

PSYCHOLOGICAL INTERVENTIONS FOR COPING WITH SURGERY: A REVIEW OF HYPNOTIC TECHNIQUES

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Illness, hospitalisation, and surgery pose many severe stresses for many patients, to the extent that their ability to understand and cope with what is happening may be significantly reduced. Many of these stresses result from the nature and significance of patients' surgical procedures and post-operative treatment. This paper reviews the range of psychological interventions aimed at helping patients cope with pre- and post-operative treatment regimens. The range and content of hypnotic interventions are examined in detail. It is concluded that more rigorous research studies are required to determine the relative effectiveness of different types of interventions and to evaluate the effects of patients' psychological characteristics on the effectiveness of these interventions.

When people fall ill, require hospitalisation and surgery, they are often poorly equipped to deal with the pain, discomfort and stress of their medical condition, or of the diagnostic and treatment procedures required. Because of this lack of preparedness, a significant number experience acute psychological distress. When hospitalised for surgical procedures, over 75% of patients exhibit some psychological trauma and many show continuing psychological problems long after their discharge from hospital (Nichols, 1984). Mayou, Foster, and Williamson (1978) found that 12 months after cardiac surgery, 64% of patients were still experiencing tension, anxiety, and fatigue, with marked declines in many patients' quality of life. Morris, Greer, and White (1977) found that 30% of patients who had had a mastectomy reported stress associated with their surgery 12 months after the operation. Problems of post-operative distress and long-term rehabilitation characterise oncology patients (Wellisch, 1981) and general surgical patients report similarly high levels of distress long after their surgery (Nichols, 1984). These experiences of illness, diagnostic procedures, treatment regimens, and associated psychological reactions negatively affect patients' recovery from illness, increase the duration of hospitalisation, and provide further stresses for already overburdened hospital services.

At the time of their surgery, most patients are suffering considerable psychological stress, relating to the nature of the surgical intervention, the likely outcomes, and the pain and trauma they may experience (Nichols, 1984). In some situations where surgery is required, these stresses may appear intolerable; for example, when the operative procedure requires lengthy hospitalisation (Fredericks, 1978; Nichols, 1984) or in the case of surgical procedures involving the cardiovascular system, with the consequent fear, concern, and anxiety heart surgery causes (Marmer, 1959). In preparing patients for surgery the aim of interventions is to reduce their stress and distress at being subjected to unpleasant medical procedures. Primarily these aims are to: (a) reduce patients' stress, mainly based on anxiety and the implications of their surgery and recovery; (b) enhance patients' pain coping strategies; and (c) facilitate patients' physical and psychological recovery processes.

Researchers have examined how patients may best be prepared for hospitalisation and surgery, and various interventions have been developed to help patients cope with these stressors. These include (a) pre-surgical information giving, which may be either about procedures or descriptions of likely sensations that may be experienced; (b) behavioural interventions such as modelling, relaxation, or hypnotic techniques, or (c) cognitive-coping strategies (Mathews & Ridgeway, 1984). Cognitive-coping strategies involve having patients identify their fears and worries regarding the surgery or treatment; correcting inappropriate beliefs on which these fears are based; and intervening to assist the patient cope with the treatment process using such techniques as pain management strategies, self-distraction techniques, and/or positive self-talk.

INFORMATION GIVING

There is no doubt that information generally reduces patient anxiety (Johnson & Leventhal, 1974; Kendall et al., 1979) and reduces the requirements for sedation and analgesics (Johnson & Leventhal, 1974; Langer, Janis, & Wolfer, 1975). Many studies have compared the effectiveness of providing *procedural* information (a simple, objective description of the sequence of events involved in a diagnostic or treatment procedure) and *sensory* information (an objective description of the likely sensations experienced by patients undergoing the procedure, such as pain, discomfort, sights, smells, sounds, and tastes).

Studies with a number of different surgical and medical procedure have shown that sensory information is generally superior to procedural information in reducing stress and distress. These have included endoscopy (Johnson & Leventhal, 1974; Johnson, Morrissey, & Leventhal, 1973); laparoscopy (Reading, 1982); female pelvic examinations (Fuller, Endress, & Johnson, 1978); dental surgery with children (Siegel & Peterson, 1980) and with adults (Auerbach & Kendall 1978); and pregnancy terminations (Brockway, Plummer, & Lowe, 1976).

A preference for general or specific information appears to reflect the personality characteristics of the patient. While there is no doubt that information generally reduces patient anxiety (Johnson & Leventhal, 1974; Kendall, 1979) and reduces the requirements for sedation and analgesics (Johnson & Leventhal, 1974; Langer et al. 1975), specific information has been found to be more effective with patients who adopt an internal locus of control and who show a desire to seek out information (Pickett & Clum, 1982; Kay, 1984). Auerbach, Kendall, Cuttler, and Levitt (1976) suggested that specific information is more effective than general with individuals with an internal locus of control, and general information more effective than specific with those with an external orientation. This has been confirmed with coloscopy (Miller & Mangan, 1983) and with general surgery (Auerbach, Martelli, & Mercuri, 1983) patients.

COPING SKILLS

A number of studies have shown that coping skills training helps patients deal more effectively with surgical stress. Langer et al. (1975) found selective attention along with coping self-talk, and these strategies combined with pre-surgical information to be equally effective and each was superior to information alone, in reducing pre-surgery anxiety and post-surgery analgesic and sedative use. This has been confirmed with cardiac catheterisation patients (Kendall et al. 1979) and with children undergoing tonsillectomy (Peterson & Shigetomi, 1981).

Personality factors in surgical patients influence the efficacy of their response to coping skills interventions. In gall-bladder surgery patients, cognitive coping strategies have been found to be more effective with those who have an internal locus of control (Pickett & Clum, 1982).

The available research data suggest that cognitive-coping strategies are more effective than procedural information alone, sensory information alone, and combined procedural and sensory information, assessed using both physical and psychological measures (Kendall & Watson, 1981; Mathews & Ridgeway, 1984).

POST-OPERATIVE COUNSELLING

No studies evaluating the efficacy of post-operative recovery counselling have been found. Such recovery counselling addresses the issues raised in the patients' surgical experience and those related to appropriate recovery processes, including duration of discomfort, expected course and time of the recovery process, and residual difficulties with which patients may have to cope.

Although not yet demonstrated in research studies, the evidence suggests that for maximum effectiveness, interventions must be provided when most needed by patients. Prior to hospitalisation, patients need to know about hospital procedures and how they will be prepared for surgery. Once in hospital

and before the actual surgery, they need to know about physical reactions they are likely to experience and to receive training in specific coping skills to reduce pain and discomfort (Kendall & Watson, 1981). Following their surgery, patients need information regarding their longer term recovery and specific instructions on how best to cope with their changing physical status.

