Utilizing Unconscious Abilities in Therapy: Subliminal Therapy

by
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ABSTRACT

Subliminal Therapy is a logically organized procedure that employs the patient's unconscious mind to analyze data, draw conclusions, and make decisions accordingly to achieve the therapeutic purpose. Hypnotic phenomena are implicit in the procedure as demonstrated by the fact that patients typically and spontaneously assume a trance state during the process of treatment. In Subliminal Therapy, both patient and therapist may be unaware of the processes engaged in as the patient unconsciously produces the desired results. This paper describes the theory and assumptions of Subliminal Therapy, provides an illustrative transcription of a typical session in which it was employed, and briefly discusses limited clinical studies conducted to assess its efficacy.

INTRODUCTION

The most common use of hypnosis is as a vehicle to enhance the likelihood of acceptance of suggestions. When clinically used in this way, the suggestions are usually directed toward symptom relief or specific behavioral change without consideration of etiology. While this approach can be time-efficient, there are many occasions when suggestions are not integrated, when they are somehow rejected by the patient, either consciously or unconsciously. The use of hypnosis as a tool for uncovering and resolving hindering influence is an option in such situations, permitting acceptance and integration of the suggestions.

A second use of hypnosis is as an analytic tool to uncover causal influence that derives from past experience. Undesired, learned behaviors, responses and reactions can often be eliminated by insight, insight that leads to rational understanding of the causal influence, followed by conscious recognition of the inappropriateness of that influence in current life. The key is to identify that causal influence, and is it seldom known at a conscious level of awareness.

This paper will explore the ramifications of using unconscious abilities to accomplish such analysis.

The process of Subliminal Therapy employs unconscious abilities to review memories of life's experiences, extract relevant data, relate cause and effect, creatively evaluate and devise new solutions, and execute decisions to accomplish the therapeutic goal. All of this is accomplished in a logical progression of questions, requests and responses, interacting in a direct, identifiable way, utilizing abilities of the patient that are not generally recognized. Past views of unconscious functioning as automatic, or as a servo-mechanism, memory bank and regulator of autonomous processes, are inadequate to explain the phenomena elicited by this technique.

The unconscious elements identified and addressed as independent entities in the course of employing this technique are addressed on a first-person basis to facilitate application of the technique. The unusual nature of this procedure, e.g. communicating directly with unconscious entities, is foreign to other therapy procedures, yet this approach is generally accepted without hesitation or question by the patient; however initial adjustment on the part of the therapist may be required.

THEORY AND ASSUMPTIONS

The superstructure of Subliminal Therapy rests on four assumptions. First, intelligent unconscious capability exists. Second, the unconscious domain can communicate with consciousness in identifiable ways. Third, the unconscious consists of "parts" or subsystems which may function autonomously. Fourth, there is, in the unconscious domain, an entity that may best be described as a "higher self," an entity that is not well defined, yet is easily authenticated subjectively. This entity, which the author has named "CENTRUM," apparently functions as the focus of communication within the unconscious domain, and as a source of influence on the process taking place there.

The first assumption, that of unconscious intelligence, has been recognized by Erickson (1976):

It is very important for a person to know their unconscious is smarter than they are. There is greater wealth of stored material in the unconscious. We know the unconscious can do things, and it's important to assure your patient that it can. They have to be willing to let their unconscious do things and not depend so much on their conscious mind. This is a great aid to their functioning.

In Subliminal Therapy, patients are taught to allow their unconscious minds to work in a logical, organized, sequential process which is guided by the therapist or, under some conditions, may be self-guided.

