

THE MANAGEMENT OF UNRESOLVED GRIEF

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Unresolved or pathological grief is an often unrecognised sequel of bereavement and can be considered as a significant alteration in time and/or intensity of the grieving process, differing only in degree from ordinary grief. It may present in a wide variety of clinical forms and can involve grieving too little, too much, too soon, or too late. The variety of expressions of unresolved grief is probably the reason why it is often unrecognised and untreated and why it continues to remain the cause of significant disability in the community. It is argued that some people fail to grieve normally because of obstacles to the normal grieving process which must be removed by effective therapy. An hypnotic therapeutic technique is outlined by which effective therapy is commonly reduced to two or three sessions. The key element is regression with vivid imagery to just before the death of the valued person and then having the patient in fantasy to hold the hand of the deceased (in reality the therapist's hand) and to have an imaginary dialogue about their previous relationship and their present feelings for each other. Finally the patient says goodbye, with the knowledge of the impending and inevitable death. A series of 69 patients treated by this method is reported and the method illustrated with case profiles.

While the process of grief may occur after any form of loss, this paper is concerned specifically with grief resulting from loss by death of a close relative or friend, and in particular with grief that has become pathologically unresolved.

Western cultures, increasingly in the twentieth century, continue to distance their dying and dead both perceptually and socially. While our living standards rise, our dying standards decline. As one renowned Australian journalist, Philip Adams (1986) has put it so evocatively: "We can live and die without ever seeing a corpse - it is like growing up in a forest and being denied the right to see a fallen tree." Despite the efforts of Elizabeth Kubler-Ross (1969), together with all the subsequent scientific and lay publications on death and dying, unresolved grief still appears to remain a common problem in our society and even more sadly it is often unrecognised by both the public and the

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health care professionals alike. To reduce this common problem, many professional and public attitudinal changes are required in relation to such aspects of death as the viewing of the body, dying at home, hospices and grieving rooms in hospitals. This paper, however, is concerned essentially with the diagnosis and management of the established disorder.

DEFINITION AND SYMPTOMATOLOGY

Grief itself is a discrete psychogenic syndrome, which follows a significant personal loss and has a predictable clinical course. Most authors in a voluminous literature on the subject agree that this course follows a sequence of three to four overlapping stages – for example, shock/denial through despair/protest to realisation/acceptance, with resolution completed within 6 to 12 months.

Unresolved or pathological grief, while difficult to define precisely, could be considered as a significant alteration in time and/or intensity of this process, thus differing only in degree from ordinary grief. It may therefore present in a wide variety of clinical forms: for example, chronic depression, recurring sadness, insomnia, weight loss, concentration difficulties, severe denial, misdirected anger, a yearning but an inability to cry or rage, hallucinations, anniversary reactions, and identificatory syndrome (physical complaints identical to those of the deceased, well described by Melson & Rynearson in 1982). All of these forms are time-bound to a loss that time alone has not resolved, and both the length of this time and/or the intensity of the symptoms may help identify the problem as abnormal, although not conclusively.

Abnormal grieving could thus well mean grieving too little, too much, too soon, or too late. In any event, consideration must be given to the fact that each person, and indeed each culture, grieves at different rates and in different ways. Such wide parameters of unresolved grief are probably the very reason why it is a condition often unrecognised and untreated and why it continues to remain the cause of considerable disability in the community.

DIAGNOSIS

Having broadly defined unresolved grief, the diagnosis is arrived at simply by asking the patient about any past loss of a close relative or friend. If unresolved grief is present, almost invariably the patient will either tell of some past loss with varying degrees of overreaction or will attempt to avoid the subject, when gentle persistence may be necessary. The clinician's ability to diagnose this often distressing condition depends upon the maintenance of a high degree of suspicion whenever disabling symptoms have occurred after the loss of a significant person and which still remain for longer than a year, particularly if the image of the deceased still preoccupies the bereaved mind excessively. Parkes (1985) has identified certain circumstances and certain people who are at special risk (see Table 1).

Table 1

Type of death:

Cause for blame on survivor, sudden, unexpected, untimely, painful, horrifying, mismanaged.

Characteristics of relationship:

Deceased is spouse, child under 20 or parent of young or older unmarried child, dependant or symbiotic or ambivalent relationship.

Characteristics of survivor:

Grief-prone personality, insecure, low self-esteem, over-anxious, previous mental illness, excessively angry or self-reproachful, physically disabled or ill, inability to express feelings, previous unresolved losses.

Social circumstances:

Family absent or seen as unsupportive, detached from traditional cultural and religious support systems, unemployed or unhappy at work, dependant children at home, low socioeconomic status, bereavement overload (multiple losses).

INCIDENCE

In a series of 100 consecutive patients seen by the author in a full-time psychotherapy and counselling practice, 11 were identified as suffering from symptoms related to unresolved grief. This compares with 17% incidence in one psychiatric out-patient group (Zisook, Shuchter, & Schuckit, 1985), 10-15% in another (Lazare, 1979), and 14% in a general community (Zisook & DeVaul, 1983).

COURSE

Unlike normal grief, unresolved grief does not move through the usual stages but tends to become blocked in one or both of the first two stages of denial or protest. Significantly, a patient thus blocked does not appear to respond to empathy from individual counselling, from a family group, or from self-help groups. The widespread belief that time alone heals all grief and that the process should not be interfered with (Freud, 1958) is just not true. These people fail to grieve normally because of the various binds and obstacles and they remain time-bound to their loss. These obstacles must be removed, since once established, unresolved grief tends to persist, and may do so for many years (Zisook & DeVaul, 1983).

MANAGEMENT

The prime objective of good management is to assist in the removal of the obstacles that are maintaining the grief in an unresolved state.

EXAMPLES OF OBSTACLES

1. Excessive denial of the death, when the bereaved persists in referring to the deceased in the present tense rather than the past after 6 to 12 months – that is, they have not really said good-bye or taken leave.

2. Over-identification with the deceased (identificatory illness) when somatic symptoms occur that mimic those of the deceased.

3. Inability to cry, particularly in cases of stigmatised deaths (suicide), or in deaths relieving pain and suffering (cancer), or in deaths where the bereaved deliberately inhibits the affect by excessively caring for others.

4. Excessive guilt, where the bereaved may have never been able to express love and forgiveness, and therefore wishes to keep the deceased alive.

5. Misdirected anger, especially occurring in very close relationships where shared plans are now interrupted and feelings of desertion predominate. The anger may well be directed at the deceased, the self, or others, while expressing adoration for the deceased.