HYPNOTIC INTERVENTIONS

There have been a number of studies investigating the effectiveness of hypnotic interventions with surgical patients. Most of these, however, are based on clinical reports and many studies which have been undertaken lack scientific rigour. This may be due to a lack of adequate controls, small sample sizes, inadequate statistical procedures, and/or invalidated outcome measures. Most studies have also been characterised by the lack of potent, psychotherapeutic interventions. The few attempts which have been made for controlled investigations have demonstrated only trends in terms of patient outcomes.

A number of studies have examined the usefulness of systematic relaxation as an intervention in cardiac surgery. This procedure has been shown to be of considerable benefit to patients by reducing both pre- and post-operative levels of anxiety, depression, and psychological distress (Bohachick, 1982). Horowitz, Fitzpatrick, and Flaherty (1984) demonstrated some support for the hypothesis that relaxation techniques decrease pain related to ambulation in post-operative open-heart surgery patients. Leserman, Stuart, Mamish, and Benson (1989) concluded that practising the relaxation response before and after surgery may reduce post-operative supraventricular tachycardia, tension, and anger. Valliant and Leith (1986) combined cognitive psychotherapy with progressive relaxation training in a combined package with cardiac surgery patients. Results showed that the treatment led to a significant increase in self-esteem and a decrease in depression.

Interventions involving the use of hypnosis and hypnotic states have been shown to be beneficial in the recovery of a wide range of surgical patients. Early studies of hypnotic interventions were largely clinical case approaches, with few, if any, researchers comparing experimental and control groups of patients. As many researchers have commented, objective measurements of patient outcomes following hypnotic interventions in surgery are also difficult to carry out (Kolouch, 1962, 1964).

Hypnosis has been used with a wide variety of surgical patients, including both hospitalised patients and those undergoing surgery at outpatient clinics. A range of minor pathological conditions, usually surgically treated with local anaesthesia, in which hypnotic interventions have been used have included removal of moles and subcutaneous cysts, treatment of lacerations, lipomas, abscesses, melanomas and haemorrhoids. The hypnotic intervention was usually used to ensure comfortable immobilisation of the patient and for post-operative analgesia. For hospitalised patients undergoing surgery, hypnotic interventions

have been used for laparotomies, thyroidectomies, simple to radical mastectomies, cardiac and orthopaedic surgery, gastrectomies, cholecystectomies, and colectomies. Generally, the more serious the surgery, the less effective the hypnotic intervention appears to be (Kolouch, 1962, 1964).

Generalising across these studies, the evidence suggests that hypnosis does have a wide number of applications in helping patients cope with the physical and psychological stresses of surgery. These may be summarised as follows:

1. Hypnorelaxation can be used to help patients relax and reduces anxiety, so that patients may then be given procedural and sensory information (Kolouch, 1962). This application may be extended to patients who have fears and concerns about their surgery, induced by previous surgical experiences, with age regression and ventilation being used to reduce or remove these fears (Kolouch, 1964).

2. Some studies have reported that patient anxiety can be reduced to the point that little or no premedication is necessary (Fredericks, 1978; Kolouch, 1962).

3. Less chemical anaesthesia may be required for hypnotically prepared patients, contributing to lesser incidence of toxic side effects from anaesthetic agents (Fredericks, 1978; Marmar, 1959).

4. Patients' normal reflexes are usually not depressed by hypnosis, so that there is more rapid recovery from procedures associated with the surgery and quicker return to a normal functioning state (Fredericks, 1978). Post-hypnotic suggestions can contribute to a more rapid return of physiological functioning, such as urination and defecation (Fredericks, 1978). This serves to help patients feel more relaxed and comfortable following their surgery (Fredericks, 1978) and reduces their requirement for pain-killing medications (Kolouch, 1962, 1964; Gruen, 1972).

5. Hypnosis can be used for pain control, both pre- and post-operatively, using such techniques as direct suggestion, glove anaesthesia, displacement or alteration of the painful symptom, and dissociation (Gruen, 1972; Hilgard, 1980; Kolouch, 1962).

6. Post-operative discomfort and pain can be reduced through the use of such techniques as post-hypnotic suggestions, ideosensory and ideomotor control creating analgesia, anaesthesia and muscular relaxation (Doberneck, Griffen, Papermaster, Bonello, & Wangenstein, 1959; Kolouch, 1962, 1964; Van Dyke, 1970).

7. There is some evidence that hypnotic interventions lead to reduced length of post-operative hospitalisation and reduced incidence of post-operative convalescence problems (Fredericks, 1978; Gruen, 1972; Kolouch, 1962).

8. Severely injured patients can have wounds and fractures treated less painfully, even if they have not been hypnotised previously (Fredericks, 1978).

9. The ingestion of a meal prior to an accident will not delay prompt treatment when hypnosis is used instead of a general anaesthesia (Fredericks, 1978).

Clinicians have frequently commented on the powerful impact of suggestions made to surgical patients and their receptivity to suggestions for pre-operative relaxation and post-operative pain reduction and a generalised comfort following surgery (Doberneck et al., 1959; Hart, 1980; Kolouch, 1962, 1964; Marmer, 1959). The interventions often contribute to patients' reporting that they feel relaxed and comfortable, together with increased confidence and optimism regarding the surgical outcomes (Kolouch, 1962; Van Dyke, 1970). Van Dyke (1970) also commented that patients' increased suggestibility and receptivity to hypnosis frequently ensured quick inductions, countering the wider perception that patient interventions involving hypnosis could be time-consuming and therefore difficult to complete.

Many of these case study analyses of hypnotic interventions in surgery have suggested that there is an association between patients' subjective reports of the usefulness of the hypnotic technique and the objective success of the technique, in terms of reduced pain, medication consumption, and duration of hospitalisation. For example, Kolouch (1962) reported reduced length of hospitalisation for those patients who reported the greatest benefit from hypnosis and Kolouch (1964) found lesser need for pain-killing drugs and post-operative hospitalisation for those patients reporting increased efficacy of the hypnotic intervention. In a more controlled study, however, Field (1974) found no correlation between patients' verbal reports of benefit from listening to tape-recorded induction techniques and depth of relaxation. These findings suggest that physicians' and hypnotists' ability to positively influence patients' physical and psychological outcomes from surgery is a powerful aspect to the physician-patient relationship.

Several research studies have compared patients' recovery from surgery, using experimental and control groups. Hart (1980) compared a group of 20 open-heart surgery patients given a tape-recorded hypnotic induction procedure to prepare them for surgery, with a similar group given standard hospital care. Patients were matched on type of surgery, surgical team, age, sex, socioeconomic status, and pre-operative diagnosis. The induction material was presented in five sessions, with an introductory explanation of hypnosis and relaxation induction on the first, followed by four 20-minute induction sessions. Outcome was evaluated using a relaxation measure of blood-pressure readings, total units of blood required post-operatively, and anxiety and locus of control ratings. The experimental hypnosis group required significantly fewer units of blood, showed significantly lower state anxiety and significantly higher internality on locus of control. Hart (1980) concluded that the small study lent support for the belief that the tape-recorded hypnotic induction lessened state anxiety and promoted a more self-directed attitude towards surgical recovery.