The second assumption is that the unconscious can communicate with the patient at a conscious level of awareness and, through the patient, can communicate with the therapist. This inner-patient communication may be by means of ideo-motor signals as classically described by Cheek (Cheek and LeCron, 1968), or via other ideo-sensory means such as an imagined chalkboard on which the unconscious is requested to write, inner voices, or perceived physical sensations as taught by Bandler and Grinder (1979). The viability of ideo-motor signals have been well documented by Erickson (1976) as well as by Cheek and LeCron (1968), who have described the use of finger signals and Chevruel's pendulum for that purpose. The phenomena of memory itself can be considered an illustration of unconscious-to-conscious communication in that memories are perceived via the senses. Perception of such communication in predetermined ways, via the senses as employed in Subliminal Therapy, is seen as an extension of this phenomenon.

The third assumption is that the unconscious mind is made up of multiple "parts." The literature is rich with examples of recognition of the existence of such parts. Hilgard (1978) states: "Personality is much less unified than we would like to believe and volition is subject to dissociation just as are perceptual processes." James' (1890) assertion that "Consciousness is split into parts that ignore each other" and Janet's (1907) interpretation that "systems of ideas are split off from the major personality, unconscious but capable of becoming represented in consciousness through hypnosis," substantiate this concept. Green described "...the autonomous entities working for themselves as unconscious parts of our psyche" (Green and Green, 1977). Subliminal Therapy enlists these "autonomous entities" for therapeutic purpose. In this respect, Subliminal Therapy is similar to Assagioli's (1965) "Psychosynthesis," which is described as a process of integration of the parts of the psyche, and to Watkins (1978) "Ego State Therapy," in which various "states" are cathected.

The fourth assumption, that of the existence of "CENTRUM," is less easily defended by reference to the literature. The existence of a Higher Self, hereafter referred to as CENTRUM, was originally assumed as an explanation for various phenomena observed clinically; phenomena that defied other

explanation. As the services of CENTRUM are engaged in the process of therapy, communication apparently does take place and practical benefits accrue which convincingly validate its existence. The reader is encouraged to experiment with self and with others to test this assumption.

The capacity for unconscious reasoning, involving intelligent, creative abilities, makes it possible to bypass much of the resistance typically evident in therapy. Moreover, should the therapist so choose, this capacity can free the therapist to conduct the course of therapy without being concerned with the content and influences being addressed by the patient. As reported below as a test of limits, therapy has been successfully conducted without the therapist even knowing the nature of the presenting problem. Even more startling, the patient may not be consciously aware of the mental processes engaged, or of the factors and influences addressed.

In many instances, the technique of Subliminal Therapy can be employed as the sole treatment. In some situations, however, it may be more effectively employed as an adjunct to other modes of treatment. If resistance to therapy is encountered in the use of other interventions, an excursion into the process of Subliminal Therapy may resolve the resistance and permit resumption of the original treatment. In any event, and regardless of the technique being employed in therapy, Subliminal Therapy can be used as a means of systematic probing, of measuring progress in therapy, and possibly of testing attainment of the therapeutic goal.

PROCEDURE

Subliminal Therapy is a step-by-step process in which the therapist guides the patient to unconsciously investigate the cause of the presenting problem and to then resolve the problem by achieving a more mature understanding of the causal influences. Assuming the problem is psychogenic, resolution by this means may reasonably be expected. To enable the therapist to intelligently guide the course of therapy, the unconscious is taught to signal the patient via ideo-sensory means when a requested step has been accomplished. This prearranged response is then verbally reported by the patient, or observed if finger signals are employed. A more fully developed explanation of this process is presented in a manual for therapists (Yager, 1985).

In some cases, the patient may have the knowledge and skills necessary to resolve the problem (either consciously or unconsciously), in which case the function of the therapist is only to guide the patient through the structured process of the therapy. In other cases, the patient may lack the knowledge and/or the skills required, in which case the role of the therapist becomes that of educator, in addition to guide. If education is not required, the therapeutic goal may be accomplished within minutes after the therapist provides initial orientation and instruction. If frequent intervention and support by the therapist is required, therapy will require proportionately longer periods of time.

The process is most effectively utilized when the patient has a clearly defined, therapeutic goal. Therefore, the first step taken by the therapist is to insure clear expression of the goal by the patient and, if necessary, to assist the patient in defining the goal in the form of a simple, verbal statement of desire.