6. Interlocking grief reaction, where previous unresolved grief feelings may well prevent a resolution in a second or third event through fear of arousing old conflicts.

7. Secondary gains occasionally maintain a continuous helplessness.

Any of these obstacles may well keep the bereaved person's hopes back in the past and allow little hope for the present or the future. A key to the removal of these obstacles is guided affective imagery, which of course may or may not incorporate hypnosis.

Melges and DeMaso (1980), in an article elegantly titled "Grief Resolution Therapy: Reliving, Revising and Revisiting," described well the use of guided imagery to help the patient progressively to relive, revise, and revisit sequences of the loss, but in present time and with obstacles being progressively removed. Much of this is saying "goodbye" in a way that had previously been impossible (e.g., a viewing of the body being denied), but some of it may be ventilating and undoing blocks such as anger, hurt, or guilt. A surprising aspect of their therapy was that it averaged 6 to 10 half- to one-hour sessions for complete resolution. In the author's series of 69 patients suffering from unresolved grief, it became quite obvious that the utilisation of hypnotic techniques incorporating similar imagery methods, but in trance states, reduced considerably the number of therapy hourly sessions to an average of two to three, with considerable relief often obtained after the first session.

HYPNOTIC TECHNIQUE

Following a discussion with the patient explaining the aims and means of treatment, a modified rapid Spiegel and Spiegel (1978) method of induction is used, incorporating visual imagery of the patient's choice of a relaxing place to enhance dissociation. Later in the author's series, indirect hypnotic techniques were used similar to those described by Daniel Aorez (1985), during which

the process of trance flowed smoothly on from the explanatory process with very little demarcation. Trance is assumed to be present by the usual observations of muscular relaxation, regular quiet breathing, and eyelid fluttering, but also by asking the patient questions regarding the clarity of their imagery and noting their complete effortless absorption in it. No hypnotic capacity assessments are performed.

Regression and revivification to a time just prior to the death of the relative or loved one is then undertaken and the patient encouraged to hold in fantasy the deceased's hand (in reality the therapist's hand) and to initiate an imaginary dialogue about their previous relationship and their present feelings for each other. Finally the patient is encouraged to say goodbye with the knowledge of the impending and inevitable death. During this session any blocks such as hurt, guilt, or anger are gently but directly sought by the therapist and ventilation is encouraged using the trance logic of the patient to let them go and resolve them.

The ensuing emotional ventilation and abreaction may vary in intensity from almost nil to noisy sobbing and, in time, from a few minutes to an hour if allowed. The advantage for the therapist of holding hands is to monitor the patient's feelings by noting various changes in pressure, moisture, and temperature – changes often occurring despite no apparent changes in the patient's expression. This delicate biological feedback mechanism can provide a good deal of information about the patient's responses. In any event, it can be utilised to initiate the goodbye process in a prolonged abreaction by the therapist's gently and slowly releasing the hand concurrently with suggestions of a fading away of the deceased. This gradual hand release appears often to be a quite powerful stimulus to saying the goodbyes that were never able to be said previously. On some occasions, of course, the patient may initiate the release of hands – a tangible indication of finishing the previously unfinished business.

While gradually terminating the hypnotic session, the therapist can finally emphasise all the pleasant and happy times the patient may have shared with the loved one and the pleasant memories that may always remain. The patient generally does not talk aloud in the fantasy dialogue with the deceased, but of course may do so in response to the therapist's queries or suggestions. In my experience, urging patients to talk directly to the therapist while in trance can sometimes be disruptive to their concentration.

On coming out of trance the patient feels almost immediately that something previously unfinished has been completed or at least a start has been made on the resolution process. Usually one follow-up session is sufficient, but just occasionally complicated blocks may require more sessions to allow full ventilation and working through in trance by patient/therapist discussion or by ideomotor communication using ego-state methods similar to those described by Barnett (1981).

RESULTS OF A SERIES OF PATIENTS

In a follow-up of 69 documented patients suffering from unresolved grief, either alone or associated with some other conditions, all described a subjective relief from previously uncomfortable feelings directly concerning their loss. These uncomfortable feelings, apart from excessive hurt, guilt, and anger often included a persistent yearning for recovery of the lost person after one year – a cardinal aspect of unresolved grief according to Bowlby (1973) – and often reflected in such behaviour as an inability to visit the cemetery, to look at photos, or change the room of the deceased. Changes in this type of behaviour are a clear indication that the resolution process has commenced.

All but seven patients volunteered considerable relief of other associated symptoms which included depression, various degrees of lack of motivation, low self-esteem, anxiety, vertigo, tinnitus, tics, stuttering, compulsive eating disorders, hyperventilation, and the identificatory syndrome. Many of these symptoms were probably directly related to the lack of grief resolution and hence the improvement, but a few could well have been related to other concurrent problems in a psychoneurotic type of personality and were not improved. Thus while unresolved grief itself is amenable to good management by the techniques described, it cannot be considered to be a panacea for all associated symptoms.

FIVE CASE PROFILES

1. *Mr N.A.* (37 years), four years hyperventilation, panic attacks, and chest pains which often woke him at night, was referred by his GP. There was no obvious cause for his symptoms. Further history-taking revealed that the onset had been six months after his father died suddenly of a heart attack. The patient reluctantly admitted a fear of dying like his father – that is, identification syndrome. After one hand-holding session and two sessions teaching self-hypnotic relaxation techniques, all panic attacks subsided and he improved rapidly, without recurrence after two years.

2. *Mrs A.P.*, aged 60 years, was referred by her GP with a two-year history of anxiety and depression and use of dicyclomine hydrochloride (Merbentyl) for abdominal pain. A history revealed a poor marital relationship and one son, aged 30, who had committed suicide two years previously. She now accepted the death but felt enormous guilt for failure as a mother, anxiety as a Christian about the after-life of the son, and a resentment towards her husband for alienating the son. After two grief-resolving hypnotic sessions, during which all of these uncomfortable feelings were revived and ventilated, she gave up her sleeping tablets, felt able to cope with life, lost the abdominal pain, and was able to visit the cemetery without discomfort for the first time. One year later she remained free of her depression.

3. *Miss L.O.* (15 years) brought by her mother for “nerves” and stuttering on and off for years. Alone with the therapist, she tearfully admitted her

father died when she was only three and a half. She had no conscious memories of the death but she experienced an immense feeling of sadness.