Field (1974) matched two groups of 30 patients awaiting orthopaedic surgery. The experimental group heard a 20-minute tape-recording that gave suggestions of drowsiness, relaxation, comfort, freedom from pain during and after surgery,

quick recovery, and confidence, together with simple information about the surgery. The control patients listened to a tape describing facilities in the hospital. The two groups did not differ on surgeons' ratings of nervousness on the day of surgery, or on surgeons' ratings of recovery. The researchers reported low correlations between observers' ratings. Within the experimental group there was a significant negative correlation between depth of trance and nervousness (-0.49) and positive correlation between depth of trance and speed of recovery (0.46).

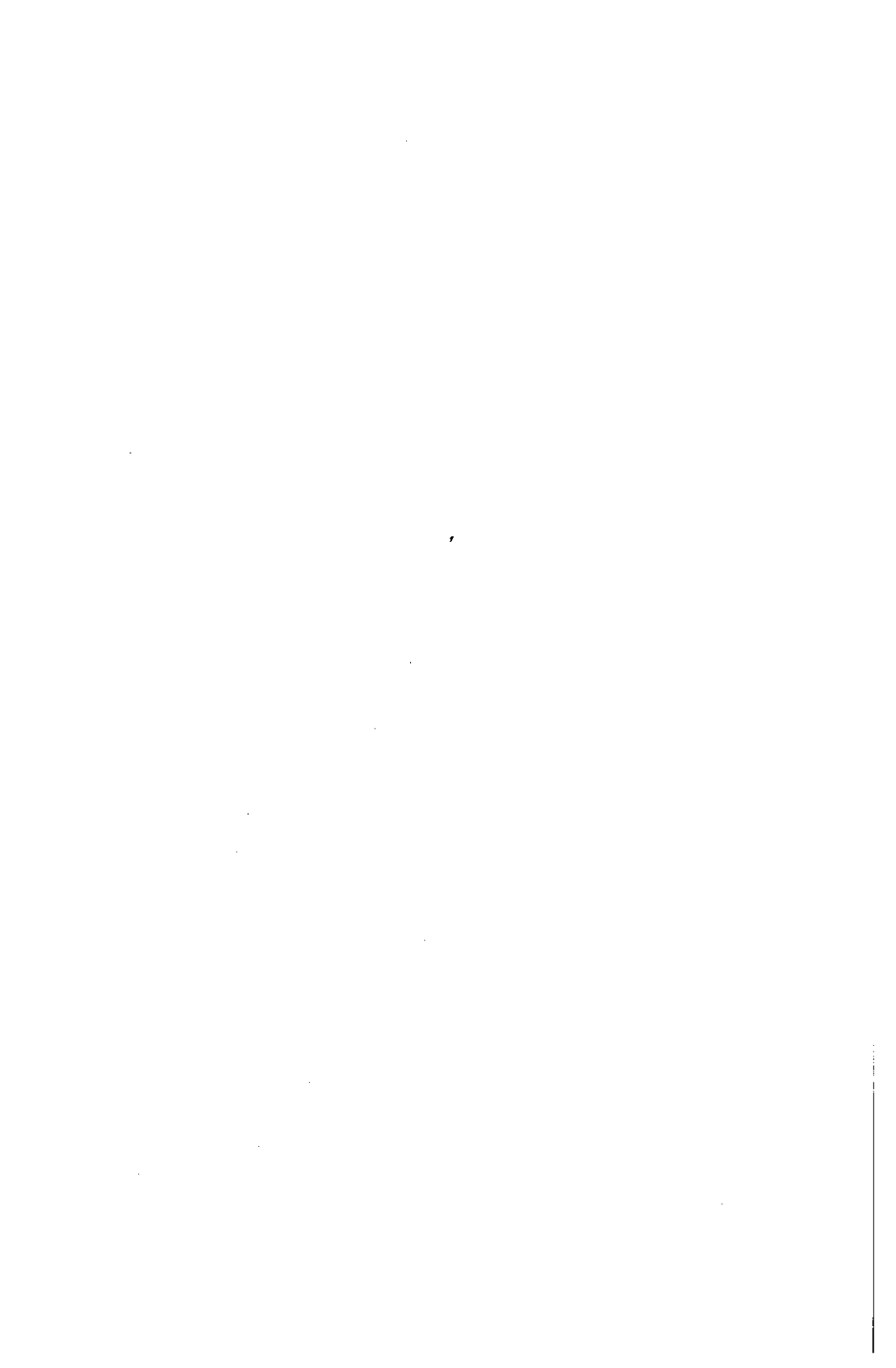
In summary, the anecdotal and limited research evidence available to date suggests that hypnosis may be a powerful intervention to help patients cope with the many stresses of hospitalisation and surgery. At the very least, the research studies show quite effectively that patients report that the use of hypnotic techniques reduces their fears and concerns and creates feelings of optimism, confidence and hope (Doberneck et al., 1959; Kolouch, 1962, 1964; Van Dyke, 1970). These positive influences on patients' morale and motivation for getting well all aid in their recovery processes.

Without the conduct of experimentally rigorous research projects, utilising experimental and control groups of patients and more objective outcome measures, it is not possible to assert categorically that hypnotic interventions are any more useful than other cognitive-coping strategies available in the medical literature. Additionally, more attention must be given to the content and process of hypnotic interventions to evaluate their relative efficacy. For example Surman, Hackett, Silverberg, & Behrendt (1974) found no differences between experimental and control groups using an auto-hypnotic technique with cardiac surgery patients. It was the researchers' conviction that hypnosis can be of great benefit in maintaining mental equilibrium following extensive surgery and in reducing physical distress; but that their investigation demonstrated that a single pre-operative visit to the patient to teach the intervention does not amount to an adequate psychotherapeutic strategy. There have been no research studies which have evaluated the effectiveness of specific hypnotic techniques in patients' pre- and post-operative preparation and management. Nor have researchers evaluated the effects of various personality characteristics on the effectiveness of hypnotic interventions. It has already been seen that patients' coping efficacy may depend on the presence of personality characteristics, such as locus of control (Kay, 1984; Pickett & Clum, 1982). Other studies of preparation for surgery have stressed the need to tailor any psychological preparation to fit different personality types (Andrew, 1970; Field, 1974) and similar studies need to be carried out before it will be possible to evaluate fully the potential of hypnotic techniques to help patients cope with the physical and psychological stresses of hospitalisation and surgery.