The therapist next explains the process of Subliminal Therapy by presenting a model of the mind in which concepts of unconscious and conscious organization and capabilities are defined. The author has written a book for patients which introduces these concepts (Yager, 1984) C a book I encourage my patients to read before therapy begins, thereby foreshortening one-on-one time. In this model the unconscious is described as consisting of multiple "parts," each having a function and purpose and each having come into existence when that function was "learned" during the course of life's experience. It is explained that humans generally function pretty well, which demonstrates that these parts do not function in random fashion, but rather function cooperatively, with a common sense of direction and

purpose. This also supports the concept that there must be a guiding entity in the unconscious domain, an entity that communicates with other parts of the mind, thereby providing continuity and direction, influencing the course of living. This entity is introduced as "CENTRUM." Patients readily accept this model of the mind and accept the assertion that the unconscious is both well-intended and capable of analytical reasoning.

Patients also readily accept more unusual statements such as: "Anything you can do consciously you can do unconsciously, and you can probably do it better there because there is access to more information" and "The cause of the problem is in the unconscious. After all, if it were conscious you would already have solved it. Therefore, the solution must ultimately take place unconsciously."

When the patient is familiar with this model of the mind, instruction is provided about how to perceive communications from the unconscious domain. Early in the development of Subliminal Therapy, ideo-motor signals and Chevruel's pendulum were used as the vehicle of this communication. Experience has shown that it is more practical, flexible and efficient to suggest that the patient form a mental image of a chalkboard on which the unconscious can write answers to the therapist's questions and requests. The patient is instructed to simply "observe" the chalkboard and to report only what appears there. It is at this point in the process that the patient typically and spontaneously slips into an altered state of awareness identifiable as hypnotic trance. This state is evidenced by eye closure and roll, flaccid muscle tone, diaphragmatic breathing and general physical calmness. Such physical demonstration is not always evident; many patients continue to function with their usual mannerisms, with only a "dreamlike," unfocused appearance to their eyes as they perceive the unconscious communications.

The most frequently encountered problem in the use of Subliminal Therapy is a strong tendency on the part of a few patients to report cognitive opinions in lieu of communications from the unconscious. Other less common problems are to give reports biased by a desire to please, or by conscious disagreement with the answers actually perceived. The therapist is urged to spend an apparently disproportionate amount of time emphasizing to the patient that, although there may be disagreement with the answers perceived, or there may be impatience with delay in unconscious responses, or a wish to please, time and money will be wasted unless reports include FULLY and ONLY what appears on the chalkboard. With minimal practice, the therapist learns to sense cognitive responses by the way the words are presented or emphasized. "I think..." or "Well, ..." or "I don't believe so" are obvious examples of cognitive responses. A simple "yes" or "no" or "now" or "yes and no" are apt to be valid unconscious responses, as are the expressions "It says..." and "There's a 'yes' and a 'no'."

There is substantial variation in time, from patient to patient, between question (or request) and response from the unconscious domain. Most will respond in the order of a few seconds; a few might require a minute or more. Where the response is slow, patience on the part of the therapist is required. The patient is probably experiencing a distortion of time and so is not bothered by the delay. If the therapist is concerned that nothing is happening, a clarifying question can be interjected such as "CENTRUM, are you working on the requested task?" If the response is "yes," be patient.

To insure adequate theoretical understanding by the patient of how dysfunctions and limitations can be learned at both conscious and unconscious levels of awareness, the therapist explains: "You were not born with the problem you have presented; there was a beginning, a first time, and the memory of that first time is probably in the unconscious. CENTRUM has the ability to examine that memory and to learn from it from the perspective of present knowledge and understanding, as opposed to the perspective of limited knowledge of that earlier time." The process is then described to insure understanding that the dysfunction or limitation began, not as a "problem," but rather as a "solution" to a set of circumstances that were then in effect. Only from the perspective of the present is the dysfunction

or limitation recognized as such. Treatment is further proposed as a method of resolving conflicts by replacing lessons learned and decisions made "then" with lessons and decisions appropriate "now," modifying conditioned responses in consequence.

