

## Yoga-nidra and hypnosis

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Trance states have long been used within a healing context in India. The use of chant, evocation of trance through ritual, and altered states achieved through meditation has been a means for self-realization, psychological well-being, and increasing health. Indigenous psychologies have elucidated various types of states of consciousness. Folk healing traditions often utilize trance as a means to invoke health, and exist concurrently with modern, western forms of psychiatry and psychotherapy. Comparisons have been made between techniques such as the western modality of hypnosis and meditation and yoga. *Yoga-nidra* (the yoga of sleep) is one of these practices. It is similar to hypnosis and other techniques of mind-body methods of healing used in psychotherapy. *Yoga-nidra* has been introduced as a contemporary, systematic process of healing by various schools of yoga, both on the subcontinent and in Western countries. These methods are purportedly developed from ancient yogic texts. This article will provide an overview of *yoga-nidra*, both its origins and current form of practice, as well as a short review of the literature on its efficacy. It will be compared to hypnosis, a systematic, mind-body, trance-inducing technique, used as an adjunct with western forms of psychotherapy. Suggestions will be presented for using these modalities to integrate indigenous concepts of spirituality and psychology and the western models of mental health delivery in contemporary India, and populations of Indian cultural origin living abroad.

**Keywords:** yoga-nidra; hypnosis; meditation; psychotherapy; India

Indigenous healing practices in India utilize altered states as a means to facilitate healing (Campion and Bughra 1998). The transmission of the spontaneous, hypnotic-like state of *samadhi* has been attributed to gurus, such as Ramakrishna and Neeb Karori Baba (Sharma 1981; Pande 2003). Meditation and yoga, practices considered similar to hypnosis and other western, mind-body techniques, are described from antiquity (Hovec 1975; Hammond 2013). Yoga and meditation are still among the main healing modalities sought in contemporary India, along with talismanic cures, exorcisms, ayurvedic medicines, and music, despite western paradigms of mental health being practiced there for approximately 100 years (Prasadarao and Sudhir 2001; Blanche 2004; Hogan and Vaccaro 2007). Hypnosis is a well-known technique of eliciting trance states that has its origins in Europe, and has been used therapeutically for at least 400 years (Hammond 2013). Franz Anton Mesmer is generally acknowledged as the progenitor of hypnosis, though similar techniques are attributed to ancient Greek and Egyptian sleep temples. Paracelsus developed a theory of magnetism predating Mesmer's, and he is believed to have studied ritual healing, in part

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from traveling to India (Hammond 2013). A considerable body of evidence regarding its efficacy is apparent (Mendoza and Capafonzo 2009; Barabasz et al. 2010). Similar to hypnosis in some respects is yoga-nidra.

### Yoga-nidra

Yoga-nidra is a meditative practice that reportedly dates to antiquity (Panda 2003; Parker, Bharati, and Fernandez 2013). References to yoga-nidra are considered implied in descriptions of the god Vishnu in classical Hindu prayers (Panda 2003). Descriptions in ancient texts are generally considered to be vague, and describe the state obtained by the practitioner, rather than the process (Parker, Bharati, and Fernandez 2013). Traditions associated with yoga-nidra, or describing similar states of consciousness through meditative practice, are *Mahayana* and *Vajrayana Buddhism*, *Kashmiri Shaivism*, Patanjali's *Yoga Sutras*, and Shankaracharya's *Yoga Taravali* (Parker, Bharati, and Fernandez 2013). Contemporary descriptions equate it with a kind of lucid dream state, in which dream imagery takes place for the practitioner, but they do not identify or become attached to them, but remain an objective observer (Miller 2005). Swami Satyananda Saraswati, founder of the Bihar School of Yoga, is credited with the current popularization of yoga-nidra (Panda; Henry 2005; Parker, Bharati, and Fernandez 2013).

Parker, Bharati, and Fernandez (2013) report that several studies have referred to relaxation and guided imagery techniques as yoga-nidra, and call for an operationalization based on physiological markers; i.e. EEG readings of brainwaves produced by the practitioner during meditation. They equate yoga-nidra as corresponding to the dreamless sleep cycle of the brain, or non-activity of the mind (*manas*) and equate Delta brainwaves as a neurological indicator for having achieved the state. These researchers describe the above-mentioned Bihar School techniques, or Miller's IRest program (1995) as merely relaxation techniques, not yoga-nidra because studies facilitated with them indicated subjects only produced Alpha and Theta waves and not the slower Delta waves. Nonetheless, for the purpose of this paper, the Bihar School method will be referenced in this article due to its clearly systematic method and its popularity and influence on yoga-nidra practice in India and abroad.

