of the American Journal of Clinical Hypnosis. For me the role of suggestion (Gheorghiu et al., 1989), an altered state of consciousness (Ludwig, 1969), and the degree of absorption (Tellegen & Atkinson, 1974) have had the most appeal. Martin Orne (1977) understood hypnosis as a state in which one had an increased ability to alter one's perception of memory, mood, sensations, and subjective experiences. Martin's definition suggests therapeutic goals as well. In my mind, hypnosis involves all of these.

Hypnosis allows us to alter our perceptions of ourselves more quickly, and this can be extremely useful during the course of therapy. Hypnosis provides someone with a timeout from the secondary process—our cognitive way of thinking about things—while in a state where time has less meaning and opposites are not necessarily contradictory. In this altered state you can love and hate simultaneously. It is a state that is useful for facilitating new patterns of thinking and feeling, new ways of problem solving. Also, it involves the relaxation response (Benson, 2001), during which one can take a rest from intense cognitive processing. By taking that rest, perhaps creative ideas will come into awareness.

I rarely do formal hypnosis. However, I think I am using hypnotic principles 100% of the time in my clinical work. Every word that I say to a patient, no matter how spontaneous, is considered. I am aware that I rely on my observing ego to pounce on a wrong word or stop me in the middle of a sentence, if needed, when I notice that the words I am using are going against the grain or do not fit well with the patient's issues. Every interaction that I have with a patient is designed to meet the objective goals of the session, whatever these goals may be.

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So hypnosis is a way of saying, 'This is going to be a different experience.' It is really an elaboration of what we have already been doing, but with one caveat. I want to work with a patient in a hypnotic way, to allow him or her to take the experience home and realize there are other ways of dealing with the stresses and problems that come in. It is rather seamless, my shifting into and out of using a more formal approach to hypnosis (although, when I make an audio recording for a patient for their use at home, it is very clear).

I think more than anything, though, that if you have two people in an intense relationship, and one or the other comes up with a creative idea about what to do with the issue that is on the table, hypnosis facilitates our ability to follow through with the idea. How can we and others conceptualize the source of our own creativity? Many have tried. If one reads Carlos Castaneda's books written in the 1970s, describing Don Juan, the Yaqui Indian, attempting to teach Carlos the ways of being a medicine man, one realizes that there are different ways of seeing and believing (e.g. Castaneda, 1969). William James, in his *The Varieties of Religious Experience*, wrote:

> *It is that our normal waking consciousness, rational consciousness as we call it, is but one special type of consciousness, whilst all about it, parted from it by the filmiest of screens, there lie potential forms of consciousness entirely different. We may go through life without suspecting their existence; but apply the requisite stimulus, and at a touch they are there in all their completeness, definite types of mentality which probably somewhere have their field of application and adaptation. No account of the universe in its totality can be final which leaves these other forms of consciousness quite disregarded. How to regard them is the question—for they are so discontinuous with ordinary consciousness. Yet they may determine attitudes though they cannot furnish formulas, and open a region though they fail to give a map. At any rate, they forbid a premature closing of our accounts with reality. (James, 1902, pp. 378–379)*

Hypnosis allows us to enter these altered states of consciousness with comfort and familiarity as we join our patient's journey towards wholeness.

One of the questions I struggled with for years is how hypnosis is different from meditation or yoga. I remember the day and place I came up with an answer. I was with my in-laws. Everyone was inside and I was outside ostensibly trying to read a book. An idea came to me. I envisioned a wagon wheel. At the hub of the wheel was the altered state of consciousness, and the rim was all the secondary process thinking. The spokes were the different methods or ways of accessing the altered state. So really there's not that much difference between

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hypnosis, meditation, yoga, or perhaps even some drugs. They are all just spokes on a wheel, or more abstractly, methods to get from secondary to primary processing.

Unfortunately, at times, there are huge border wars that go on between some of the advocates of these different methods. For instance, it is hard to suggest to some that natural childbirth techniques are really quite similar to hypnosis. The metaphor suggests other meanings as well. In my opinion, if you get stuck in the hub of the wheel or in an altered state, that's psychosis. If you get stuck out on the rim of the wheel or in a secondary process, you're probably starving for non-cognitive sources of reality and creativity. You would be the same as someone who cannot see the poetry in life and is only able to deal with life by using strict cause-and-effect thinking and strategies that are more logical.

I think what happens in the healthy person is that he or she has the flexibility to travel from the rim to the hub and back again, thus alternating back and forth between artistic and scientific thinking, depending on what is called for in the moment. The healthy person is not resistant to that shifting. When you are having sex with someone you love, you are more in the hub in an altered state of consciousness. When you are completing your tax return, it is best to be out there on the rim in a secondary process. Hypnosis is just one way, of many, of getting to the hub on purpose. However, the quality that separates hypnosis from the other methods used simply for achieving an altered state of consciousness is that the resultant hypnotic trance is used specifically to solve a physical or psychological problem. It is not just an end state.

I have long felt, as did James Braid (1843/2010) and many others, that 'hypnosis' was an unfortunate label. At one point, I had decided to devote a portion of my career to changing the name of hypnosis to something more acceptable. I was told by colleagues that this would not be possible. Braid himself had tried to do it (his replacement term was 'monoideism' (Braid, 1855)). It has always been of concern to me that as soon as you mention 'hypnosis' to someone outside of the field, the conversation stops. If you try to talk about imagining or the processes of hypnosis, most people have no concept of the flow that I'm talking about. Interestingly, though, my grandchildren seem to know exactly what I am talking about.