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IMPOTENCE: A SHORT-TERM TREATMENT

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A brief review of the literature pertaining to the use of hypnosis in the treatment of impotent males is outlined. This is followed by a description of a two-session treatment which has enjoyed considerable success in the alleviation of the problem. The approach combines a number of different techniques, specifically (a) Bandler's theatre technique for phobics, (b) Stein's clenched-fist technique, (c) the cloud metaphor, (d) the pyramid metaphor, and (e) ego-state reframing. Although it is suggested that the order in which these techniques are used over the two sessions may have some influence on its effectiveness, two case studies are used to illustrate how the various elements may be varied to meet specific needs.

Masters and Johnson (1970) define impotence as a sexual inadequacy disorder in which the male is not able to achieve and/or maintain an erection sufficient to accomplish successful coital connection. In this disorder, the male is not able to initiate or complete sexual intercourse because either he does not develop an erection or, if he does do so, he is unable to maintain it.

Though Kaplan (1974) has suggested that approximately half the male population of the United States has experienced occasional transient episodes of impotence, attempts to assess the extent of the problem have been hampered by the fact that "impotence" does not exist as a diagnostic entity in any of the American Psychiatric Association's diagnostic and statistical manuals.

Though the cause of the impotence can be physical, more frequently it has a psychological origin. Reviewing cases where a thorough physical examination had been carried out to detect the existence of physiological causes, Nadelson (1978) estimated that "impotence is psychological in about 85% of all cases," a conclusion echoed by Rockwell (1987) as being a reasonable summary of current opinion.

Due to the delicacy of the autonomic vascular reflexes which govern erection, unconscious conflict and emotion, particularly anxiety, fear, anger, and depression, are likely to impair erective reflexes, making impotence one of

the most clearly defined psychosomatic disorders. The impotence-creating process commonly occurs when a formerly potent male loses his erection and is unable to complete the sex act. Remembering his failure, he becomes fearful that, on future occasions, the same event will occur. The fear itself inhibits erection; thus his belief that he will not be able to function fully is reinforced and a fear of poor performance takes on a life of its own. The harder he tries, the worse his condition becomes. The problem is compounded both through the extra attention given to it and through his frantic efforts to force an erection.

In treating the problem of impotence, hypnotherapy has been employed with some degree of success. Using a mixture of hypnotic suggestion, reciprocal inhibition, and hypnoanalysis, Mirowetz's (1966) 42 male patients recorded an 81% success rate. Although impotence was not the only type of sexual dysfunction involved, Fabbri's (1976) 78 patients showed a 72% success rate as a result of treatment with a combination of hypnosis and behaviour therapy. When he included, in the positive outcome group, those subjects who were able to achieve erection on most occasions, the overall improvement rate was 91%.

Although he gives no precise figures, Deabler (1976) has also reported success with the use of hypnotherapy. His was a more hypnoanalytic approach, being directed towards the uncovering of unconscious inhibitions, the detection and release of fear, anxiety, guilt and anger; the positive reinterpretation of sexual stimuli; and the delivery of ego-strengthening suggestions.

As these approaches are of less than one year's duration and involve fewer than 20 sessions, it seems reasonable to consider them as brief therapies. This is particularly true for DeShazer (1980) who used only a single therapeutic session. His description of three case studies is a useful illustration of the value of a permissive approach embodying indirect, symbolically related symbols and suggestions in the treatment of erectile dysfunction.

In direct contrast is Crasilneck's (1982) conclusion that a very authoritarian approach is necessary in the treatment of impotence for it enables the hypnotherapist to transfer this dominant attitude to the patient who, in turn, exhibits authoritarian control over his own bodily functions. As Crasilneck's conclusion is based upon a total of 1,875 males treated for psychogenic impotency over a period of 29 years, it must be taken seriously, particularly as he found hypnotherapy to be successful with patients who had been non-responsive to pharmacological methods. Again the treatment may be considered as brief, the average number of sessions required to bring the symptoms under control being five and the average over the whole treatment being ten. One year after terminating treatment, 87% of his subjects reported freedom from impotency without symptom substitution.

Dubey, Dwivedi, and Kumar (1986), working with 50 cases of psychogenic impotence, achieved a much lower success rate with 20% of their patients reporting mild to moderate improvement. However, 80% expressed satisfaction

at the end of the treatment, the central aspect of which was hypnotic relaxation therapy.

TREATMENT METHOD

The present treatment may also be subsumed under the rubric of brief therapy. Two sessions spaced three weeks apart are used. Within these sessions, a number of different techniques are employed, usually in the order described below. However, should it be deemed appropriate, this sequence may be varied to meet the needs of the specific case. After initial history taking, treatment begins with a modification of Bandler's (1985) *rapid phobia cure* technique. The following steps are involved:

1. The patient imagines he is sitting in the middle of a movie theatre. On the screen before him is a black-and-white snapshot of himself just before the first occasion on which he failed to achieve an erection. Alternatively, instead of this first occasion of impotence, the patient may prefer to use another episode which may have been particularly traumatic.

2. The patient then floats out of his body up into the projection booth of the theatre, from which point he "watches himself watching himself." Looking down, he is able to see himself sitting in the middle of the theatre, and also see himself in the still picture on the screen. Use of this double dissociation permits the patient to distance himself from the events which are being portrayed on the screen so that he may view the traumatic episode without becoming overly upset.

3. That snapshot up on the screen is then transformed into a black-and-white movie, which is to be watched from the beginning until just beyond the end of the unsuccessful sexual experience. The patient sets his own speed for viewing this movie.

4. When this end point is reached, the patient stops the movie, makes it into a slide, turns it into colour, then jumps inside the picture and runs the movie backwards, taking only 1-2 seconds to do so. Everything is to take place in reverse with people walking and talking backwards. Anything, such as a crazy soundtrack, which might make the movie more ludicrous, is added.

5. The film, in colour and with the patient still "inside" the picture, is run forward again. This time, however, it depicts the situation the way the patient would have liked it to have been. Accordingly, the impotence patient "sees" himself enjoying the previously traumatic episode, achieving and maintaining his erection in the way he desires. Although this fifth step is not part of the Bandler method, it has proved to be a useful addition.

After the patient has completed the remaking of his failure experience in the theatre of his mind, he is introduced to the *clenched-fist technique* (Stein, 1963) modified to meet the needs of individuals seeking help for impotence.

The patient is asked to concentrate upon a very positive sexual experience. As he recreates this experience in his imagination and begins to gain a good

feeling about it, he closes the fist of his dominant hand. As he does so, it is suggested that the action of clenching the fist will increase the power of this feeling, as will the taking of two deep breaths. The further suggestion is made that a link is being forged in the patient's mind between the action of clenching his fist and experiencing positive sexual feelings. When the patient has built the feeling as strongly as he is able, he unclenches his fist to find that, as suggested by the therapist, the positive sexual feeling remains with him. This procedure is repeated twice more, each time with a different positive sexual experience. The patient is then told that whenever he clenches his newly trained dominant fist, he will re-experience the positive sexual feelings he has just been enjoying.