During the hand-holding session involving age regression back to the father's dying, she at first reluctantly, but later tearfully, said goodbye. One week later she admitted feeling great and losing her stutter. A telephone follow-up one month later and again one year later confirmed this gratifying improvement.

4. *Mrs S.P.* (32 years) had been treated for depression, anxiety state, and panic attacks for three years by a psychiatrist both in and out of institutions and they both agreed to try hypnotic behavioural methods. A long history revealed that the onset of the symptoms occurred after her father had died from cancer five years previously. After one grief-resolving session in deep hypnosis, with considerable abreaction, and two follow-up sessions, she lost all anxiety and panic feelings, reduced her trimipramine (Surmontil) from 150 mg to 25 mg per day and quite impressed the psychiatrist with her rapid improvement!

5. *Mrs M.O.* (24 years), the divorced mother of a six-year-old child, was referred for reactive depression.

Two years previously half her family was wiped out in a horrendous murder and suicide. Her father, mother, and sister died and their mutilated bodies were not viewed by her. Her brother was brain damaged permanently. Her sister's de facto (the perpetrator) suicided. Three grief-resolving sessions (one hour) dealing with her sister, then father, then mother (her choice of order), changed her from a tearful, grief-stricken, depressed, angry, and guilty woman to a brighter, smiling, confident, independent person, capable of working, mothering, and coping with her situation rationally and with self-assurance.

The session with the mother was the most difficult, entailing a letting-go of guilt because of a minor estrangement just before the tragedy. Finally she was able to let go as she released my hand quite dramatically.

While some sadness remained, she felt she had now dealt with the whole affair, but required a further three sessions to help learn self-relaxing and self-hypnotic techniques together with ego strengthening.

DISCUSSION

Unresolved grief, causing a wide variety of neurotic type symptoms, appears to be a relatively common problem in our society. This condition is readily diagnosable and treatable, but it tends to persist indefinitely if left unrecognised or untreated. A Medlars search revealed a paucity of English-language publications on the incidence and treatment by hypnosis of unresolved grief in the general community. There are individual case reports using heterohypnosis (Spiegel, 1981; Van Der Hart, 1988) and some using self hypnosis (Fromm & Eisen 1982), but the only sizeable series were either treated by visual imagery only (Melges & DeMaso, 1980) or treated unsatisfactorily by palliative

psychiatric care. There are two vital keys to treatment in all cases of unresolved grief: recognition of the problem and the use of affective imagery. Obviously there is a close relationship between imagery and hypnosis, but the results of this series compared with Melges and DeMaso's series suggests that the use of hypnosis significantly reduces therapy time compared with guided imagery alone. This is consistent with Van Dyck's (1986) statement that in hypnosis the qualities of clarity, absorption, and especially involuntariness and effortlessness are more pronounced. All of these qualities appear to be necessary for patients to deal with the obstacles to normal grieving in present time and to re-experience the loss in the here and now. The use of hypnotic trance logic enables patients to change their construction of reality through reliving the event in their own way rather than remembering it as it was.

Hypnosis appears therefore to be the third key to success in grief resolution, and the hand-holding technique described above seems to be an important addition. A plea is made for health professionals and the community at large to become more aware of the help that is available for sufferers from this often distressing condition.

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HYPNOTIC INTERVENTION IN UNRESOLVED GRIEF

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Whilst there has been considerable interest in the problems of death and dying, we have tended to ignore the bereaved. Unresolved grief may present in a number of ways; carries with it considerable morbidity; and is a very common problem, with incidence between 10% and 17% reported in the literature. The therapeutic approach described in this paper and illustrated with case material involves the use of hypnosis. The aims of the therapy are (a) to bring the past into the present; (b) to allow the patient in hypnosis to experience being alone with the deceased very soon after the death and to encourage frank disclosure of thoughts and feelings to the deceased; (c) to encourage the patient to participate fully in a funeral service for the deceased. The results of this approach, in terms of rapid resolution of grief and well-being on follow-up, are pleasing.

Elizabeth Kubler-Ross (1969) has sparked a new interest in the issue of death and dying and this has led to much more attention being paid to those with terminal illness, in helping them approach their impending death more comfortably. However, we have tended to ignore those persons who survive the death of a significant person in their life. How do they cope? How do they manage their grieving? In fact, many have great difficulty in coming to terms with their feelings. There seems little appreciation that unresolved grief may present in a wide variety of ways, that it carries with it a very significant morbidity, and that it is a very common problem. Unresolved grief, I believe, is a clinical entity grossly under-diagnosed, and as a consequence the underlying dynamics of the illness presented remain unsuspected. Just as regressive and analytical techniques in hypnosis described by Barnett (1981) have tapped a large pool of sexual abuse in childhood, so the same techniques have drawn my attention to the problem of unresolved grief and ways of dealing with it. The reported incidence of unresolved grief in the literature ranges from about 10% up to 17% and in the author's practice of full-time hypnotherapy and counselling the incidence has always been over 10%. The

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literature contains very little information on the use of hypnotherapeutic techniques to diagnose and treat this condition. This paper deals with some of the ways unresolved grief can present and how the clinician can be alert to the telltale signs.

An effective method used by the author consistently over the last eight years to bring about a satisfactory resolution of these feelings will be described in detail.

DEFINITION

Grief can be described as the emotional response to loss – the painful effects include anger, sadness, fear, guilt, and despair. Grieving can be defined as the psychological processes whereby the bereaved gradually undoes the psychological bonds that bind him to the deceased (also called “mourning” or “the mourning process”). Grieving can also be defined as “a process of realisation of making real the fact of loss” (Parkes, 1969). Grieving begins when the finality of the loss is accepted; when as Freud puts it, “Each single one of the memories that bound the bereaved to the deceased is brought up and then painfully relinquished.” (Freud, 1958).

Grieving begins, not with death but with knowing that it is near. The effects experienced through bereavement will vary from time to time, but sadness will usually continue through the first year as succeeding anniversaries (birthdays, Christmas, Easter, etc.) remind the bereaved of the absence of the deceased in a special way. The duration of grief depends on the success with which the bereaved carries out his or her mourning work. There is no fixed end point to grieving, but under normal circumstances most of the work of relinquishing bonds and setting new goals will have been completed in the first few months and it gradually tapers off over the year. The process could follow on over into the second year. When grieving fails to follow this pattern it is termed pathological grief, and unresolved grief is one example of this. In unresolved grief, grieving may be totally absent, partially suppressed, or inhibited. The pain involved in severing the bonds of the relationship seems too much and so the necessary review is avoided. It is then, as Raphael (1984) puts it, “an avoidance of the pain of loss.”