It seems that to advocate hypnosis professionally is to accept a degree of isolation from one's colleagues who accept the myths about this useful clinical modality. However, as we choose our individual course in life, a comfort in being different and unique is necessary. If you have your own way of seeing the world, and if you are going to listen to your own heart and embrace a concept that may be outside of the mainstream, you must be willing to go it alone or go with

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it pretty far alone. That is why hypnosis meetings are so important; among other things, they help us to feel less alone while learning a clinical skill of enormous portent.

In my view, hypnosis is the most effective way I know of reaching the mind–body interface. When you are working with someone in trance, you can go after physical complaints that have an emotional origin, such as a psychosomatic disorder that presents emotional problems as something physical; a conversion disorder is a huge and easily discernible example. And the opposite, if you have someone in trance, you can go after the emotional or mindful issues that have physical origins. The latter would be an example of working with someone in pain. The great opportunity is that hypnosis provides a conceptualized way of doing therapy or being with someone where you have direct access to that mind–body interface. A reminder though: it has to be done with a full appreciation of both the physical and psychological parameters of the disorder.

There is no other intervention available to the therapist that is so useful in this regard. Cognitive therapy certainly does not do this, almost by definition. Psychoanalysis may provide insight and a way of working through a problem, but psychoanalysis is based on the notion that man is a closed system. In the psychoanalytic model, if the patient has a symptom that is related to an internal conflict, and you remove the symptom without dealing with the conflict, the patient often will create a new symptom as a way to continue to manage the conflict. However, I have never seen this kind of symptom substitution. I like Ludwig von Bertalanffy's idea (1969) that man is an open system. If you remove a symptom, like a rock blocking a stream, everything will flow more easily. The insight, if it's there, will come afterwards.

MJ: What kinds of problems do you use hypnosis for?

PB: I worked as a psychiatrist at the Institute of Pennsylvania Hospital for 28 years, until it was closed and I relocated my practice. During my time at the Institute, I had a very large outpatient private practice, and I admitted my own patients to the hospital and treated them on my service when needed. As an aside, I was never comfortable working with schizophrenic patients. I did not like working with medications alone, and I only dimly knew then how to form a relationship with these terribly disturbed patients and their families. Perhaps today I would be better at it. I did have a number of very ill bipolar patients and when the US Federal Drug Administration approved lithium in 1971, I began treating these patients regularly, some for more than three decades. Also, in the beginning of my outpatient practice, I saw many patients with psychosomatic gastrointestinal disease. Gradually, my practice began to fill with patients who felt stuck someplace in their life and wanted to grow. Some were stuck with depression or pas-

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sivity; others were stuck with getting caught in any of the addictions. For a number of years I enjoyed working with people's sexual problems in creative ways.

As my practice matured, my patients shared other common characteristics. As long as they were verbal, as long as they were motivated, and as long as we could establish a good working relationship, I felt I was able to help. While I always strived to establish a good working diagnosis, my patient selection was not diagnostic dependent. I treated my share of patients with borderline personality disorder, but while I helped some, I felt that by and large I was not able to be very effective. I soon realized I was not a good psychiatrist for every patient. Over the years, it has been hard to describe my practice in a few words. An earlier term I used was 'eclectic'; now it approximates 'interpersonal psychotherapy'. More importantly, I did not specialize in a pathology so much as specialize in people who were ready to grow and find some new balance in their lives, independent of their particular diagnosis.

MJ: *What are the key elements of effective hypnosis?*

PB: *THE PATIENT MUST BE ACTIVE AND AN EQUAL PARTNER*

One of the keys is that the patient is ready and able to be an active and an equal partner in the process. Sometimes a patient would come in and sit back, and say, essentially, 'Okay, do it, so I can walk out of this office and be done with it.' Of course, that is a set-up for failure. I think one of the ingredients that makes hypnosis work is an energetic patient wanting to learn it as a skill to help him or her in ongoing problem solving. Much of my work is to enhance that motivation. The sports company, Nike, never said 'Just try it'. Nike says, 'Just do it'. If someone comes in and says, 'I'd like you to do hypnosis so I can try to stop smoking,' I know that from the start we will have problems. So a partnership of active equals is essential.

CONNECTING WITH THE PATIENT VIA EXPANDED EGO STRENGTHENING

For hypnosis to be effective, it is also important to connect deeply with the patient. One good way to do this is to identify and focus on the patient's strengths. John Hartland wrote a book called *Medical and Dental Hypnosis and Its Clinical Applications* (1966). He said that if you include ego strengthening as an ongoing part of the treatment, you'll be halfway towards solving the presenting problem. I have come to believe that this is true. So I make a point in the pre-hypnotic interview and during hypnotic treatment itself to include ego strengthening suggestions. I repeat many times Émile Coué's, 'Every day in every way, I am getting better and better' (Coué, 1922). It can sound trite, but if you mean it, and repeat it nearly 20 times as Coué suggested, patients respond well to it.

I would like to expand the concept of ego building as I use it in my practice. If, based on the patient's history, you learn that the patient thinks that he or she is stupid, despite evidence to the contrary, you can throw in a couple of suggestions when they are in hypnosis that they are bright and clearheaded. It shows them that you have been listening closely to them, that you have listened deeply, and found the good stuff. Perhaps 'gold' is a better metaphor. However, all therapy is based on relating to the patient's positive attributes, strengths, or 'gold'.

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You know when a dentist drills, they get down to the healthy part of the tooth and then restore to its original shape and function. Although what I do is not dentistry, it is important to have the belief that in every human being there is a foundation of pure gold. You need to find it and then build from there. Your patients will know it if you see that part of them at some profound level. That is when a therapeutic alliance is created and healing begins. It is the bedrock of all successful therapy.