The therapist explains this phenomena of learning to the patient in terms of suggestibility and of conditioned response. Suggestibility is explained as a mental condition in which new inputs (suggestions) are internalized and integrated without being subjected to conscious, critical judgment. Hypnosis is explained as an example of such a condition and other examples of suggestibility are offered. For example, the small child is also exceedingly suggestible, having as yet only minimal accumulation of knowledge to use as a basis for critical evaluation. The therapist explains that we are also very suggestible, even as adults, at times of intense emotional experience, and when we are confused. It is pointed out that such mental conditions allow occasional learning of undesired behaviors, as well as the constructive learning that takes place during life.

The phenomena of conditioned learning is explained to the patient by referring to Pavlov's experiments with animals, especially those with dogs that were conditioned to respond by salivating to the stimulus of a bell. The therapist explains that there was, at one time, a rational connection between the stimulus and the response. When food was presented, it was logical for the dogs' salivating to be associated with the bell. Similarly, an adult who experiences a lifelong fear of the dark, learned such fear in a context where it was absolutely logical to associate fear with darkness.

The Process

It is recommended that the first questions posed to CENTRUM, for response on the chalkboard (or by other ideo-sensory means), include: "Is CENTRUM willing to cooperate as I guide the process toward achievement of your conscious goal?" and "Does CENTRUM agree that the conscious goal is desirable and appropriate?" The answers to these questions determine the immediate course of therapy. A negative response to either must be addressed and resolved before further work can be accomplished. CENTRUM must be persuaded to concur with conscious opinion, or vice-versa, and this is best accomplished by the therapist acting as an intermediary between CENTRUM and consciousness such that mutual understanding is accomplished. Each mental entity, in other words, must be encouraged to express beliefs and desires and motivations to the other so that the other is able to understand and intelligently rebut. When each fully understands the other, agreement consistently ensues.

Unwillingness to work may be the consequence of CENTRUM's wish to protect consciousness from unpleasant or traumatic information. If CENTRUM is reluctant to proceed with conscious awareness of the work engaged, request that the work be accomplished without conscious awareness and, assuming willingness, proceed with the patient consciously blind to content. This also, of course, requires that the therapist function with limited feedback.

The first task requested of CENTRUM is that of an investigation; that CENTRUM review, without conscious awareness if necessary, all available memories of experiences and influences during life that are significant to the patient's present goal. The purpose of the investigation is explained to be the development, at least at an unconscious level of awareness, of understanding of those influences that are of concern in the present. The therapist requests that this investigation be conducted from the perspective of the knowledge and maturity of the present, so that the understanding obtained is not limited to the perspective of "then." It is requested of CENTRUM that completion of the investigation be indicated by causing the word "complete" to be written on the chalkboard.

If the “complete” response is forthcoming, treatment is continued. If the answer is "no," steps necessary to promote that understanding must be taken. CENTRUM may be led through a step-by-step

investigation, beginning with the first experience and proceeding through succeeding experiences, to achieve understanding of the etiology of the dysfunction. Conscious awareness of related memories may be requested so that informed guidance can be provided by the therapist; however, such awareness may not be forthcoming. Any steps considered appropriate may be taken, limited only by the skill and imagination of the therapist. Fortunately, lack of unconscious understanding of the material addressed is not frequently encountered; however, until such understanding is present, it is futile to proceed.

CENTRUM is then asked to exercise reasoned judgment in deciding on the appropriateness of the conscious goal in present life circumstance. A typical question would be: "Is that goal advisable, is it supportive of your well-being, is it in your best interests now, in your present life situation?" Assuming an affirmative response, CENTRUM is asked if willing to do the things necessary to cause the goal to become reality. Although an affirmative response to this question is usually received, there may be an occasional "no." Such negative response usually indicates that some other "part" of the mind is resisting the work and this resistance must be resolved before progress can be made. Resolution will likely entail identification of the basis for the resistance and education of that part regarding current reality.