Yoga-nidra practice consists of the practitioner lying supine on the floor, and focusing on body parts, breath awareness, and suggested imagery (Panda 2003). Eight stages are indicated: (1) *Preparation*, (2) *Relaxation*, (3) *Resolve*, (4) *Rapid Shifting of Consciousness*, (5) *Mental Channel Purification*, and (6) *Moving Visualization of Scenarios*, (7) *Resolve (repetition)*, and (8) *Finish*.

Preparation consists of settling the body into the corpse pose (*savasna*), and focusing intention to practice without losing consciousness while remaining still (Panda 2003). Relaxation consists of relaxing the body via various breath exercises (*pranayams*), with or without the use of mantras. Resolve elicits the *sankalpa* or intention; a kind of autosuggestion to be placed in the practitioner's unconscious as a 'seed in the mind.' *Rapid Shifting of Consciousness* includes the process of *External Rotation of Consciousness*. This is similar to a *body scan* technique used in Buddhist mindfulness and relaxation where the individual places their attention in various parts of the body. However, it is also done more swiftly compared to the mindfulness meditation practice. *Internal Rotation of Consciousness* focuses on suggestions for visualizing *chakras* or energy vortices within the subtle or *etheric body*. It is the internal balance of focus on the external and internal, imaginal body. *Mental Channel Purification* includes the use of reverse counting while imagining breathing through opposite nostrils. *Moving Visualization of Scenarios* consists of the visualization

of religious and nature images. Panda (2003) states that the rotation of consciousness, or *nyasa*, is a tantric technique extrapolated from earlier methods of meditation by Saraswati. It is used to bring about a state ‘... which is neither awake nor sleeping. In yoga-nidra the yogi stays somewhere between the waking and the sleeping states ...’ (Panda 2003, 271).

### Yoga-nidra & hypnosis

Contemporary practice of yoga-nidra has some similarities to modern hypnotic and classical hypnotic techniques. These are not unlike those discerned between mindfulness meditation and hypnosis as adapted for psychotherapeutic uses (Yapko 2010).

The administration of yoga-nidra is often provided by an instructor or yogi, and can also be performed in an autohypnosis fashion (Panda 2003). As with hypnotic suggestions, instructions for yoga-nidra practice are provided with the subject/recipient’s eyes closed, and with an inner focus of awareness. Hypnotic induction, however, often includes formal or informal testing for hypnotizability, and use of ratification techniques, such as arm levitation, catalepsy, and time distortion (Yapko 2003). Ratification is used in hypnosis to create awareness that the hypnotic state is special, and thus act as a convincer for the subject as having entered into it. It demarcates a more intensified liminal space for healing than psychotherapy; the boundaries between the therapist and the patient are further removed from the typical, psychotherapeutic environment, and the therapist participates more intensely in the patient’s phenomenological field. Yoga-nidra operates within the realm of an indigenous spirituality and psychology, for those born into or adhering to a Hindu cultural or spiritual paradigm. Phenomena that can be labeled hypnotic, such as time distortion, primary process imagery, dream imagery, and catalepsy may take place, but are not necessarily utilized as a convincer for ratification of the special, meditative state (Bowers 1978; Yapko 2003). The special quality of awareness evoked is held as an a priori, cultural, and spiritual assumption within the context of the procedure.

The yoga-nidra practice of *sankapla*, or resolution before and after the exercise, is similar to a post-hypnotic suggestion. However, one chooses the resolution on one’s own, rather than with the help of an operator or therapist giving the suggestions (Panda 2003). The mind is fixed on a thought or willed resolution that is planted and cultivated at the beginning and end of the meditation. Hypnotic suggestions are typically delivered by an outside source, and there is an attempt to bypass the conscious mind and implant them in the unconscious (Yapko 2003). Yoga-nidra differs in that amnesia and other hypnotic phenomena may be apparent, but the practitioner attempts to remain alert with non-attachment to any imagery, sensations, or experiences (Panda 2003).