Once you have created that linkage, you are bound together in a workable therapeutic relationship. From that point on in your relationship, you add as much ego building as you can in your work together. If sometimes you can't see any such gold, you have to get the patient's help to see it. Occasionally a person comes along who may not have any redeeming value. In this case, I would choose not to work with the patient. But I think, in general, and with the vast majority of people, you can reach down, identify with the patient's strengths, and then do ego building as you begin subsequent therapy.

It is a powerful thing to come into a doctor's office with a problem, and suddenly realize that he or she sees right through to where you have hidden your best parts, because you did not want anyone else to see it or be responsible for using it. Why would anyone hide their best parts, the essence of who they are? Sometimes it is simply to protect them in an otherwise hostile environment. We have all seen patients with a history of abuse who have been told that they were no good. Subsequently, they will not readily show their good parts to others and sometimes to themselves in a necessary effort to protect their very sense of self. And, yet, when they come into an office, a safe and protected environment, the clinician may see their strengths and build on them. It is a very powerful process. And I think that it is a very, very important part of what we do. It facilitates the whole process of hypnosis and therapy.

ALLOWING ACCESS TO CREATIVITY

In addition, hypnosis allows the clinician and the patient to access creativity. It allows for very creative ways to communicate with a patient's strengths. You see, everyone has 'resistance'. We all have ambivalence about change; otherwise, we would not need help with making important life changes. But once you've identified where their strength is, and identified a way to work with it without directly confronting their resistance, you're on your way.

Let me give you an example—this was a case I have previously written about (Bloom, 1990). I was working with a woman who came to see me because she was unable to consummate her engagement. She was a young woman who worked for an airline in a freight room. Why couldn't she consummate? She heard her mother's voice saying 'no' every time she became engaged and considered having sexual relations with her fiancé. In the past, she had always broken off the engagement. However, she had recently become engaged again and this time she wanted to marry him. She also wanted to consummate this engagement, but was frightened that she wouldn't be able to because of her mother's voice saying 'no'. After working with her for several months, she came in for her appointment and related that two young men in the freight room at the airport were trying to 'hit on her'. She was terrified and in obvious distress and slumped down in the chair and grew silent waiting for my response.

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Suddenly I felt an urge to turn and look away towards the far corner of the room. I said, 'Oh, look,' and she looked with me into the corner as well, 'there's a ticker-tape machine.' I looked back to see if she thought I was nuts. However, she was absorbed and looking at the 'machine'. I pretended to pull the tape out of the ticker-tape machine and, while she was looking at me, I said, 'Look at what this tape says.' And while she was deeply in trance staring, I said, 'The United States Public Health Service has notified all young women that these two men, by name, have the most virulent case of syphilis ever recorded. All young women are advised not to have any contact with them.' While we previously had used hypnosis only for relaxation, she was now clearly in a deeper trance. I proceeded and, with an imaginary pair of scissors, cut the tape off from the ticker-tape machine and held it up before her. She spontaneously opened her purse, I dropped the imaginary tape in, and she closed her purse again. Quietness settled in the office. That was two minutes into the session. We had 58 more minutes to go. What to do?

Now, if you really see the patient—if you see who they really are—and you see what the issues are, you may still not know why you did something like that. But you have to learn to trust it. It was Christmastime. So I decided to spend the balance of the hour discussing how she could travel for little or no cost because she was an airline employee and only needed to pay the tax for a ticket to travel anywhere. For US$15 she could fly from Philadelphia, Pennsylvania to Dallas, Texas, shop at Neiman Marcus, and fly back home. It became a simple social conversation. Every time she would start to talk about the young men who had expressed an interest in her, I would steer her away. However, at the door at the end of the hour she turned and patted her purse and said, 'Thank you', and she walked out. Well, the young men never bothered her again, but what happened was interesting. She no longer heard her mother's voice saying 'no' but was, for the first time, able to freely say the desired 'yes' to her fiancé.

On further thinking, I conceptualized that she had not previously internalized an ability to say 'no' when the relationship was not quite right. She had to hallucinate her mother's voice saying 'no'. She needed a way to visualize and internalize the ability to say 'no' so that she could ultimately choose to say 'yes' when it was right. And by symbolically accepting the ticker-tape, and 'taking' it into her purse, she internalized her ability to say 'no'. Thus, she became truly free to say 'yes'. This interesting dynamic insight was obtained after the creative moment was experienced. I believe we all know more than we are consciously aware and we need to trust this spontaneous process when it occurs. It is an expression of knowledge, which we all have outside our usual awareness. When it appears to us consciously, I urge us all to use it in the service of our patients.

A bit more reflection on this story. I could have just said, 'Oh, jeez, what happened, did somebody slip some LSD in my lunch or something?' and stop myself from pursuing what might appear to be a random or silly idea from the outside. However, I was already doing a little bit of this sort of thing in my medical residency (for example, the surgical patient who found the 'gate' metaphor so helpful). But having known and used hypnosis for a few years, I could now understand the use of creative imagery, and let myself be totally free to flow with it. I have learned that it comes down to trusting your instincts and gut. This is the essence of successful therapy. It is never just theory dependent.

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Once you have a patient that you understand, and you let them know that you know where they're solid, you are free to be creative. I do not think that there is any therapeutic approach other than hypnosis, which allows so much for this kind of creative intervention, generated from either the patient, or yourself, or both.

I'll give you another example, also described in a previous publication (Bloom, 1990). I was seeing a graduate student in psychology when I was a resident in psychiatry. She was very controlling. One day she announced, 'Next week's my birthday.' So I immediately told her, 'I want you to bring me a present for your birthday.' She nodded, and we continued with the session. The next week, she came in and placed two marbles on the desk and said, 'I brought you a present for my birthday. Choose one.' I was in a dilemma. If I picked one marble, why not the other one? What to do? There was a sudden moment of silence. Then I just picked them both up, put them in my mouth, and I said, 'You brought me a present for your birthday. Now I have two marbles in my mouth. What are you going to do?' She started belly laughing, and I started belly laughing. She said, 'Take the marbles out, you'll choke.' Good advice, I took them out.