He is then asked to recall the situation about which he is unhappy — that of failing to achieve an erection. As the patient imagines this occurring, he is to clench his non-dominant fist, locking up the negative feelings within him. It is suggested that this fist acts as a magnet, drawing to it everything that is negative within his mind and body. Further suggestions are given that, although he cannot prevent negative emotional and physical feelings entering his mind and body, he has the power to take control of them and place them wherever he wants to, such as in his non-dominant fist.

When he has all such feelings, or most of them, locked up in this fist, he does two things simultaneously. He closes his dominant fist, triggering a surge of positive sexual feeling, while at the same time he opens his non-dominant fist allowing the negative sexual feelings to disappear into thin air. The suggestion is then given that, in future, whenever negative sexual feelings surface, he can transfer them into his non-dominant fist. Once he has done so, he can then open his fist to release these feelings while closing his dominant fist to generate the desired positive feelings. In other words, he can take control of his sexual mood state. The more he uses the technique the more powerful it will become. It is also suggested that he identifies the negative state as early as possible so he can prevent it becoming entrenched within him.

The patient is then guided through a technique designed to "remove" the reasons for unwanted behaviour (Hitchcock, 1981). He is asked to *visualise a cloud* hovering nearby, and to give a previously established ideomotor signal when he is able to do so. Into this cloud he mentally places all the reasons, direct and indirect, which he thinks have contributed to his impotency. As he does so, the therapist suggests that his unconscious mind will also be putting in other reasons of which he is consciously unaware.

The patient is encouraged to let his mind drift in a pleasantly relaxed way and whenever any reason for his problem, no matter how trivial, comes into his mind, he is to put it into the cloud. As he does so, he will probably notice the cloud becoming increasingly dark until, when he has put in every reason he is able to think of, it will be inky black. Completion of the task is indicated by means of an ideomotor signal.

At the suggestion of the therapist, the patient is asked to "look" at the black cloud containing all these negative programs and, as he does so, become aware that somewhere behind it he will "see" a source of light, at first quite dim but becoming increasingly bright. Once the patient has indicated, by means of an ideomotor signal, that this visualisation has been achieved, it is explained to him that this light is really a sun, the sun of his own desire to be free of everything that has been preventing him from enjoying life to the full and, in particular, anything which has been preventing him from achieving and maintaining his erection.

A count of five may be used at this point, coupled to the suggestion that the light will grow stronger and brighter with each number until it begins to burn away the black cloud. As this is happening, the patient will become increasingly aware of the warmth of the sun so that, as the cloud and everything in it burns away completely, he is able to bask in this warmth, feeling the sun's rays penetrating every cell of his body, bringing a sense of self-confidence and self assurance. The metaphor of the cloud is designed to remove the reasons for unwanted behaviour. Another ego-enhancing metaphor, the pyramid (Gibbons, 1973), is then used to help individuals realise the existence of unused potentialities within themselves.

The patient is to imagine himself back in ancient Egypt, standing in the desert before the cave-like entrance to the large pyramid. As he enters, he finds himself in a downward-sloping passageway, well lit by torches. Reassured of his safety and security by the therapist's words, he follows this passageway as it takes him deeper and deeper into the heart of the pyramid.

At the very end of the passage, the patient comes to a vast storehouse filled with treasures of all descriptions. This, it is explained, is the storehouse of all the vast untapped resources within him. Herein lies all the potential for good and for achievement which he has not yet turned to his advantage. All of this treasure is rightfully his for it has been stolen from him through force of circumstance. However, unless he carries it back into the world outside to enjoy and to share with others, it may eventually be sealed up within the room and lost forever.

However, when the patient endeavours to gather up part of the treasure, the therapist suggests, he finds he is unable to do so. Some force is preventing him — a force which he realises emanates from a huge black statue in the centre of the room. This statue, powered by a brilliant jewel embedded in its forehead, is the embodiment of all the negative forces of failure and defeat which reside within him. It has been placed in the room as the guardian of the treasure, making all other guardians unnecessary.

To free this vast storehouse of his potential so that he can become the person he is capable of being, the patient must first overcome the negative tendencies within himself which are acting to prevent this, these tendencies being personified and embodied in the guardian statue.

He is encouraged to approach the statue and knock the jewel from its forehead. As it lies on the ground, its lustre fades, so that it looks dark and ugly like a piece of coal. This can be stepped upon and crushed into black dust. Its power gone, the statue may then be pushed so that it falls and breaks into many pieces, leaving the patient free to gather up as much of the treasure as can be carried, taking it with him as he retraces his steps up the passage to the entrance. He steps outside into the warm sunshine, returning to the world of his everyday life with the treasures he has gathered. These treasures can be anything the patient wants — such as the ability to gain and maintain an erection whenever he so desires. No matter how much treasure he may have gathered, he will be able to return to the pyramid as often as he wishes for the storeroom will never be empty.

Use of this metaphor often stimulates the patient to draw on previously unused and unsuspected inner resources. The pyramid may also be used as a symbol, the patient being told that on any occasion when he feels a lack of confidence in his ability to do something, he can think of the pyramid and the treasure it contains. As he does so, he will feel a sense of confidence, strength, and power flowing through him, filling him with the certainty that he is capable of accomplishing the task about which he was doubtful, such as enjoying successful sexual experiences. The power of this symbol may be increased by having the patient clench his dominant fist to increase the surge of confidence and power.

The final technique used with patients desirous of overcoming their impotence is that of *ego-state reframing* (Grinder & Bandler, 1981; Watkins & Watkins, 1979), an approach based on the concept of communication with the part of the mind responsible for the behaviour the patient wishes to change.

Initially it is explained to the patient that all of us have different parts, or ego-states, within us, which may want to do different things. For example, one part may want to enjoy sexual intercourse, while another part wants to avoid this due to feelings of anxiety. However, once the patient has identified the particular pattern of behaviour, such as sexual functioning which he wants to change, communication is established with the part of ego-state responsible for that pattern. This is done by asking "Will the part of me that controls my sexual behaviour communicate with me in consciousness?" As the patient waits, he will usually become aware of some "sensation," perhaps a tingle, a movement, a sense of internal excitement, or something else which provides the communication. To establish the meaning of this signal, the ego-state is asked to repeat it if it means "Yes." Lack of a response may be interpreted as "No."

When communication is established, a distinction is made between behaviour and purpose. The ego-state is questioned: "Would you be willing to let me know in consciousness what you are trying to do for me by creating impotence?" If a "yes" signal is forthcoming, the part is asked to communicate its intention. This usually "pops" into the mind. Should no signal be received, the desire

of the ego-state to keep its purpose from the conscious mind is respected, and the next step takes place.