This cultivation of awareness is described as a means to produce a *witness* state of consciousness, between waking consciousness, *jagrata*, and dream consciousness, *svapna* (Panda 2003; Henry 2005). Panda makes a connection between this and Ernest Hilgard’s idea of the *hidden observer* in the *neo-dissociation* theory of hypnosis. The hidden observer is considered to be a part of the psyche that is consistently aware, regardless of the level of conscious control of the subject. Panda states that they are one in the same.

The first author (SH) has had the experience of working with guided imagery techniques, mindfulness-meditation, and extensive use of hypnosis in clinical practice, as well as personal use. I have also used a Bihar School variant of yoga-nidra (Janakananda 2012). My experience is that yoga-nidra differs from the former techniques, especially hypnosis, in that suggestions for rotation of consciousness and imagery, as mentioned above, are given quickly. This swift attentional function does indeed have a tendency to keep the practitioner more alert through various internal experiences. In hypnosis, the opposite is often

produced. Various techniques, such as fractionation (brief re-alerting and re-entrance to the trance state) and pauses in the hypnotic induction are a means for deepening the sense of trance, and the conscious mind of the patient is bypassed precisely to influence unconscious cognitive sets and influence behavior (Erickson, Rossi, and Rossi 1976; Erickson and Rossi 1989).

### Research on yoga-nidra

Several psychological and physiological cures are attributed to yoga-nidra (Panda 2003). Among the ailments it is described as having curative factors for sleep disorders, anger management, obsessive-compulsive disorder, various digestive disorders, such as colitis and peptic ulcers, cardiovascular disease, arthritis, osteoporosis, dementia, and immune system function (Panda 2003). These claims are not entirely ascertained, and appear to be largely anecdotal at this point. But a small body of literature suggests generally efficacious results for some ailments, and some indications of yoga-nidra's physiological effects. These include of the impact of yoga-nidra on stress and anxiety (Kumar 2008); increasing alpha output on electroencephalograph and galvanic skin response measurement (Kumar and Joshi 2009); the reduction of illness-related stress in multiple sclerosis and cancer outpatients (Pritchard, Alison-Bowers, and Birdsall 2009); reduction of menstrual-related difficulties (Rani et al. 2013); inflammation reduction (Kumar and Panya 2012); and positive effects on heart rate variability (Markil et al. 2012). The findings are promising, but in the early stages of investigation, and further, more robust studies need to be conducted to provide stronger evidence of its efficacy and effectiveness.

### Hypnosis in India

Hypnosis as a therapeutic and medical modality is no stranger to India. Esdaile introduced Mesmerism to the subcontinent in his use of it as an analgesic in surgery, and, as stated earlier, hypnosis may have some historic connections to India via Paracelsus (Hammond 2013). A survey of websites and a discussion with a master's level psychotherapist who resides in Mumbai for this article indicated that many lay hypnosis institutes provide trainings, and are often a clinician's first contact with it. The practitioner, who chose to remain anonymous (personal communication with the first author (SH) of this paper, 12 December 2010), discussed their general training from a lay-hypnosis organization loosely affiliated with a similar organization in the USA. This included various basic hypnotic techniques, and *Neurolinguistic Programming* techniques (Hall and Belnap 2000), integrated with cognitive-behavioral therapy. These techniques are similar to those taught in professional societies in the USA, which are responsible for consistent, scientifically sound trainings (Hammond and Elkins 2005). Indeed, the first author (SH) has attended lay hypnosis trainings in the USA, as well as those offered by the professional societies, and served as faculty for professional societies. I am of the opinion that they are remarkably similar in content for preparation of practice, and have found that many lay hypnotists are quite competent technically, and as limited clinicians. However, there is a lack of scientific rigor, and no real repercussions for any potential ethical deviances by lay hypnotists, nor protection of the general public from potential negligence or maleficence. Licensed or degreed mental health professionals offer some training courses to clinicians in India. The Indian Society of Clinical and Experimental Hypnosis, a component section of the International Society for Hypnosis (2009), offers conferences and training. But psychotherapy largely goes un-

regulated, even with an official licensing board (Hogan and Vaccaro 2007), and there is no regulation of the practice of hypnosis in India.