We spent a few sessions trying to decide how we could, as students in the fields of psychology and psychiatry, look at the event that had happened between us and understand it. We never came up with a theory that worked for us. We considered the (Freudian) possibility that the marbles represented testicles, as well as many other explanations and theories. It just went on and on. As I looked at our relationship, I noted that, at first, she controlled me by asking me to pick one of the marbles and I then controlled her by putting both marbles in my mouth. The process in this moment had yanked the control between us back and forth, but it became much weaker between us from that point on. A creative moment, one we never anticipated, or planned, but it changed so much in the relationship and therefore in therapy.

BEING ATTENTIVE TO INDIVIDUAL NEEDS

There was a panic disorder patient that I treated who had never left her home in 20 years except to go to her job a short distance around the block. She had not been into the city of Philadelphia from the suburbs. She had not been to the New Jersey Shore. She had never been on an airplane. I prescribed clonazepam and fluoxetine, and after a lot of counselling, including some hypnosis, she was gradually feeling better. With encouragement, she drove into Philadelphia. She then, in succession, drove to the New Jersey Shore and took a train to Washington. For her train ride, I insisted that she go first class with a waiter at her beck and call. Such an advance in her freedom had to be celebrated tangibly as the special event it was. She then took a short plane ride and began planning to attend a wedding of a close friend in Italy. She went to Italy and on her way back home through Heathrow, she sent me a postcard of Winston Churchill waving a V for Victory sign. But what images did I suggest to help her on the flight overseas? Sometimes creative ideas are just plain fun to plan and to implement.

The hypnotic work I did with her focused on what she would do on the plane ride to Italy. My goal was to bind her anxiety. She was a heavy woman and felt the tightness in the small restrooms on airplanes. I said, 'When you go into the restroom on the plane, I want it clean when you leave. You go in there, and you see paper towels on the floor, I want them picked up. I want the sink washed out, clean. And then I want you to leave it,

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much cleaner than the way you found it.' Of course, she had hardly any room to move around in there. However, if she started to get panicky back in her seat and began to get restless, and then decide that she had to go to the bathroom, I gave her a chore to perform. This chore gave her something other than her anxiety to focus on. She left every bathroom spotless. It worked and she's flown the Atlantic Ocean many times since. Moreover, to this day, it has been funny in a strange way, because now when I travel by plane and I go into a bathroom, I say to myself, 'Remember to pick up any paper towels.'

I told her this when I returned from a trip. 'We have to stop this. It's taking me an extra five minutes to clean up the bathroom.' Well, she and I laughed and laughed; we were bonded like that. By the way, her favourite place now is the two islands in the Seine River in Paris, and she has just gone back after this past Christmas. She's still on the medications, and I saw her every two or three months until I retired. I would ask her, 'Where'd you fly last time?' She'd tell me, and then note that she always left the bathrooms cleaner than she found them. She does it every time.

So was this hypnosis? In my view, it was hypnosis. She had a task and she was absorbed; she was no longer feeling anxious. She was not alone and I was with her in spirit in those moments. Hypnosis can provide a very definitive timeout experience for people. She was in an altered state: she experienced a degree of absorption and a change in perception about how she views the world in those moments.

It is interesting: if you decide not to call what you do hypnosis, I'm not sure it makes any difference. If I continue treating patients in the way that I do, and I don't call it hypnosis, I don't think it would make any difference either. Nevertheless, I think it is a useful label to give to a process or activity that teaches people about the use of their whole selves as therapists. In very particular situations it has enormous use—for instance, if you are going to have some major surgery. If you are allergic to anaesthetics, a very carefully induced hypnotic trance can help you get through it. Yes, there are specific techniques, but mostly hypnosis is a way to describe a style that seems to work; a style which, I think, involves more of the wholeness of the therapist while creating wholeness in the patient. It involves a lifetime of work in order to get it right.

MJ: Is there anything else, or do you think that pretty much covers the essence of what's really needed for hypnosis to work?

PB: I would put only one caveat in there: it is to keep an eye on the uniqueness of the patient and their resistances, if any. *Prima non nocere*; first, do no harm. And you want to be sure that the experience is fresh each time and that you're alert each time with the individual patient, so that you can shift and be flexible and modify as you go along. These are necessary therapeutic skills and should never be abandoned.

I also think it is true that you only do in hypnosis what you would do without hypnosis; that is, your clinical training is the foundation of your work. The risk is that you will go for the intuitive without a thorough diagnostic assessment and application of your basic therapeutic skills and tools before you even consider hypnosis as a therapy. It always comes down to diagnosis, connection, and creativity.

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MJ: *If having a bond with the patient and being able to be in touch with your creativity are essential components of effective hypnosis, is there anything that you think might also facilitate the process?*

PB: Well, one thing that I do before I see a patient for the first time is to spend about 20 minutes on the phone getting a sense of what's going on. I want to know whether the problem is one that is within at least some of my ability to address. I usually have made a decision by the end of the phone call to accept or not accept the patient for treatment.

I once had a resident whom I was precepting in my office. I would take any phone calls that came in during our sessions. At the end of the year I said, 'What'd you learn the most from me?' He said, 'The way you talked on the phone.' I didn't expect that, but I understand it very well.

MJ: *A compliment.*

PB: Yes. In addition, I will never turn my back on a patient, literally. When they come in I will always be facing them. I learned that in high school drama class: you never turn your back on the audience. I'll have two nicely upholstered chairs in the office that are absolutely equal. They are also equal distance from the door, so no one's trapping the other.