The therapist then poses the question of capability to CENTRUM by asking: "Is CENTRUM now capable, without further assistance, of accomplishing the consciously desired goal?" If the response is "no," assistance may be provided by the therapist in the form of instructions about communicating with involved parts and replacing suggestions that were appropriate "then" with suggestions that are appropriate "now." Thus conditioning is changed so that the response is no longer as it has been. Alternatively, CENTRUM may be requested to employ creative abilities to devise one or more preferred solutions, thereby providing flexibility in resolution. However, since it is essential that CENTRUM have the necessary abilities if the goal is to be achieved, the creative capacities of the therapist may occasionally be called upon to provide them.

Having been assured of the willingness and ability of CENTRUM to accomplish the desired goal, the therapist asks that the work be accomplished. This step may seem redundant, the indication for it being implicit in foregoing work, however, it is usually necessary; inaction results without the request. This absence of voluntary activity is common to every step of this treatment and those familiar with hypnotic phenomena will recognize it as characteristic of hypnotic response.

There may be peripheral factors that are significant to the success of the therapy which have not been resolved in the foregoing work. It is the task of the therapist to insure that opportunity is provided for CENTRUM to consider and resolve them. This step is accomplished by asking CENTRUM if there is more to be done, and by taking the necessary steps to complete remaining work, alternately repeating the question until the answer is "no."

The key question, "Has your goal now been accomplished?" is then asked. A negative response on the chalkboard is indicative that another part of the mind, perhaps without awareness of CENTRUM, is active in a restrictive way and must be dealt with. Communication between that part and CENTRUM may be established simply by request, and may provide resolution of the problem, by means of mutual understanding between them, without further steps being taken. Resolution may require that the resisting part be guided to consider the basis of the resistance from the perspective of present reality, thereby affording opportunity to change its position. That the resisting part may not have awareness of the work just accomplished may seem incomprehensible; however, it is never-the-less likely. In some cases, unless willing to communicate with CENTRUM, the part may require guidance through the same therapeutic process as just experienced by CENTRUM.

An affirmative response to the preceding question, followed by similar probing questions designed by the therapist, may tentatively satisfy both patient and therapist that the work is indeed complete. As

further test of the completeness of the work, CENTRUM may be asked to convince the patient of completeness, and/or the patient may be guided to test completeness by imagining a situation in which the desired goal is in effect. Any difficulty in creating this imaginary situation is evidence that the work is not complete, that one or more parts of the mind still resist the desired change. In this event, the therapist repeats the procedure outlined above until the goal is apparently accomplished, and then tests again.

Because the patient is often consciously unaware of the content of the work that has been completed, conscious conviction of completion is seldom expressed. If deemed advisable, conviction may be obtained by requesting CENTRUM to provide it by causing some experience (e.g., an itch, a tickle, a thought, an involuntary movement, etc.) the purpose of which is to convince the patient of completion. The results of this can be dramatic and occasionally humorous. It is not clear that cognitive conviction is necessary. However, it does seem to have real, if undefined, value when provided.

As the final step, CENTRUM is requested to provide conscious awareness of the content of the work just accomplished, and of the basis for that work, including memories of related events, understanding, and insight. Such awareness is usually provided and the patient seems to benefit from it. However, the awareness may be denied, and in this event the patient may or may not wish to pursue the matter. Pursuit will require using the same basic procedure as used to address the problem itself to resolve the reason for denial. Some part or parts of the mind are preventing conscious awareness. Those parts must be persuaded to permit it. If the patient is indifferent about knowing, the matter should be dropped and therapy considered provisionally complete.