Grieving is a psychological process and it therefore takes time. But time itself will not complete the process. Various factors may interfere with that process and as a result the necessary expression of appropriate affect is inhibited. Inherent in bereavement is the increased risk of mortality (Parkes, 1969) and morbidity, and unresolved grief accentuates that risk. Many writers have attested the need in unresolved grief to remove the “blockages” to effective grieving and to encourage the expression of the repressed feelings. Freud (1958) talks of the process of “remembering, repeating and working through.” Others refer to “regrieving.”

However, there is little in the literature relating to the use of hypnosis in the treatment of unresolved grief. Fromm and Eisen (1982) have published a delightful account of a woman who used self hypnosis as an aid to the normal mourning process. Turco (1981) reported a regrief therapy that was facilitated by hypnosis, while Van Der Hart (1988) has recently reported the use of hypnosis in an imaginary leave-taking ritual and of the rapid response obtained. Melges and De Maso (1980) have discussed a grief resolution therapy involving visual imagery allowing the patient to "relive, revise and revisit" scenes of the loss in present time, with good results. While hypnosis was not intended nor deliberately induced by the authors, it could well be argued that the very process of guided imagery involving going back in time and space (a remembering) would naturally bring about an altered state. It is interesting to note that the technique described by Melges and De Maso (1980) has similar features to the approach described in this paper, namely a reorientation of the bereaved in time and space back to the time of the bereavement; identification and removal of the blocks to full expression of the appropriate feelings; and permission, even expectation, that these feelings will be expressed.

PREDISPOSING FACTORS

The factors which may encourage the development of unresolved grief include:

The pre-existing relationship between bereaved and deceased. Pathological relationships in terms of extreme ambivalence or great dependency predispose to difficulties in grieving.

Co-existing stress. Stress, particularly other losses occurring at the same time as a bereavement, will tax the resources of the ego and reinforce the initial need on the part of the bereaved to deny the reality of the loss of the deceased.

Previous losses. If the bereaved has suffered previous loss, the process may become inhibited, particularly if the previous loss is itself still unresolved.

Type of death. Sudden, unexpected, or traumatic death are more likely to cause difficulties in coming to terms with the reality, as too will stigmatised death (e.g., suicide, AIDS, etc.)

Social environment. If the family and social structure fail to support the bereaved or fail to allow full expression of the feelings experienced, then the stage is set for unresolved grief.

Non-attendance at ritual funeral. Should the bereaved be unable to attend the funeral (e.g., overseas) or choose not to attend, difficulties may occur in initiating the mourning process. Indeed, one may need to be alert that non-attendance may be a sign of non acceptance of the death. I draw your attention to three current funeral practices, one of which almost certainly will result in unresolved grief and two of which *may* do so.

1. Hospital burial: For perinatal and infant death the hospital is given permission by the parents to arrange the burial of the infant. No-one attends this funeral and no words are spoken over the body. Such a funeral predisposes to difficulties on the part of the parents in grieving for their child and obviously should be avoided. Funeral directors have advised against such burials for some time.

2. The pre-paid funeral plan: Essentially this plan is good in that it helps people to come to terms with their own approaching death, as they decide on the arrangements for their own funeral. However, I feel it is advisable that there be some consideration given to those who will be bereaved either by (a) including them in making the arrangements for the funeral in the first place and/or (b) allowing enough flexibility in the arrangements to let some final decisions be made by the chief mourners when the time arrives.

3. Chapel only burials: These funerals have arisen in response to difficulties in conducting funeral processions over long distances in metropolitan areas and increasing time constraints at crematoriums. The funeral service is held at the funeral parlour. The coffin is then removed and taken to the cemetery or crematorium as the mourners then enjoy a cup of coffee with their friends or relatives. While one can appreciate the factors involved in the evolution of this service, one must be aware that this *could* be used as a means of continuing to deny the reality of the death.

PRESENTATION

Unresolved grief may present in one of a number of ways. The patient may simply tell you (the patient knows). In this presentation the patient will make a statement that clearly indicates that he/she believes that his/her current symptoms are due to the death of someone close (e.g., "I've never really been right since my father died"; "It all started three years ago, about the time my mother died"). With such a presentation, it is important to listen carefully and note exactly what the patient says because often the subconscious mind is trying to tell you just what the real conflict is (e.g., "You know, it was the first time I ever said 'I love you', and I do not think she heard me"; "If only I had come home half an hour earlier that day").

You may become suspicious as you talk to the patient during history-taking (the patient does not know but you suspect). In this case, the presenting problem may be included in a wide range of conditions, such as eating disorders, anxiety, panic attacks, insomnia, psychosomatic symptoms, identificatory illness, depression, behaviour problems, or phobic states. There may be some casual remark about the death of someone close or it may become evident in the family history. Close proximity of the date of onset of symptoms with the death should make one highly suspicious of the presence of unresolved grief. However, even if the date of the death antecedes the onset of symptoms significantly, this does not rule out the possibility of unresolved grief, as there

can be trigger incidents that bring the matter closer to the surface and hence the development of symptoms.

A few questions may quickly reinforce any suspicions that you may have: How did he die? Was he ill long before his death? Where were you when he died? How did you become aware that he had died? Did you see him dead? Did you go to the funeral? Was he cremated or buried? Do you think much about him now?

As you question, be alert to the non-verbals: the glistening eye, the avoidance of eye contact, the hesitation to regain composure, restlessness in the chair, the faltering voice. If doubtful, ask "How do you feel right now as we talk about your father?" There is little sense in asking a patient, "Did you cope okay with your father's death?", as so often "coping well" means they coped poorly by suppressing their emotions.

Sometimes a problem only becomes apparent during treatment (neither you nor the patient knows). These patients may present as in the above paragraph, but no connection has been made with bereavement. The true nature of the problem may only become apparent in hypnosis as one seeks to uncover the cause of the symptoms – ideomotor signalling, affect bridge, and corridor technique would be relevant. The bereavement may have been overlooked in taking the history or perhaps hidden, genuinely forgotten by the patient, or thought to be irrelevant, as is sometimes the case with an abortion.

MANAGEMENT

After obtaining a full history and family history, the nature of hypnosis is discussed during the first interview, questions are answered, and a positive approach to the resolution of the symptoms is taken. While quite firmly stating that I believe that the patient's symptoms can be overcome, I make no detailed explanation as to how that will be achieved. I tend to hasten slowly, so that the patient may become comfortable with me and with the hypnotic state. After the initial interview, my usual programme could continue as follows.