And I have no diplomas on the wall. A schizophrenic taught me that. She said, 'If you have all this evidence of academic excellence, and I can't hold two thoughts together to get through high school, I don't need to know that. If you're competent, you're competent.' And she said, 'Above all, don't have a calendar right behind your head because I don't know what day it is; I can't keep track of it. Much less a bookcase right behind your chair because then I'll just imagine all those books are flowing out of your head.' I listened and learned. And so, if you look behind the patient and behind me, there's nothing but a blank wall. When our eyes are locked, there are no distractions. I think those kinds of things set the stage for feeling comfortable and secure.

The context of the office is important too. When I bought furniture for my first office at the Institute, I went to the business section of John Wanamaker's department store, and I said, 'I want an office. But I want something between a den and an office. And I want the one word, when my patient sits down in the chair and I ask them what the one word is, to be 'comfortable'.

About 90% of the time they still say that. So I think that sets it up for patient bonding and also for hypnosis. I don't darken the room. I don't play music. I don't have a reclining chair and all that. It is a seductive enough intervention that I just don't think I want to add to that. More importantly, I also think that a reclining chair makes patients passive and the therapist active, and really, I'm trying to teach the patient a skill and to be more active. So I think those are some of the ways to make the environment safe and secure.

Another element of hypnosis which is very important to the practice setting is sound control. I don't like an absolutely dead office, but you want to be reasonably insulated from your partners next door. Near the hospital, we had an elevated train. Between 5:30 and 6:00 in the evening there would be a train every few minutes. I would use the sound of those trains, as many do, for the Doppler effect. I would suggest that when the train

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passes and the sound goes low, that's when you'll go deeper, and deeper. You use all the environmental cues you need in enhancing the trance experience.

When Eric Erickson describes the eight ages of man in his book *Childhood and Society* (1963), he starts out with basic trust. And I think that's as good a place as any to start with hypnosis. And it is important when they close their eyes, that when they open their eyes you're exactly where you were when they closed their eyes, and you don't touch them unless their eyes are open, and it is for some specific reason, for which you get permission before inducing the trance. But I think patients can pretty much decide whether they can trust their therapist. It is important that they do.

Another way to answer your question about the ways to enhance this relationship and, therefore the work we do, is to be as open a person as you can be, as long as it is in the service of the patient's welfare. If my disclosures injure the privacy of my kids or my wife, I won't share personal information. If it is too intimate about me, and it isn't appropriate, I won't do it. So I don't tell patients where my kids go to school, but I might mention their names. In general, my patients know who I am as a person. How else can I do therapy if I'm not real? Nevertheless, it always has to be in the service of the patient. I am concerned that many residents and medical students whom I teach are reluctant to be real in this way.

MJ: As far as assessment goes, what do you really want to know about the patient? Is there anything you routinely ask or seek to assess or understand in preparation for hypnotic treatment?

PB: Well, every patient who comes in gets an hour-and-a-half formal diagnostic interview; identifying data, chief complaint, history of present illness, the whole thing. I conceptualize the case, make a diagnosis, and develop a treatment plan. It is all written down, and when they leave at the end of the first session, the chart is complete and I'm finished. That's the structure I use: the next time they come in, I'll go over all of this with the patient. The treatment plan may or may not include hypnosis at that time. I do not treat the majority of my patients with formal hypnosis, but as I have said before, I am sure I use hypnotic principles 100% of the time.

My job is to present a variety of therapies and then tell them which ones I'm choosing, and to gain their interest and collaboration to go along. If I choose to add hypnosis to the treatment, we may address some specific questions they may have about their experiences with hypnosis or hypnotic phenomenon. Are they able to daydream? But I do not do tests for hypnotizability in my office. I have a standard induction that I do which I think acts as its own test, because I can see where they fit in terms of what I do.

I do run a risk at the beginning of delaying the creative, more flexible approach to therapy by always using a formal diagnostic assessment. But I think that the greater risk is jumping in too quickly and realizing you haven't done your homework. Someone might call me, and say, 'I had a bad reaction to something, and I'd like hypnosis to explore the origins of it.' Well, if you think carefully about this, they have diagnosed themselves and prescribed the treatment. I say, 'No way. You're going to come in here, I may see that you're right, but, nonetheless, I'm going to look for all the other possibilities. We're going to talk about all the treatment options.' They might reply, 'Oh, no, all I

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want is hypnosis to learn about why I had the reaction I had.' 'Well, I'm sorry. I don't do that kind of work. I'm a psychiatrist, and remember this is what psychiatrists do,' and I back away. Some of them will call back and say, 'Well, okay. I'd still like to see you.' However, some do not.

I think it is very important that you don't do anything in your intake for possible hypnotic treatment that is different from what you would do with any other patient that you might be seeing, with or without hypnosis. If you do this, you are treating your hypnotic patients differently. And since I believe that hypnosis is only an adjunct to treatment, as many of us keep teaching that it is, then why should that change what you do in such a fundamental way?

MJ: Are there any strategies that you go back to that you find yourself using repeatedly because they just seem to work?

PB: Yes, it is a strategy I learned from Erika Fromm. It was 1982 in Glasgow, Scotland, at the 9th International Society of Hypnosis Congress, the second meeting I attended. I participated in a beginning workshop as a young faculty person facilitated by Erika Fromm. She modelled an induction that included walking down some carpeted steps to a garden, walking around a crushed stone path, sitting on a bench, letting the sun hit your face, and then getting up, walking to and circling your arms around a tree of strength. The induction (described in more detail below) is all about ego strengthening the person. It is a beautiful induction for both ego strengthening and therapy. So I use this strategy with many, if not all, patients in the second or third time I work with them, to give them a chance to experience this.