This involves creating new alternative behaviours to satisfy the purpose so that the unwanted behaviour, impotence, can be allowed to disappear. The assumption is that while the ego-state's purpose may be admirable, the means used to achieve it, which might have been initially effective, are no longer beneficial. Thus more helpful new behaviours are requested. These are generated by asking the part to be creative and provide a number of alternative ways of achieving its purpose which would no longer require impotence. A "yes" signal is given as each new alternative is generated.

Once the signals have occurred, the part responsible for the patient's sexual behaviour is asked: "Are you willing to generate these new alternatives in the appropriate context so that impotence may disappear?" If there is no response, it could be suggested that the new behaviour be given a trial for the next six weeks, or four weeks, or even one week, until a "yes" response is gained.

Finally, to ensure that no part of the patient objects to the new alternatives, a check is made, through the question: "Is there any other part of me that objects to the new alternatives?" If there is, it is necessary to ask the part responsible for sexual behaviour to generate more choices. These are again checked until several alternatives acceptable to the entire individual are in place. These may or may not be in the conscious awareness of the patient.

Most patients become intensely absorbed in this procedure, apparently finding the concept of separate ego-state quite acceptable once the initial explanation illustrates everyday examples from their own experience. Should patients remain sceptical, however, they are simply asked to pretend it is happening, acting "as-if."

The techniques described have been used with 17 men seeking assistance for their impotence. Most of these have somewhat similar background experiences leading up to their sexual dysfunction, and this pattern can be illustrated by a consideration of individual cases.

CASE STUDY I

John, a 47-year-old businessman, had been impotent with his wife for three years before he sought therapeutic help. As medical examination had detected no physical abnormality, he had come to the belief that it was his mind at fault rather than his body. Previous to the onset of the problem, sexual relationships with his wife had been quite satisfactory, intercourse taking place several times a week.

He remembered quite vividly the first occasion on which he had been unable to gain an erection. This had occurred after returning from a party at which both he and his wife had drunk more alcohol than usual. Although this lack of an erection did not recur immediately, John began worrying that it would do so. Several weeks later, while making love with his wife, he found that

he was unable to maintain his erection, something which then began to occur with increasing frequency. Within four months of his first "failure," he was no longer able to gain an erection while engaging in sexual intercourse with his wife. Five or six weeks later, John began an extra-marital relationship with the secretary of a colleague, perhaps, as he put it, as an attempt to reassure himself about his sexual potency. For the first four weeks of this relationship, he gained the reassurance he sought, finding that he had no problems with his sexual functioning. However, over succeeding weeks, intermittent failure occurred so that, with increasing frequency, he was unable to achieve an erection. Three months into the relationship, he was consistently impotent, an occurrence which ended the affair.

Approximately a year later, though still impotent with his wife, John embarked upon a second affair. This followed the same pattern as the first one had, though the onset of regular impotence arrived more quickly on this occasion. For the first three weeks, John felt that all was well, his impotence a thing of the past. Then came increasing failures until, after the affair had been in train for about seven weeks, John was again unable to achieve an erection. This relationship came to an end shortly afterwards.

With both affairs, though John continued to feel excited sexually, this feeling did not translate itself into the appropriate physical response. He would become increasingly anxious about his sexual performance, wondering whether he would be able to achieve an erection and, if he was able to do so, whether he would be able to maintain it. This anxiety appeared to be his main emotional reaction, guilt not appearing to be a factor.

Much of the first session with John involved history taking, the creation of rapport, and the establishment of an expectation of success generated through examples of other patients suffering from impotency who had been able to overcome their problem and function quite normally. Also, in this first session, I guided John through the theatre technique using as material both the first occasion on which he had failed to achieve an erection with his wife and a particularly traumatic failure during his second affair. We also established the conditioned reaction between his clenched right fist and the accessing of positive sexual feelings.

In three weeks following this session, John was delighted with his improvement. He attempted to make love with his wife on eight occasions. Although he was unable to achieve an erection on two occasions, success crowned his efforts on the other six. However, with two of these, he was unable to maintain the erection. Despite this somewhat limited improvement, John arrived for his second session in high spirits. For the first time in well over a year, he believed there was the possibility that he would be able to recapture his previous sexual potency.

During this second session, the cloud and pyramid metaphors were used together with the ego-state reframing procedure. John's reaction to this latter technique was very positive. He felt a strong sense of having been in

communication with the part of himself which was controlling his sexual behaviour and an equally strong feeling that this part was completely agreeable to relinquishing impotence in favour of more beneficial ways of achieving its purpose. Neither the purpose nor the alternative behaviours had been made conscious to John, which is often the case, but this in no way diminished his confidence in a positive outcome. However, he did want the clenched-fist procedure to be repeated. Although John had experienced considerable success in using it to engender positive sexual feelings and to prevent himself sliding into despondency over his inability to achieve an erection, he still felt a lack of confidence in his ability to control his sexual mood state in this way.

Telephone follow-up over the next three months indicated that John had been able to achieve the outcome he desired. Within two weeks of the second session, his sexual behaviour had returned to what it had been three years earlier. He was now able to achieve and maintain an erection while engaging in sexual intercourse with his wife, which he did twice or three times a week. A final telephone contact confirmed that, 18 months after termination of treatment, John was completely sexually functional.

CASE STUDY 2

Alec, a 39-year-old lawyer, had been completely impotent for a period of over four years, both with his wife, to whom he had been married for 15 years, and with his mistress of seven years. In both these relationships, he had had no problems with his sexual functioning until an occasion when his wife came close to seeing him together with his mistress. Apparently he had been dining with her at a restaurant when he saw his wife arriving with some friends. Fortunately he had observed his wife before she had seen him, and he had been able to slip out through a side door. However, since that time he had felt an increasing sense of insecurity and guilt which, it appeared, was interfering with his potency.

Like John, Alec did achieve some improvement after the initial session. Though in the month following this session his sexual functioning did improve, he was, on numerous occasions, unable either to gain an erection or, if he was successful in doing so, to maintain it sufficiently long to effect penetration.

Though he made considerable use of the clenched-fist technique and the ego-building metaphors, Alec was unable to achieve the control over his sexual functioning that he desired. However, some improvement was observed after the second session when the theatre technique was used.

This particular technique is usually the starting point for the treatment, but in Alec's case this was not so. During initial conversation he mentioned feeling as if some self-destructive part of his mind was making life difficult for him. Since he had raised this point, it seemed appropriate to immediately launch into the ego-state reframing procedure which, together with training in the use of the clenched fists, occupied most of the first session.

Initially only Alec's first impotence experience was "defused" in the theatre. He was then taken through the cloud and pyramid metaphors. Apparently, while imagining these, other failure experiences intruded. These he spoke about after the metaphors had been completed. Accordingly, these occasions were also used as material for the theatre procedure. At the end of the session, Alec's feelings were very positive. He anticipated complete success.