First Hypnotic Session

Eye fixation and progressive relaxation induction, moving into visual imagery relaxation, often seeding back to the past with a stroll through the family home in childhood. I encourage the experience of levitation and finally introduce the idea of a "safe place" to express feelings and "be yourself" in a "house on the hill."

Second Session

Modified Spiegel Induction with reverse arm levitation for deepening. I teach self-hypnosis and then focus on the idea of becoming responsible for one's own feelings (and hence not responsible for the feelings of others).

Third Session

After performing the Spiegel Induction and some deepening, I move into a grief reaction.

GRIEF REACTION

I have already stressed the importance of obtaining all the relevant details about the circumstances of the death. The aim of the therapy is to bring the past into the present; to allow the patient to be alone with the deceased very soon after the death and to encourage frank disclosure of thoughts and feelings to the deceased; and to encourage the patient to participate fully in a funeral service for the deceased.

In practice this means that, having induced a reasonable depth of hypnosis, I encourage the patient to go back in time to the death and to reframe the situation so that he/she can be there with the deceased. This may be achieved in a variety of ways. I may simply begin to relate to the patient the information given to me concerning the events leading up to becoming aware of the death and simply changing the tense. (E.g., "You remember how your father came into the kitchen that morning and said, 'Rosemary, would you go and check your mother?' You sensed immediately what had happened and you have a real mixture of feelings as you walk up the passage now and into your mother's bedroom. Close the door so it is just you and your mother.") It may be easily achieved by asking the patient to walk down a corridor with doors leading off either side, each door with a number that represents each year of life. The patient is asked to stop at the appropriate door and then the suggestion is given: "As you open the door, you are walking into your father's bedroom and becoming aware that your father has just died. I am ushering out anyone else there. Close the door so it is just you and your father."

I then encourage the patient to go to the bedside, take the deceased in their arms, and hold him or her close. I request an affirmative finger signal if they are able to comply. If not, I suggest they hold the hand of the deceased. Occasionally, even that is resisted. Ascertain why. It is usually a feeling of anger and this must be dealt with first before going on. The patients are encouraged to say *all* they need to say to the deceased and to be aware of anything the deceased may be saying to them. It may be very useful to suggest that they become the deceased and in turn have their say, especially where forgiveness is considered a key to unblocking the grieving process. When they have done that, I suggest I help them lay the deceased in the coffin, close it and assist them to take the coffin to the cemetery, and then attend the burial or cremation.

All this is done, step by step, allowing the patient to dictate the time for each manoeuvre. Reaction to this may vary greatly from very little external reaction through to obvious intense abreaction. However, very significant

physiological response can occur with little external evidence. Having tapped significant emotions, patients will often feel drained and it is prudent to warn them of this and to allow some time in hypnosis at the completion of imagery for recovery and for some ego strengthening.

At the following session one can assess the degree to which the intervention has been successful. In my experience there is often remarkable change in how they feel. At other times, there may still be evidence of other issues not yet resolved that need special attention. These can be dealt with either face to face or in hypnosis.

An Example

Presume the patient's name is Nancy, aged 33 years, whose father died seven years ago. She loved him dearly. She failed to visit him as usual the day before he died and became aware of his death for the first time when her mother rang. I then induce hypnosis and say:

Now as you relax, I want you to imagine that you are walking down a corridor with doors leading off either side. Each door has a different number and each number represents one year in your life. I want you to go back to door number 26, the door represents the twenty-sixth year in your life and when you get there raise your yes finger. [Wait until the yes finger is raised.]

Now as you open the door you immediately become aware that the phone is ringing, and when you pick up the phone you will become aware that it is your mother calling. She is telling you that your father has just died. You are now putting down the phone, getting dressed, going out and getting in your car and driving directly to the hospital. You are getting out of the car and going into the hospital and now you are standing at the door that leads into your father's room. I am going to clear everybody out of that room now and I want you to go into the room and close the door so that it is just you and your father. Go across to the bed and take him in your arms and hold him close. If you have any difficulty in doing this, raise your yes finger. [Pause]

As you hold him close, I want you to tell him everything that you want to say. Do not miss a thing. Tell him how much you love him. Tell him how much you care. Tell him how much you are going to miss him now that he has gone. Tell him that seven years from now you are still going to be very uncomfortable about the fact that he died. Tell him how guilty you are going to feel because you did not come in and see him on that last day. [Pause]

At times like this, it is not unusual to find that the words that you want to say do not come very easily. But because you know him so well, and he you, and because you are holding him so close now, you will find that somehow the words get through and if you listen very carefully it

may well be that your father is saying something to you. You can hold him for as long as you need to, and when you do not need to hold him any more, raise your yes finger. There is no hurry.

[Pause and wait for the yes finger to rise, which may only be a few seconds or it could be several minutes. If there is a lengthy delay, then it may be necessary to enquire if there is any difficulty. When the finger does rise, go on.]

Now just rest him back on the bed and I want you to take a step or two backwards. Look at him, Nancy. He is dead. He is not moving. He is not breathing. He is pale. And as you know, when someone dies we need to put their body into a coffin. The coffin is there. You can see it and when you are ready I will help you to put your father's body into the coffin. We will not do that until you are ready and when you are ready, just raise your yes finger. There is no hurry. [Await the raising of the yes finger.]

I am helping you to put your father's body into the coffin now. You can see your father's body lying in the coffin and soon I am going to put the lid on the coffin. But I will not do that until you are ready. When you are ready, just raise your yes finger. There is no hurry. [Await the raising of the yes finger.] I am putting the lid on the coffin now and I am going to help you to take the coffin with your father's body to the crematorium. You can see the coffin containing your father's body at the front of the crematorium now and I have a button, and when I push that button the coffin will slowly disappear. Indicate when you are ready, but before you do so I want you to make absolutely certain that you have said everything you want to say to your father. When you are sure of that, raise your yes finger. There is no hurry. [Await the raising of the yes finger.]

I am pushing the button now and the coffin containing your father's body is slowly disappearing from sight. It is gone. And now as you and I turn and come out of the crematorium, you will find an attendant at the front door with the urn of ashes. You may like to have them incorporated into a wall at the cemetery, or perhaps put under a rose bush, or perhaps scattered somewhere. On the other hand there may be a place that you know is very special to your father where you would like to put them, or perhaps a place that is very special to you. It may even be that there is a place that is special for you both. When you know what you want to do with the ashes, raise your yes finger. [Await the raising of the yes finger.]