Now this is very interesting. Some years later I was facilitating a basic workshop in San Antonio. Erika was also there at the meeting, so I invited her to come to one section of the workshop so she could be introduced and interviewed by the participants. I wanted everyone in that class to be able to say that they had a chance to meet Erika Fromm and speak with her. As part of this, I said, 'Erika, we're going to have a discussion with you.' But first, I told the group, I would guide them through a hypnotic induction—'the same induction that you, Erika, taught me years ago'.

She sat there while I took the class through the induction. And it was marvellously successful. But Erika looked at me curiously. She said, 'Except for a few words here and there, such as your use of the tree of strength, I hardly recognized this.' I think that, in part, she was complimenting me for making the induction my own. But I also think that a lot of wisdom is passed down from generation to generation and is changed by the nature of the person who uses it. We have all had that same experience of students thanking us for insights we never remember giving. It is not always a linear process.

So why do I use it? Well, it is one of the first things I learned. I learned it from someone who was terrific, and I learned it in a way that will be useful to my patients. If you do it enough times, then you can observe how different people respond to the same induction. By comparison, it tells you important things about the patient and their unique situation; it is also a nice way of seeing who you're working with. Can someone do this? Can they not do it? All useful information.

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MJ: *Could you provide an example or examples of your favourite inductions*.

PB: Sure. There are two inductions that I often use. After performing a thorough diagnostic interview and explaining what hypnosis is and is not, and how we will use it with this particular patient, I usually begin by introducing hypnosis with eye fixation, and then Jacobson's Progressive Muscular Relaxation, followed by three deep breaths, which I suggest is a way to breathe in all the remaining tension, then blow it all out.

Then follows an arm levitation with an imaginary helium-filled balloon creating arm rigidity and a change in perception of where the arm is comfortable. After the subject tries (often to no avail) to push his/her arm down, I encourage an awareness of a change in perception in the comfort of the elevated arm. Obviously, I model the attempts to push my own elevated arm down in such a way as to suggest that the patient will have as much difficulty pushing their own arm down as I 'did'. If I can get the subject to perceive his or her arm as more comfortable elevated than down (after experimenting with both positions), I have taught the patient that hypnosis can help him or her change perception—perhaps to a wide variety of issues, some related to the presenting symptom.

I then ask that the helium-filled balloon 'allow the arm to be lowered back into the lap' (note the dissociative aspects of this suggestion) and then follow this by repeating Émile Coué's ego strengthening suggestion of 'Every day in every way, I am getting better and better'. I then provide a period of silence for any use the subject wants, and follow this with re-alerting. The surprise at the induced arm rigidity, and the change in perception of where the arm is most comfortable, often convinces the patient that this is a unique experience.

I do not use standard scales of hypnotizability. However, by using this first induction, I can get a sense of the subject's hypnotizability, his or her ability to use images, and whether or not he or she can go deep enough to accept non-verbal suggestions for arm immobility and changes in the perception of comfort. After this first session, I know with whom I am working.

However, in the second induction, I often use the Tree of Strength induction that I mentioned earlier. It builds on the first induction as follows: I ask the patient to fix their gaze on an object—a corner of a picture frame, a marking on the wall, and so on. Then they count backwards from 10—one number for each exhalation while lowering their gaze to successive objects further down. When they reach zero they should close their eyes and deeply relax. (Some patients prefer to keep their eyes open and that is okay.) After repeating Jacobson's Progressive Muscular Relaxation and taking the three deep breaths as before, I ask them to imagine a circular carpeted stairway of 20 steps curving down to an open window-walled room looking out onto a beautiful garden. This counting again accomplishes a second induction into a hypnotic trance in the same session, often called a re-fractionation. The carpet on the stairs extends up the walls and onto the ceiling with soft recessed lights shining down on shiny brass handrails. As the subject descends slowly down the stairs, counting each step backwards from 20, they enter an even deeper trance state than before.

At the bottom of the stairway, I invite the patient to step into the window-walled room and notice there are French doors leading outside to a beautiful garden surrounded by a crushed stone path. I suggest that they go out into this scene and walk

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counter-clockwise around the garden. Note that this second induction has rich and vivid imagery, which not only serves as a deepening device, but also offers many opportunities for ego strengthening and trance work on the issues concerning the patient. These will become more evident as I describe the next suggestions.

Soon the subject in this trance image approaches a bench just off the path. I suggest that they go to it and sit down. They immediately notice how beautiful the plantings are, how manicured the lawn of the encircled garden is, and when they look up, they see a pale blue sky with wispy white clouds. Suddenly they feel the healing warmth of the sun bathing their face and they take this healing light and warmth deeply in and throughout their bodies—wherever they need or want it. (This is the first major suggestion and can be elaborated if a particular body part needs more attention.)

Soon, after accepting all the healing light of the sun that they need, they get up from the bench and begin walking again counter-clockwise round the garden path. After a while they see a large tree (oak or whatever) just off the far end of the path that encircles the garden. I say, 'Go over to the tree and hug it and notice how your fingertips barely touch behind the tree. Now look up through the powerful branches, through the delicate leaves, and on into that same blue sky with wispy white clouds. Now this is a tree of strength and it has qualities/attributes that will flow into you as needed.' At this point, the therapist can include qualities they know the patient needs, based on earlier discussions. They are mentioned one at a time with several seconds between each item. For instance, I usually say: comfort … clarity … calmness … courage … caring … health … judgement … wisdom … love … being loved … independence … and strength. Many others can be added. I also ask the patient to imagine other desired qualities and say them quietly to themselves. I then provide a period of silence for them to do this work. This is the second most important part of this image/ego strengthening. It is highly personal and grows out of the therapy itself.