### **Mental health care in India**

Mental health services in the subcontinent are primarily offered in urban areas, with larger populations. However, most of the population of the subcontinent still live in towns and villages outside of the major urban areas (Chatterjee 2009). It is largely due to this that mental health services in India are lacking (Chatterjee 2009). This is in spite of the introduction of community psychology in the 1970s and 1980s and over 100 clinical psychology departments (Prasadarao and Sudhir 2001; Bhatia and Sethi 2007; Hogan and Vaccaro 2007; Chatterjee 2009). The majority of the population does not have access to counseling and psychotherapy services. A very small portion of the westernized population in urban areas that may be amenable to them actually uses them (Laungani 2004). There is a movement to foster professionalism in psychology, but many individuals practice unlicensed, and without degrees (Hogan and Vaccaro 2007).

### **Western psychology in India**

Psychology is in many ways a foreign concept in India, despite its academic and clinical presence for more than 100 years (Laungani 2004). Indian culture, by and large, has been dominated by a sense of inferiority since colonization by the British, and western modes of science and philosophy were upheld as superior to indigenous ways (Sinha 1994; Prasadarao and Sudhir 2001; Bhatia 2002; Blanche 2004; Laungani 2004; Hogan and Vaccaro 2007). Nonetheless, they are still practiced throughout much of the country. Some psychologists have attempted to recreate or cross-pollinate western psychology with Hindu ideas that were indigenous to the subcontinent, giving rise to *Indian Psychology* (IP) (Sinha 1994; Bhatia 2002; Laungani 2004). However, there is still little academic and clinical acceptance of IP in India, and most practitioners continue to use Western paradigms of mental health and dysfunction for the provision of services (Bhatia 2002).

The disparity between rural and metropolitan India is not just economic, but also cultural (Laungani 2004). Rural India has been less Westernized, and provision of therapy needs to be delivered in a culturally specific manner. This poses a problem, as most therapists in India prefer western models. Training supervisors generally frown upon the use of existing models of indigenous Indian therapies (Van Hoecke 2006). Wig (1999) used the analogy 'Indian Made Foreign Doctor' to describe the perceived conundrum that faces university-trained psychiatrists when they enter work in communities after medical school. Laungani (1997, 2004) was critically aware of how training in western models of psychotherapy causes south Asian clinicians to adopt this paradigm, and to superimpose a Western perspective on the collectivist and spiritual paradigm they have been raised in. Specifically, Western modes of psychotherapy and counseling are at odds with the native models of therapies and healing. Typically an expert is sought with instructions for a cure, not a horizontal relationship with a therapist more typical in Western models.

From a reverse perspective, i.e. culturally Indian patients in the US seeking treatment, we also see the impact of interacting with a cultural divide. The second author (SR) has found that the lack of the Western practitioner's knowledge of cultural issues can create a divide between patient and practitioner. In considering factors influencing patient decisions in seeking treatment as well as compliance to treatment, one must take into consideration the issues related to feelings of guilt vs. shame regarding the illness, the opinion of a larger

family structure, and reliance on ceremony/ritual, be it religious or simply a part of the family cultural lore. The interface of Western medicine and more traditional methods is a crucial piece in accessing this population. Attending to these issues translates into utilizing the extended family and members of the community, and potentially enhancing the provision of services to the patient.

Cross-cultural issues often play into the inadequacy of the now usual ‘medication check’ approach to treatment in psychiatry. A more complex approach that integrates more ceremonial or physically palpable techniques is required. For example, giving a more ritualistic type of regimen (i.e. breathing techniques, visualization exercises, and prescribed exercises) in addition to medication can be perceived as more valuable.

Many of my (SR’s) patients present with more somatic complaints, or somatic metaphors of psychic pain. Two examples are of patients with conversion disorder; young, newly married Indian females from lower middle class upbringing. Their presented complaints are faintness, dizziness, and odd descriptions of symptoms like ‘tongue keeps clicking in mouth’ or ‘prickly sensation in head.’ The description of anxiety was teased out from initial descriptions of ‘something trying to get out of the head,’ or ‘heavy feeling in the heart/chest.’ They clutched the symptomatic area as though the sensation was physical. With these patients, a concrete method of asking them to place right hand over heart and left hand over the belly and do breathing exercises in through nose, was more helpful, and they were compliant. Patients of more ‘American’ background, having been more assimilated into the dominant culture, are more apt to turn to medication. I (SR) often have to spend quite some time convincing Indian patients that a medication is likely indicated. On multiple occasions, they have only utilized the relaxation techniques.