Unfortunately this was not to be. Alec still had frequent episodes when he was unable to gain or maintain an erection. However, he could be considered as a partial success. Alec is able to function successfully on approximately half the occasions when he attempts sexual intercourse, with either his wife or mistress, a result confirmed by follow-up telephone calls over a period of 14 months.

CONCLUSIONS

The techniques outlined in this paper are all useful, but it is a matter of choice how they are combined and sequenced. Flexibility is the essence.

Often, as in the two cases described above, the patients will be your guide. Their own comments will usually provide the opportunity for the introduction of one or another of the techniques. Then an appropriate word or two will ensure a smooth transition into the next approach.

Whether such a treatment may be labelled as hypnotherapy is debatable, primarily because it is difficult to arrive at a definition of what hypnosis actually is. As mentioned earlier, one of the difficulties of discussing the incidence and treatment of impotence is that no agreed-upon definition exists in any of the American Psychiatric Association's diagnostic and statistical manuals. The situation with hypnosis is equally unclear. As Rossi (1986) puts it:

Since the inception of hypnosis more than 200 years ago, it has been impossible to find general agreement among professionals on just exactly what hypnosis is. No definition or empirical test has ever been devised to accurately assess whether or not a hypnotic state even exists. (p. xiv)

However, if Erickson and Rossie's (1977) definition of hypnosis as an approach "that provides a subject with opportunities for the intense self-absorption and inner experience called trance" (p. 40) is adopted, the techniques described in this article could be so designated for they enable the patient to turn inwards and become absorbed in his own inner imaginings.

The two cases used to illustrate the approach to impotence are typical. John is an example of its completely successful implementation; Alec of its partial success. Of 17 cases treated in this way over a period of 19 months, 9 may be recorded as completely successful, success being defined in terms of patient's report of no further problem in either gaining or maintaining an erection and the absence of any symptom substitution. Of the 8 not covered by this definition, 4 reported a definite improvement in their sexual functioning

though they still experienced the occasional inability to gain or maintain an erection. The remaining 4 patients reported no improvement.

All these patients had been impotent, defined as an inability to gain an erection, for periods ranging from 11 months to 5 years. However, there appeared to be no relationship between length of time a patient was impotent and his response to the treatment. The 4 unsuccessful patients had been impotent for periods of 14 months, 27 months, 39 months, and 43 months, while the successful patients spanned a time range of 11 months to 5 years.

However, it should be noted that the potentially positive placebo effect of any active intervention could help account for the success of brief psychological interventions. Therefore, treatment methods would need to produce a success rate of better than 30% to be regarded as worthy of serious consideration as a possible treatment method for impotency. The treatment method outlined in the present article appears to be able to meet this criterion and does so within a maximum of two sessions.

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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.

HAY FEVER IN HYPNOSIS: A CAUTION

Wendy-Louise Walker

I make considerable use of the imaginative involvement dimension in hypnosis with a wide range of patients and problems. I am aware of the intense subjective reality and the almost hallucinatory brilliance of imagery experienced by a gifted subject after the appropriate hypnotic ritual, and of the ease of eliciting powerful emotional responses in hypnosis, positive or negative. I know that subjects vary in the amount of suggested detail they find optimal to facilitate their imagined experiences in hypnosis. Since I favour a collaborative model of therapy, I have my patients plan the hypnotic content of therapy sessions with me beforehand, careful to avoid situations or images that may have undesirable connotations for individuals. Once, however, despite quite careful checking and a splendidly collaborative venture, I created a situation that triggered a sudden and violent attack of hay fever.

My patient was a gifted hypnotic subject, a middle-aged woman who was virtually living out her husband's pessimism and grief (so suggestible was she). Since the husband had retired because of chronic illness and was demanding, incessantly critical of her, and also difficult to get away from, teaching Cynthia to escape into happy, creative spaces of her own mind was among our therapeutic goals in our weekly sessions.

It was a bright, spring day and Cynthia said she would like to imagine walking alone in the bush and appreciating everything around her: "You know, the colours, the birds, spring flowers, all that sort of thing that you describe so well for me," she encouraged, "those sessions carry me on for days." I

asked if there was anything in the bush I should avoid or specifically suggest as absent: spiders, snakes, anything that might bother her. "No," said Cynthia, settling back in my comfortable, old, leather hypnosis chair, "just take me somewhere lovely in the bush and describe it all in detail. I love the way the words turn into things. I love everything in the bush and I haven't walked in the bush for years and years."

Encouraged, even flattered, I carried out the normal, easy hypnotic induction for Cynthia — my own modified eye-fixation technique — counted from 1 to 30 for deepening and began suggesting a leisurely meander through the bush, with suggestions of increasing absorption and delight. I excelled myself, recalling all manner of small pleasures to suggest, the satisfying crunch of dead leaves underfoot, a range of spring flowers, birds fluttering and twittering in undergrowth, the texture and smell of different eucalypts . . . until her path was to lead to the bank of a small creek, where she would just sit and enjoy her experiences. In an earlier session, Cynthia had been absorbed by imagining the sight and sound of a waterfall, and I had this little creek tumble down over a rock ledge into a deep pool overhung by blossoming bushes . . . wattle bushes, with fluffy, perfumed, golden balls of wattle trailing down towards the water. The gold wattle dust turned in slow circles on the surface of the water, the birds sang little descants over the sound of the waterfall . . . and, you can guess it . . . Cynthia began to sneeze violently.

I banished the bush scene, while Cynthia, still peacefully in hypnosis, sneezed on. I suggested that the allergy would subside over the next fifteen minutes and brought her out of hypnosis. Cynthia told me, laughing between sneezes at my obvious guilt, that she had forgotten she was allergic to wattle bloom, though she had not experienced this for many years. The allergic reaction subsided rapidly and no therapeutic harm was done. In fact Cynthia, who had otherwise greatly enjoyed her bushwalk, told me that, in an upside down sort of way, this experience demonstrated to her just how powerful hypnosis was. "I saw that lovely, gold wattle, layer over layer of it, reaching out over the water and I smelt its really strong perfume. Then, sneeze! But until you sent the scene away, I was still there enjoying it, just sneezing."

Of course one cannot foresee every difficulty in hypnosis. I am convinced that Cynthia's sneezing was an allergic reaction to imagined wattle dust and was not an indirect expression of negative transference. Since then, however, I have inquired not just about spiders, snakes, and other possibly noxious creatures, but also about plants to be avoided in my frequent suggested bushwalks with patients.

BOOK REVIEWS

Hypnotherapy Scripts: A Neo-Ericksonian Approach To Persuasive Healing.
Ronald A. Havens and Catherine Walters. New York. Brunner/Mazel. 1990.
xviii + 196. \$59.00

This is an excellent book capturing the essence of what has come to be known as the Ericksonian approach. Erickson described hypnosis as a valuable therapeutic tool for enhancing a client's self-awareness and facilitating therapeutic communication. Believing that the therapeutic impact of meanings clients generate for themselves is inherently greater than anything said directly by therapists, he used hypnosis both to persuade his patients to take responsibility for healing themselves and to equip them with the skills for doing so.