While the subject is still in trance, I suggest they let go of the tree and resume walking around the garden path on soft crushed stones. Soon another bench appears and they sit down. This is a third area and is important for reviewing the tree of strength's attributes and, if desired, a quiet place to contemplate some of the issues that brought the patient into therapy in the first place. It is also a great occasion for suggesting silence and reflections. I often take a moment here to go over again Émile Coué's 'Every day in every way, I am getting better and better'. It can be a place for creativity and/or just an opportunity to experience simple peace.

On arising from the bench, the walk around the garden is complete and before going back into the window-walled room, the subject takes one last look at the garden—because they will be back again and again in the future. They see the first bench with the healing light of the sun, the tree of strength, and the second bench of peace and quiet.

Turning and entering the window-walled room, going up the steps—5, 10, 15, 20—to where we began, I invite the patient to experience another thoughtful moment of silence before awakening. I ask the patient if they are ready to awaken (or re-alert) and then slowly count from 1 to 3 while raising my voice level and energy: 'And now you will feel refreshed, alert, and eager to share your story. 1 … 2 ... 3.' Obviously, some patients want and need a little longer to re-alert and that is just fine too.

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If the patient is not fully back at this point, or seems to show some evidence of being stuck emotionally or otherwise in trance, I simply ask them if they would like to go back into trance for a few more moments before awakening completely. I use this as a two-fold suggestion—to go back and then awaken—so that the patient is essentially agreeing to do both. If the patient says 'yes', they can now finish the trance work and then awaken. It is the rare patient whose personal material makes re-awakening harder. The task here is to recognize that clinical skill and dynamic empathy, relative to the uniqueness of this patient's history, is very useful in making their re-entry smooth and the overall experience successful.

A case worth mentioning illustrates how the patient and therapist must work together when using this induction. I was once working with a nurse who had AIDS from an infected needle stick. She was highly dissociative and in those days she was diagnosed with multiple personality disorder (MPD). She was in a lot of pain due to the diffuse arthritis of her hip. She was in a wheelchair and could barely walk. No one was willing to take her outside of the hospital because she would occasionally have seizures. Because of AIDS, no one wanted to do mouth-to-mouth resuscitation on her if she had a respiratory arrest. As I do not specialize in multiple personality disorder (now termed dissociative identity disorder or DID), I told the patient honestly, 'You know more about multiple personality than I do, and since I don't know very much about it, I just want you to be one person, or alter, if I'm going to be here to teach you hypnosis for your pain.' I asked her, 'Can you do that?' She thought for a moment and then said, 'Yes. I can do that.' But I added, 'I do want to tell you, though, that I understand you've used this dissociative technique to be able to survive some terrible things that happened to you when you were young, and now it's continued into your adult life.' She replied, 'Yeah. It's a real albatross around my neck.' I imagine that she agreed to limit her dissociative identity disorder so that I could teach her a dissociative technique of hypnosis for control of her pain. Tricky business, but I think ultimately very useful for the patient.

So I said, 'Okay. As to going outside, everyone's scared. What are we going to do if you need mouth-to-mouth? I mean you might have AIDS. I won't put myself at risk, but at the same time, I'm not going to let you die. What can we do?' She said, 'Well, I have this plastic oral airway here and if needed you can put it in my airway and we both will be safe.' She also added, 'Besides, I don't think I'll have a seizure outside.' So I took her outside. This was the first time in months and she did fine—no seizures. One morning, the nurses on the hospital's DID unit told me, 'She's had 20 different alters this morning alone. I don't know how you're going to be able to work with her.' I said, 'Well, we'll give a try,' because I knew I was only going to see one.

As an aside, I could not very well tell the staff that she had this kind of control and could limit her personalities when she worked with me but not with them. However, there was another lesson here as well. If patients with MPD or DID feel comfortable and like their therapist, who is inexperienced in treating multiples, the patient will not expose the depth or complexity of their dissociative experiences for fear of losing the therapist. The danger here is that some good therapists say that they never see multiples, whereas I believe their patients may not be willing to share this pathology with them. We need to be humble here, least we fool ourselves.

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So back to our story. We were now outside, sitting on a bench. She swivelled off the wheelchair to sit on the bench. After I took her through Erika's trance of the Tree of Strength, I helped her get off the bench and, while I supported her back, she saw a nearby tree and reached for it. Unexpectedly, she started sobbing and told me, 'I've never hugged a tree.' Meanwhile, we are outside on the hospital grounds on a large closed field. Some of my other psychiatric colleagues were taking their patients for a walk, and here is Bloom with his patient hugging a tree and crying. It was quite a scene—my patient hugging a tree while my colleagues' patients were sedately walking around the track. She improved in several ways. First, she was no longer overwhelmed by her dissociative experiences, and second, she made an enormous leap towards wholeness when her abuser was identified and prosecuted in a class action suit, which she joined. This latter development gave a reality and meaning to her dissociative identity disorder that helped her to heal. Unfortunately, long-term follow-up was never obtained. My hope is that she ended up doing very well.

I also use variations on this basic strategy, depending on the patient. So, for example, instead of going around the garden after you go down the stairs, you can use going down the stairs as a fractionation or deepening method, and then go instead to a beach if the patient prefers a beach. Or you can invite the patient to 'go down another path'. I usually ask the patient at the next session where they would like to go to 'park themselves' while we do the therapy we need to do. I also encourage them to visit this place for five minutes at a time, several times every day. One lawyer I was working with for severe pain would close his office door, tell his secretary to take his calls for five minutes, and use this strategy maybe four or five times a day. He was a litigator and in intense pain from kidney colic, and this strategy helped him tremendously until he was definitively treated.

MJ: So the Tree of Strength induction can be used for ego strengthening, but you also use it for specific suggestions for whatever other issues that a person might have?