Go and do it and then raise your yes finger.

[Await the raising of the yes finger. What follows now will be positive suggestions, indicating a return to normal, given more time. The drift of the suggestions will depend on the nature of the relationship between the patient and the deceased.]

Now you have said goodbye to your father, a person who is very special in your life. I often think of uncomfortable feelings rather like a cuckoo in the nest taking up all the room and denying space for other feelings. But today you have been able to let many of those uncomfortable feelings go and although that has not been pleasant for you, you will find now that you will come to feel better. You will have a feeling of relief, of having let something go.

You will find that you will continue to think of your father from time to time when it is appropriate, but when you do so you will find that many of your thoughts have turned to good memories, pleasant memories, memories that make him such a special person in your life. I am sure that your father would be pleased to know when you think of him you do so with a smile on your face, rather than a tear in your eyes. You will find, more and more, that you are able to speak more easily of him to others as the occasion arises and you may well find that you are able to have a photograph of him prominent in your house. But now as you continue to relax, you are turning and walking back out of that room and back into the corridor. Walk up the corridor now to door number 33, back to the here and now, and as you do so I want you to be thinking about what you are going to be doing for the rest of today and how you want to feel as you do those things.

Sometimes, particularly where it becomes obvious that there is some concern about the thinking of the deceased, I will vary the above at the time that they are holding on to the deceased person. Having held the deceased and then signalled that they have said as much as they need to say, I will continue:

Now I want you to come out of you and become your father and when you are your father, I want you to raise the yes finger. [Await the raising of the yes finger.]

Now you have been listening to what Nancy has been saying. You have heard what she is thinking and what she is feeling and I want you now to tell her all the things that you feel are important to say. When you have done that raise your yes finger. There is no hurry. [Await the raising of the yes finger.]

I want you now to come out of your father and be Nancy again and when you are Nancy, raise your yes finger. [Await the raising of the yes finger.]

Now you have heard what your father has had to say and I want you to think about that. It could be that there is something further that you want to say and now is the time to say it. When you have finished raise your yes finger. There is no hurry. [Await the raising of the yes finger. When the finger rises, I then suggest that they rest the deceased back onto the bed, stand back and look.]

FOUR CASE PROFILES

1. *Mr M.O.* (28 years), with a depressive reaction, was referred by GP. His wife had died after a 10-month illness with acute myeloid leukaemia, dying from a particularly nasty infection. He began to withdraw socially, gave up his work, took on tertiary education but failed to complete the first year. When I saw him it was two and a half years after his wife had died and he complained of feeling confused and of lacking direction in his life. Five months earlier he had been quite severely injured in a boating accident on the Murray and in an ironic twist of fate, awoke to find himself in the very ward in which he had sat and watched his wife die. After an initial two hypnotic sessions in which I taught him self-hypnosis, we did a grief resolving session which elicited moderate abreaction. One week later he reported that he was "exhausted" after the previous session. We went on to deal with his anger that his young wife should have died. One week later he was all smiles, feeling really well and ready for a three-week holiday. Twelve months later he remains well and now has a job in the public service.

2. *Mrs C.P.* (39 years), was referred by GP for tongue thrust that threatened current orthodontic treatment. She volunteered that her hypertension, diagnosed and treated for the last five years, worried her and she wondered if hypnotherapy might help. On taking the family history, she revealed she had had an abortion "I did not want to have" five years before. After two hypnotic sessions in which I taught her self-hypnosis and encouraged her to express some of her repressed anger concerning the abortion, we moved into a grief resolving session. She was encouraged to hold her baby, then to become her baby. Finally we buried her child. It took a further two sessions to deal with all her repressed feelings concerning those significant figures around her she perceived as having pressed her into the abortion. Her blood pressure subsided within six weeks and medication was ceased. Twelve months later she remains well and her blood pressure is normal.

3. *Mrs P.F.* (58 years), was referred by her GP because of her unresolved grief. Her son had been killed in a car accident on Mother's Day. The accident occurred in a country town five years earlier as he was returning to see her. She did not see her son dead and had completely rejected her husband, who identified the body and returned home to tell her the news. Since that time "I am existing, not living." "I was not even angry - too sudden - killed one day, cremated the next and then it was all over." She still expected her son to come home and had not visited the cemetery. At the second hypnotic session, we drove into the country and went back in time to happen upon a car accident in a country town. She fantasised being with her son in the ambulance to RAH and when he was certified dead. Time was given for her to hold him and talk and then I suggested she had to break the news to her husband. All this was accompanied by a moderate degree of abreaction. She chose not to put the body into the coffin till "later." The following week she was

already feeling better and had found herself laughing at times. We carried on with the funeral in trance amid more abreaction. She improved dramatically over the next week and seven years later remains fit and well, with a close relationship with her husband.

4. *Mr A.C.* (28 years) was referred by his GP with agoraphobia. He complained of a seven-year history of uncomfortable feelings when travelling in public transport, as a passenger in a car, at cabarets, in shops, etc. Recently he had noticed increasing difficulty riding his motorbike to work, becoming increasingly nauseated and even vomiting until he turned back to home. Family history revealed his father had suffered a "stroke" as he ran onto a football field when the patient was 13 years old. His father was in a nursing home for two years before he died and during that time the children were not permitted to see him. He attended the funeral but clearly recalled that he was the only one not crying. During the second hypnotic session ideomotor signalling revealed the origin of his current problem – he recalled seeing his wife placing flowers on her father's grave. When he returned the following week he explained that during the previous hypnotic session, as he watched his wife at her father's graveside, he had suddenly recalled his father's death and funeral. Hypnosis was then induced and we went back over his father's death, allowing him time to hold and talk to his father and then attend the funeral again. All symptoms had resolved two weeks later.

DISCUSSION

I am sometimes asked how patients react to the idea of talking to the deceased who is already dead. In my experience this has never proved to be a problem. The concept seems to be readily accepted and I feel that the experience of being able to see and talk with the deceased as a dead person seems to reinforce the reality of the death. It gives patients a parallel image of the deceased both alive and dead and it seems to promote the process of grieving. Furthermore, it reinforces the idea that the bereaved can talk to the deceased and vice versa, which many people find comfortable. A hypnotherapeutic approach to the problem of unresolved grief can be of value because it facilitates the diagnosis of the unresolved grief in cases where the patient may present with symptomatology apparently unrelated. The use of analytical techniques can quickly focus attention on the real problem.