Another technique these patients seem open to use for insomnia is what I call a ‘touchstone.’ For example, the patient will place one palm on the headboard while lying in bed and allow their mind to wander to a place they register as safe and calming. I often give them the personal example of my own, that I would imagine I am in the bed I had in medical school in my apartment and I could hear ocean waves. This use of imagery for a psychiatric condition points to potential integration of yoga-nidra into Western medicine for this population. Yoga-nidra’s ceremonial, Indian approach could be more readily adapted.

### **Integration**

This brief overview of psychology and delivery of mental health in India points to a need for integration of indigenous and Western models of healing to best meet the needs for a Hindu population. Since both yoga-nidra and hypnosis are taught and utilized in India, it would appear apropos to call for their further integration. Yoga-nidra is consistent with the goals and aspirations of IP in that it draws from Hindu spirituality and psychology. The similarities between the two should be further explored, and an understanding and practice of both could inform clinical and research efforts.

The Hindu concepts of mind and spirit are readily adaptable to psychotherapy for their emphasis on altering consciousness for healing. The systematic yoga-nidra practice from the Bihar school displays commonalities with clinical hypnosis, mindfulness meditation, guided imagery, and relaxation training. The study of yoga-nidra may inform the practice of Western forms of psychotherapy. It is important that other systems of yoga-nidra be further studied and considered for integration into practice. Continued study of the physiological state elicited by yoga-nidra practice could add to the greater operationalization of this meditative state from an empirical perspective (Parker, Bharati, and Fernandez 2013). Further efficacy studies of yoga-nidra can help to bridge the gap between Western and in-

digenous Indian systems of healing, and add support for it as a system of healing. Training programs, run by clinical faculty, for both yoga-nidra and hypnosis could provide standardized, evidence-based, training and practice. This could potentially add more respect from academic circles for, and further application of IP within the subcontinent, and as a means to work cross culturally with the immigrant Indian populations in other countries.

A specific application of yoga-nidra integration with Western psychiatry could potentially be with *transcranial magnetic stimulation* for depression (TMS) (George et al. 1999). TMS therapy is an FDA-approved treatment that uses direct electromagnetic stimulation to areas of the brain that are hypoactive in depression. The patients must remain awake for the 37 min of treatment and they preferably need to do something that is engaging the brain in a positive, uplifting manner. Yoga-nidra training with or without the integration of hypnosis as a pre-procedure could provide this, especially with patients from the Indian population.

It should not be forgotten that yoga-nidra is foremost a spiritual practice. It is important to keep from providing a merely reductionist approach to it, as has happened in many respects to the use of Eastern methods of mind/body healing in the Western paradigm (Goldberg 2010). Keeping this in mind while proceeding with the previously mentioned suggestions can perhaps add more of a means for spiritual growth as well; a potential end-game in long-term psychotherapy as opposed to mere symptom removal.

India is a pluralistic society. The Hindu faith, though the majority, is only one of several religious and cultural paradigms mental health providers interact with. It is hoped that other suggestions for psychotherapy integration can be envisioned for Moslem, Jain, Buddhist, and other belief systems. Finding further commonalities may well be a step in providing a better understanding of mental health concepts across cultures and spiritual paradigms.

This article also brings into focus India's rich tradition of spiritual science that the west has benefited from, and continues to do so in many ways. Western scientific paradigms are, in many ways, still in their infancy by comparison. A best-case scenario would be to cultivate a 'mutual admiration society,' where both Western and Eastern cultures marvel at their differing perspectives, rather than scenarios of Westernization supplanting indigenous perspectives (Watters 2010). In the worst-case scenario, India would continue to hold its cultural, philosophical, and spiritual history in lower esteem, and Western science as a pinnacle of intellect and achievement. If Indian mental health practitioners continue with hybridization of indigenous conceptions of yoga and spirituality with Western psychology, it may not only bolster India's sense of self-understanding as a culture, but also assist individuals and families on its own, and other shores. Seeking further commonalities between the techniques of yoga-nidra and hypnosis may yield continued, beneficial results in this area.

### Disclosure statement

No potential conflict of interest was reported by the authors.

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