PB: Yes. The second bench in that scene is a nice spot for doing any needed hypnotic work. If I am providing straightforward suggestions for the chief complaint, I don't really need a specific context. Once the patient has learned the basic strategy and how to use imagery to experience being in a safe place, I'll say, 'Look. Pick your own place. Raise your right forefinger when you get there. Tell me where you are, and then we'll get to work.' And then I go right into the symptom, to do what we're doing hypnotically; but it is necessary to first teach the patient how to do this.

MJ: Is there anything else that you have found helpful in your work?

PB: I often make audio recordings for patients to practise with. I still use tapes, although I probably have to update my equipment and get modern on this, and learn how to burn CDs. But not everyone has more advanced equipment and it is unfair for me to ask them to buy this expensive technology. In the beginning of treatment, I ask the patient to bring a tape in. I don't store tapes because I want to see their motivation to contribute to the process by buying their own tapes. It isn't the money—it's the assessment of motivation to be active in treatment. I tell them that it will be a week or so between the

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first and second session, and I ask them to practise by listening to the audio recording at home at least five times between sessions. As a result, instead of having the next session be the second session, it will be in fact the seventh session if we count the practice times at home.

I think that audio recordings can enhance the rapidity of learning. Hypnosis and accessing the trance state is like any other skill, and can be enhanced with practice. Eventually, I encourage patients to practise without the audio recording, so as not to get dependent on it. However, you know it surprises me sometimes when a former patient will pull out a tape a year or more later and relate its daily use. But not everyone needs an audio recording. I had a young colleague stop me in a workshop—he told me 15 years ago he'd been my demonstration subject, and how that ego strengthening had been with him ever since. Sometimes we affect people beyond our imagination!

MJ: *Anything else?*

PB: Well, I think, the most important thing to me is creativity. There was a phrase that I got somewhere years and years ago. Probably it isn't quite what I read, but I remember it as this: The art of therapy is the fusion of scientific knowledge and intuitive insight. You have to be as scientifically grounded as you can, while also being open to your creative instincts.

I once worked with a ballerina from Philadelphia. She said that she wanted to enhance her creativity on stage. I asked her, 'Well, what do you do when you're about to go on stage?' She replied, 'I contemplate about how I'm going to try to do my best.' I said, 'No, no, no, no, no, no.' I asked her, 'What happens when you really do your best?' She says, 'Oh, it's quite different. The music dances me.' 'Ah,' I said, 'that's better.' So now she says she knows what to do. Before she goes on stage, she knows that she is well prepared and goes into a light trance. She then slowly lets her logical thinking recede, and simply lets the music dance her. How nice, how creative!

So for me the most exciting part of this—the time I'm most alive—is when I feel myself also stepping back, as she stepped back to let the 'music dance her', and allowing the creative processes to occur. If I could leave my experience as a legacy, I would urge all of us to embrace this aspect of who we are; to not settle for anything less until you have reached your capacity to be fully creative. Some of us are true artists. Some of us have this art of healing from time to time and know the value of it. For some, it takes more work to experience these creative moments in therapy. There's a place for all of us. For me, as a psychiatrist, hypnosis has added greatly to what I do in practice. It has not replaced my medical knowledge, but has added to it. It has enhanced my creative self and the wholeness that I feel I have now that I did not have before. It has been a life gift.

REFERENCES

Benson H (2001). *The Relaxation Response*. New York: Harper Collins.

Bloom PB (1990). The creative process in hypnotherapy. In Fass ML, Brown D (eds), *Creative Mastery in Hypnosis and Hypnoanalysis: A Festschrift for Erika Fromm.* Hillsdale, NJ: Lawrence Erlbaum Associates, pp. 159–168.

Copyright © 2013 British Society of Clinical and Academic Hypnosis

Bloom PB (1991). Some general comments about Ericksonian hypnotherapy. *International Journal of Clinical and Experimental Hypnosis* 33: 221–224.

Bloom PB (2001). Treating adolescent conversion disorders: are hypnotic techniques reusable? *International Journal of Clinical and Experimental Hypnosis* 49: 243–256.

Braid J (1843/2010). *Neurypnology; or, the Rationale of Nervous Sleep, Considered in Relation with Animal Magnetism*. New York: General Books LLC.

Braid J (1855). *The Physiology of Fascination; and the Critics Criticized*. Manchester: Grant.

Castaneda C (1969). *The Teachings of Don Juan: A Yaqui Way of Knowledge*. Berkeley, CA: University of California Press.

Coué E (1922). *Self Mastery through Conscious Autosuggestion*. New York: Malkan Publishing Co.

Erickson EH (1963). *Childhood and Society*, 2nd edn. New York: W.W. Norton and Co.

Gheorghiu VA, Netter P, Eysenk HJ (eds) (1989). *Suggestion and Suggestibility: Theory and Research*. New York: Springer-Verlag.

Hartland J (1966). *Medical and Dental Hypnosis and its Clinical Applications*. Oxford: Bailliére Tindall.

James W (1902). *The Varieties of Religious Experience*. New York: Longmans, Green, and Co.

Ludwig AM (1969). Altered states of consciousness. In Tart C (ed.), *Altered States of Consciousness*. New York: John Wiley & Sons, pp. 9–22. (Printed by permission from *Archives of General Psychiatry* 15 (1966): 225–234.)

Orne MT (1977). The construct of hypnosis: implications of the definition for research and practice. *Annals of the New York Academy of Sciences* 296: 14–33.

Tellegen A, Atkinson G (1974). Openness to absorbing and self-altering experiences ('absorption'), a trait related to hypnotic susceptibility. *Journal of Abnormal Psychology* 83: 268–277.

von Bertalanffy L (1969). *General System Theory: Foundations, Development, Applications*. New York: George Braziller, Inc.

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