In hypnosis, the mind returns to a primary process thinking mode, characterised by fantasy and imagery as distinct from the logic and reality orientation of the secondary process thinking. It allows, then, for a structured recall of memories and the feelings attached to them. The therapy can be directed by the therapist with immediate feedback available. Not only does this promote the setting for "remembering and repeating," but in unresolved grief it also allows for an ego state approach along the lines suggested by Barnett (1981), which promotes perspective and integration of the painful memories and experiences.

For example, patients can appreciate the fear of facing the future engendered at the time of the bereavement while at the same time reality testing is reassuring them that they will cope. Furthermore, hypnosis offers the opportunity to be exposed to the feelings in tolerable amounts (the grief reaction can be "held over" to the next session) and if necessary material that cannot be comfortably assimilated can be returned to the unconscious until it can be safely dealt with.

In cases where one is doubtful about the presence of unresolved grief, an unnecessary grief reaction in hypnosis will not cause any distress. I have had only one patient who was unable to go through with this procedure. She was in her early thirties and had suffered the loss of her very precious three-year-old child three years earlier when the child had been run over by a car. Within two years the mother was diagnosed as having leukaemia. Despite several attempts she was unable in trance to bring herself to take hold of her baby in her arms and eventually she withdrew from therapy. She died within twelve months.

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CASE NOTES, TECHNIQUES, AND ANECDOTES

This section of the Journal is a forum to which readers are invited to contribute brief items drawn from their own experience. These may be vignettes of case situations, unusual or ingenious devices and techniques, or simply thought provoking experiences.

Correspondence regarding these items is also invited.

MUSIC AS A PATHWAY FOR SELF-HYPNOSIS

Wendy-Louise Walker

When I am using hypnosis in the treatment of stress and anxiety, I mostly set "homework" to be carried out between therapy sessions. Often I simply have my patients practise in everyday life skills they have learned in hypnosis. If I want them to practise with self-hypnosis, that is, to produce a marked alteration in consciousness, I like to ensure that their solo hypnotic trips will be positive and not negative experiences.

Ensuring that self-hypnosis is a safe and happy experience can be a problem with psychologically damaged highly hypnotisable patients. Highly hypnotisable people, the one or two in 10 who are the hypnotic virtuosi, are accustomed to spontaneous hypnosis-like shifts in consciousness in everyday life. When the highly hypnotisable are psychologically damaged, they often have difficulty with self-hypnosis. In the clinical situation, such a patient has the safety and protection of a guide – the hypnotist/therapist. If instructed to use self-hypnosis at home, the gifted subject *can* go into trance very readily, giving him/herself the hypnotic instructions. However, like the sorcerer's apprentice, such a patient does not always maintain a positive directing of experience and imagery. In my experience, the hypnotic virtuoso patient needs careful instruction in exactly how to carry out self-hypnosis and in exactly what is to be done in that altered state of consciousness. In this context, I have found music to provide a safe and delightful pathway for sessions of self-hypnosis.

For less hypnotisable patients, music can also provide a pleasant framework for sessions of self-hypnosis and can be very useful for the patient who has

difficulty in suspending self-watching. In using hypnosis therapeutically, I commonly use music as a deepening technique (Walker & Diment, 1979). My patients are thus accustomed to the experience of using music as a pathway into an altered state of consciousness and they find this congenial. For self-hypnosis in the times between therapy sessions, I first discuss plans with the patient, in the waking state. I find out what music the patient has available and, if necessary, give the titles of some appropriate pieces from my own collection. As music has powerful effects on emotion in the waking state and as these effects appear to be augmented in hypnosis, we find pieces that are enjoyable for the patient and that produce positive emotions rather than negative ones. It is likely that the patient would start by using pieces that he or she is accustomed to in the hetero-hypnosis situation for deepening. Such pieces could range from, baroque chamber music, Renaissance dance music, right through to pieces by Halpern on the synthesiser. I explain to my patient in the waking state that the music in the self-hypnosis experience will provide a focus of attention, a beginning and an end of the trance experience and, further, that it will define the experience as a pleasant and a positive one. I will then outline the specific goals for self-hypnosis with this patient – I would not use self-hypnosis without carefully defined goals specific for that patient, especially with the highly hypnotisable.

In hypnosis, after the therapeutic work for the day had been done and before bringing the patient back to the waking state, I would give instructions for self-hypnosis. If the area were stress management in a highly hypnotisable but reasonably well adjusted person, my instructions might go something like this:

Now listen carefully while I explain how you will use the experience of hypnosis at home to break the spiral of mounting tension and anxiety in everyday life. Each day, when you come home from work, you will take 20 or 30 minutes just for yourself, as we agreed in our conversation a little while ago. You will select an audio tape of the right sort of music, warn the family to leave you alone for 20 or 30 minutes, start the music playing and lie down quietly on the lounge. You will close your eyes, say to yourself, "Now I am going into hypnosis," and focus your attention on the music just as you do with me when you are using music as a pathway to take you into hypnosis. You will quietly, almost automatically, let your body relax each time you breathe out as you focus your attention on the music and you will let the music become a moving pathway of sound that carries you, peacefully and happily, into hypnosis.

The further the music takes you, the more involved you will become in listening to it and the further things around you will fade away beyond the peripheries of awareness. As you go on listening to the music, losing yourself in the experience of moving further with it, your body will become profoundly relaxed while you experience whatever delightful fantasies or

images the music makes in your mind. Whatever you experience will be pleasant, since the music will structure your experience and rule out the possibility of your thinking or feeling anything negative. As the music goes on, you will go further and further into hypnosis. When the music ends, no matter how far you have gone into hypnosis, you will register that the music has ended and you will calmly, peacefully, and deliberately bring yourself back to the normal waking state. You will feel very refreshed after the session. Each time you practise self-hypnosis in this simple and delightful way, it will become easier and more effective. It will break the build-up of tension from the working day before you join the family circle. The effect of this over a couple of weeks will be quite magical.

Should someone barge into the room or the phone ring, there will be no problem. You will simply let your mind slip back to the waking state with no more disruption than waking from a light sleep.

This is a special way of listening to music and you will only do it on purpose to go into hypnosis, only when you say to yourself, "Now I am going into hypnosis." You *will never* do this accidentally when listening to music in the ordinary way. It will *never* happen when you are driving a car. It is a special experience that you will only produce on purpose.

Now we will return to the waking state. Afterwards I will play a piece of music and you can practise putting yourself into hypnosis here with me. Then you will be confident by yourself.