Notes

The process described in the preceding dozen paragraphs is only one of many possible. In the manual for therapists (Yager 1985), the author details a "decision tree" algorithm that can be followed. The therapist is not limited to any particular design, and is encouraged to tailor the process to the client. For example, the therapist may conclude that interacting directly with a given "part" may be desirable rather than using CENTRUM as an intermediary. One part may be enlisted to communicate with another; communication between parts may be accomplished without conscious awareness; the therapist may or may not insist upon a given request being accomplished. Possible variations are endless.

SESSION TRANSCRIPTION

The following is a transcription of a portion of a session with a 25 year-old female. The session was the fourth in a series in which she had addressed several minor issues via Subliminal Therapy and so was familiar with the process. The therapeutic goal was to "eliminate her bulimia."

Responses from CENTRUM and other unconscious parts, as reported by the patient, are italicized and immediately follow the questions and requests posed. Comments have been inserted for clarification are italicized.

Dr. CENTRUM, do you support your conscious wish to eliminate the binging and purging? YES

The reader will note that CENTRUM is addressed in the first person. This practice avoids confusion, expedites the work, and is readily accommodated by the patient.

CENTRUM, are you willing to do the work necessary, as I guide the process, toward accomplishing that goal?   YES

Then CENTRUM, please investigate, with or without conscious awareness, all aspects of this goal, Identify the part, or parts, that cause the binging and purging and communicate with them to learn of their reasons for doing so. Identify any part that might resist your achievement of your goal. Review memories of related events and do all else necessary for you to understand all possible aspects of this problem. Let me know by writing the word "complete" on the chalkboard when you have completed this task to the limit of your ability. COMPLETE

CENTRUM, please write on the chalkboard any reason you are binging and purging.

GUILT
PEOPLE
SELF-IMAGE
CLEAR GOAL
FEAR

This set of responses was unexpected. Usually only one is forthcoming.

Peggy, do you consciously understand what CENTRUM means by "guilt?"

Peggy I think I do... If I eat inappropriately, I feel guilty. Then I vomit to punish myself.

Dr. CENTRUM, it that what you referred to? YES

Peggy, what is your conscious reaction to that? Does it make sense to you?

It seems important to obtain conscious opinion and perspective from the patient rather than for the therapist to provide it.

Peggy I don't want to feel guilty. I want to eat appropriately, yet I'm confused. When I don't like part of myself, I punish it.

Although the meaning of this statement is not clear to me, it seems clear to her, so I proceed...

Dr. CENTRUM, do you understand why you do that? NO

CENTRUM, is some part of your mind causing that to happen? YES

CENTRUM, are you in communication with that part? SOMETIMES

Are you in communication with it now? NO

Are you willing to communicate with that part now? YES

And CENTRUM, is that part (or parts, as the case may be) willing to communicate with you? NO

Are those parts willing to receive information if they can do so without having to respond, without having to expose themselves? CONFUSED

My error. I should have been clearer in my question.

CENTRUM, I believe that part of your mind is well-intended. I believe it is doing what it is doing for reasons it considers to be in your best interest. I doubt that the part is aware of the consequences of what it is doing. I doubt that it is aware of present reality. I think it is functioning on the basis of what "was," rather than on the basis of what "is." I also believe that part is probably feeling threatened by this work. I want to make it possible for that part to learn about present reality, to catch up with the rest of the mind. If it can do so without threat, by listening only, it may be willing to do so. Therefore, I ask again if the part is willing to receive information for consideration without having to respond? YES

Then CENTRUM, please communicate to that part your understanding of the present, of the consequences of what it is doing and of the advantages of cooperating with you. Inform that part, educate that part, persuade that part to your way of thinking and let me know by the word "complete" when you have done so. COMPLETE

CENTRUM, now that the part has received that information, is it willing to communicate fully with you toward mutual understanding? YES

Note the continuing emphasis on mutual understanding. It is an underlying theme of this technique.

Then CENTRUM, please communicate and when there is full mutual understanding, let me know by the word "complete." COMPLETE

CENTRUM, does that part, or those parts, still want you to punish yourself? NO

CENTRUM, is it OK for you to know and understand consciously what is going on? YES

CENTRUM, please provide that awareness now...