After return to the waking state and before general debriefing, I would say to the patient:

In a little while I will play some music for a few minutes. You will close your eyes, say to yourself the magic words, "Now I am going into hypnosis," focus your attention on the music and let it become a moving pathway of sound to take you into hypnosis . . . When you hear the music stop, you will calmly and deliberately bring yourself back to the waking state, by counting backwards from 5 to 1; 5, 4, 3, 2, 1, just like that. Any questions? Okay, here is the music . . .

Before sending my patient home with the task, I reinforce the notion that this is a special way of listening to music, of becoming lost in it, and that it is only to be done on purpose in a safe place, not behind the wheel of the car. Specific *content* can be added to the experience for individual patients, that is, things to experience, or suggestions can be made in hetero-hypnosis. For example, it can be suggested that after each session of self-hypnosis, the patient will feel more optimistic, competent, and in control or will become increasingly sensitive to beautiful things in the world around. Such suggestions would be reinforced in subsequent therapy sessions.

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BOOK REVIEWS

Case Approach to Counseling and Psychotherapy. Gerald Corey. Monterey, CA. Brooks/Cole. 1982. xi + 131. No price given.

The aim of this book is to bridge the gap that the author perceives as lying between the theory and practice of counselling. It was written to supplement the core textbook that he has written on counselling, with case illustrations and discussion. Aimed at students of psychotherapy, it uses one hypothetical case of a middle-aged, emotionally repressed woman in each of eight therapeutic approaches – psychoanalytic theory, existential therapy, person-centred therapy, Gestalt therapy, transactional analysis, behaviour therapy, rational-emotive therapy, and reality therapy. In the last chapter, the author describes how to work with the same client eclectically, fashioning his own therapeutic approach from some or all of the theoretical stances, and pointing out how the approaches he selects and emphasises would vary with different clients.

As well as the one case used consistently to illustrate all therapeutic approaches, other clients are used in each chapter to illustrate various uses of the techniques, including an eight-year-old boy who was abused by his father, and a male homosexual couple. At the end of each chapter is a list of questions, encouraging students to analyse the usefulness of each approach, compare their merits and disadvantages, and to think about how they would use them.

Hypnosis would be a useful adjunct for most of the techniques described. General practitioners and other clinicians who use hypnosis, but are not familiar with a variety of psychotherapeutic techniques, would find this book a clear and useful guide to broadening their therapeutic skills, provided they remain within their range of training and expertise. Psychologists may find it useful to brush up on some techniques they may not have thought about since their student days.

I found the book carefully written and thorough, although I felt a slight sense of irritation in "Ruth's" descriptions of her progress sounding more like the descriptions of a therapist (as indeed they were) than of a client. The strongest point of the book is its emphasis on eclectic and creative therapy. The importance placed on the therapist's being aware of his or her own feelings and input into the therapeutic scenario is most welcome, as it is too often neglected in clinical writings. In all, it is a thorough and competent coverage of the eight therapeutic modalities and their uses.

SUSAN BALLINGER, Randwick and Nowra, N.S.W.

One to One: Experiences of Psychotherapy. Rosemary Dinnage. Harmondsworth. Penguin. 1989. 218. \$12.99, paper.

Treat yourself to a fascinating read that looks like work.

The book is an account of interviews with 20 people who have been, and in some cases still are, in long-term psychotherapy. Each tells his or her story of the impact of the therapy and the therapist. The chapters are introduced by a mini sketch of the person's living conditions and interactive style. It's rather like looking over someone's bookcase. My only problem was rationing myself to one story per night.

One to One gave me insights into many puzzling issues, such as the patient who seems not to be making progress but insists on staying in treatment. I must say that some of the accounts reinforced my belief that long-term therapy can simply confirm a patient's belief that change is impossible.

There are many themes running through the stories, and perhaps the best way to give the flavour of the book is to choose a few of these and illustrate them by quotations.

Does it work?:

I was struck many years ago by something a senior analyst said. "You know," he said, "analysis can do very little, but just occasionally that little is enough." And I think that's it in a nutshell. (p. 38)

I don't expect to be *happy* exactly, but I don't think I'll have to go around hating myself all the time – just disliking myself some of the time. (p. 129)

Symptom impact:

I got much worse symptom-wise during the treatment, to the point where I was terribly nervous about travelling or going out anywhere. (p. 138)

Termination:

I think we felt the time was right to stop. (p. 129)

I can't remember exactly what he said . . . it was that he wouldn't go on seeing me, basically that I was impossible . . . that there was nothing to be done about me. So there I was, chucked into the bloody dustbin. (p. 139)

Dependency

I was afraid of getting too committed. (p. 128)

I wonder if the most important ingredient in therapy might not be the provision of a relationship in the life of a bleak, lonely person.

One doesn't need to be a Freudian to recognise oneself in these fascinating vignettes. Enjoy them.

LORNA CHANNON-LITTLE, Behavioural Sciences in Medicine, University of Sydney.

Developing Ericksonian Therapy: State of the Art. Jeffrey K. Zeig and Stephen Lankton (Eds.). New York. Brunner/Mazel. 1988. xxxi + 523. \$89.00, cloth.

This volume presents the proceedings of the Third International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy held in Phoenix, Arizona, 3-7 December, 1986. More than 70 presentations were delivered and 30 of these form the chapters of this book. The Principles section includes such as "Position Statements" and "Utilisation Approach"; the Practice section includes such as "Therapy Techniques," "Tailoring Treatment," and "Marital and Family Therapy."

Authors include traditional Ericksonian presenters including Rosen, Barber, O'Hanlon, Rossi, Yapko, Lankton and Lankton, Gilligan, and Zeig as well as other notables such as Satir, de Shazer, and Johnson. A panel of Erickson's children gives insights into Erickson the man.

Each chapter provides an individual view of some aspect of working effectively to assist human beings in dealing with their human dilemmas. Questions such as "what makes Ericksonian therapy so effective?" (Rosen) are juxtaposed with the call for more rigour and follow-up rather than cleverness (Barber), concerns about manipulation (Booth), the need to discuss the problem with the client (O'Hanlon).

Readers of this volume are given the opportunity to explore their own interaction with the wide variety of presentations. Although the focus is Erickson's approach, the topics, ideas, and questions extend beyond Erickson – as would be expected from Erickson's own personal way of working – and so interested readers will include those wanting to learn about Erickson, those wanting to deepen their understanding and exploring, and anyone asking the question "what makes therapy effective?"

This book is about "Developing" rather than just Erickson. It is about effective therapy – the State of the Art.

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