Peggy It's complete. I was thinking about the other parts being my protection. The others that punished me - they didn't understand.

Dr. CENTRUM, do you now have all the conscious understanding that you need to eliminate the self-punishment? YES COMMUNICATION

The word "communication" was not expected. I assumed it was an indication from CENTRUM that although all necessary conscious understanding was there, some kind of communication was still needed.

Peggy CENTRUM says he needs to communicate all information to other parts.

My assumption was apparently correct. Also notice the gender of CENTRUM is masculine; a common phenomena.

Dr. OK CENTRUM, please do that. Communicate full understanding to every part of your mind so that there can be cooperation. OK

CENTRUM, is there more to be done to eliminate the guilt that is causing the bulimia? LET GO OF GUILT

Again, here is guidance for me from CENTRUM. To be provided such guidance is the exception, not the rule.

CENTRUM, do you know how to do that? FORGIVING

And who must be forgiven? OTHER PARTS

CENTRUM, do you forgive those other parts? YES

And Peggy, do you consciously forgive them?

Peggy Yes, I do.

Dr. CENTRUM, does any part, for any reason what-so-ever, not forgive? NO

CENTRUM, is there more to be done to eliminate that guilt? NO

Very good. Now lets address the second of those reasons. Peggy, do you consciously understand what CENTRUM meant by "people?"

Each of the five stated reasons, guilt, people, self-image, clear goal, and fear, must be addressed in a manner similar to that above. There is bound to be a significant amount of interaction between the five, and it may be necessary to re-address each before the goal is finally achieved.

CONCLUSION

The author's experience with hundreds of patients has indicated a high order of efficacy, as have anecdotal reports from others, yet this is not sufficient evidence. Unfortunately, only minimal research has been accomplished to date, as reported in following paragraphs.

Subliminal Therapy was initially tested in 1977 by a review of the clinical records of 41 consecutive patients, of random age and sex, who presented a total of 161 problems including a wide variety of behavioral, somatic, emotional, phobic and sexual concerns. These patients were treated on an individual basis, by the author, in a private clinical setting, for an average of 6.2 hours. Success was self-reported one-month post-treatment (minimum) by 13 of the patients (32%) in the achievement of all therapeutic goals, and by an additional 17 (41%) in the achievement of at least half of their therapeutic goals. These results are reported without claim of research controls. The data were complied, in some cases, months after the therapeutic work was done.

In 1978, a quasi-controlled study was conducted in which three females were treated for hay fever. Following three individual treatment sessions using Subliminal Therapy, two reported their symptoms had completely vanished, the third reporting improvement of 35-40%. The three sessions lasted an average of 21 minutes each, so that each subject was seen individually for 63 minutes.

In early 1979, as a test of the theory that the therapist could successfully treat patients without knowing the nature of the presenting problem, five subjects were so treated. The therapist (the author) was given the first name of the subjects, and information as to whether they wished to eliminate something or achieve something. Only after the conclusion of the study was the therapist made aware of their presenting problems. Four of the five successfully accomplished their goals.

Later in 1979, a pilot study was conducted in which a computerized version of Subliminal Therapy was employed in lieu of a human therapist. Five subjects presenting simple phobias were treated in a context that limited instructions to printed material; contact with the therapist being limited to logistic issues. Four of the five subjects reported successful elimination of their phobias. Two reported success during the first treatment session, one subject required two sessions and the fourth required three. The duration of treatment sessions was determined by the subject being treated and varied from 17 minutes to 48 minutes.

Additionally, Subliminal Therapy has been clinically validated by being employed in the treatment of a wide variety of presenting disorders in hundreds of cases, by multiple therapists. Reports on all aspects of its application are solicited and consultation regarding specific clinical problems will be cheerfully provided. Address the author at 3737 Moraga Ave., Suite A-203, San Diego CA 92117-5404.

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