Haven and Walters have provided a book which enables therapists to put this approach into practice. It begins with an overview of the assumptions underlying neo-Ericksonian hypnotherapy, then moves on to a summary of the concepts and procedures involved in a typical hypnotherapy session. These concepts are explicated by scripts which include verbatim examples of trance inductions, metaphorical and direct suggestion for various types of presenting problems, and trance termination procedures. An audiocassette providing two examples of how trance might be induced accompanies the book.

The scripts provide a comprehensive guide to the use of the Ericksonian approach, the areas covered including trance induction, general purpose metaphors, affirming the self, alleviating unwarranted fears, undoing bad trances, recovering from trauma, developing spontaneity to overcome sexual difficulties, enhancing relationships, restructuring body images, utilising unconscious resources to promote healing, improving performance by removing self-imposed barriers to achievement, direct statements and suggestions (particularly good on relieving anxiety and building self-esteem), overcoming habit problems such as smoking, managing pain, and trance termination procedures.

I particularly like the authors' gentle, non-intrusive approach. They see the primary goal of hypnotherapy as that of evoking a trance state within the client, assuming that he or she will be able to use that state to access the inner resources necessary for change. Should this not eventuate, they use general metaphors and, as a last resort, direct suggestions. Such a combined presentation of metaphors, direct suggestions, and direct statements provides, in the view of Haven and Walters, a most effective hypnotherapeutic approach, especially for habit problems and pain management.

Their use of diagnostic trance is a further illustration of the neo-Ericksonian approach. This involves an exploration of the various unconscious images and associations connected with the patients' presenting problem. Clients are asked to close their eyes, relax, and concentrate upon the unpleasant sensations or feelings they associate with their complaint. They are to wait patiently and quietly while observing those unpleasant sensations and to report whatever thoughts or images come to mind. Once this has been done, they are to find a thought or image which removes or displaces their unpleasant feelings.

This is a book well worth the reading. However, one reading will but scratch the surface of the riches contained within its covers. Therapists both experienced and inexperienced will benefit from ownership, not in order to place it on their bookshelves, but to keep it beside them as a helpful companion.

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Hypnotherapy: A Practical Handbook. Hellmut W. A. Karle and Jennifer H. Boys. London. Free Association Books. 1987. 301. \$31.95, paper. (Available from Astam Books, 162-168 Parramatta Rd, Stanmore, N.S.W. 2048; (02) 550-3855).

This book reflects its conception in workshops that were run by the authors at Guy's Hospital, London. The book is a practical guide to the use of hypnosis in the clinical setting, and both the style and substance of the book is, as the authors say, "very much on the lines of 'How to do it' " (p. 1). The book is divided into 4 parts with a total of 20 chapters: basic techniques (6 chapters), treatment strategies with adults (4 chapters), treatment strategies with children (4 chapters), and hypnosis in analytic psychotherapy (6 chapters); the back-matter contains notes, a bibliography, an index of scripts, and a general index.

Within the boundaries set by the authors, this book is successful. The authors make it clear that hypnosis (or hypnotherapy) is a technique that needs to be integrated into a therapeutic approach, rather than being used as a therapeutic approach; relatedly, the authors also make it clear that if you do not (or cannot) work with a particular type of patient or disorder without hypnosis, then you should definitely not work with that type of patient or disorder with hypnosis. The authors are refreshingly forthright in stating that "It is unlikely that we have much to say that is truly original" (p. 3). It is also the case, however, that the authors speak in a way that is essentially straightforward and sensible.

There are aspects of the book that one could disagree with. If you're looking for a book that is up with current experimental and clinical research on hypnosis, then this is not the book. Or, if you know nothing about hypnosis or therapy and want to learn from scratch, then this is not the book. If, however, you have a basic understanding of hypnosis, more than a basic understanding of therapy, and are willing and able to read material on hypnosis critically,

then this is a book that would be useful. Although the book is presented in a sometimes overly chatty way and there is some repetition across the chapters, this is not a bad thing because most readers will probably dip into parts of the book when needed, rather than read the book in one or two sittings as a whole.

If you have either presented or participated in workshops on hypnosis, then you know that a common affliction of the beginning hypnotist is not knowing what to say next (or first) to the hypnotised person. To overcome this affliction, it is very useful to have a script to follow. This book contains 52 scripts that cover a range of types of patients and disorders. One could quibble with aspects of these scripts, but the authors provide the best advice here in suggesting that readers adapt the scripts to their own individual styles. For this reason alone, the book is worth having on a shelf in your clinical practice. Overall, this is a useful book for those who are learning how to integrate hypnosis into their therapeutic approach.

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I: The Philosophy and Psychology of Personal Identity. Jonathan Glover. Harmondsworth. Penguin. 1988. 207. \$14.99.

This is a wide-ranging, stimulating but undogmatic discussion of a puzzling philosophical psychological problem: the nature and development of the sense of personal identity. It is divided into two approximately equal parts: What is a person? and Self-Creation (the formation and growth of personal identity or the sense of I-ness).

Jonathan Glover is a philosopher, who emphasises the questions which philosophers over modern time have asked and the answers they have proposed. He also introduces a good deal of psychological material, including psychiatric data on multiple personality and data from hypnotic studies indicating some division of consciousness, and a good deal of neurological information, especially on split brains. He calls into question many of the traditional answers to the question "What is a person?" Amongst these are the continuing background of bodily sensations, the sequence of cognitive and orctic experiences, and the notion of an ego which is the possessor of experiences. While recognising its deficiencies he favours the commonsense view that behaviour is guided by beliefs and desires in interaction. He gives reserved support for Parfit's recent view that so-called personal identity depends less on actual identity in the strict philosophical sense than on the survival of successive social self-concepts; this is not an easy distinction to make in a few words.

Glover deals effectively with a central philosophical psychological question. Though I have doubts that he provides an answer, I have no doubt that he provides a considerable stimulus to thought. It is interesting that he supports

determinism in relation to human behaviour whereas humanistic psychologists, while putting equal stress on personal identity and on behavioural control by the "I," reject it.

This is a book which is well argued but often difficult, and which should be read by senior students of philosophy and psychology; by teachers of psychology, psychiatry, and social work; and by practitioners in clinical psychology, psychiatry, and social work. I commend it also to philosophers.

W. M. O'NEIL

Stress Control Through Self-Hypnosis. Arthur Jackson. Sydney. Doubleday. 1989. x + 193. \$16.95, paper.

The first question about any book on self-hypnosis has to be, "Is it safe?" I am not totally happy about this one. Induction procedures are described carefully enough, but I am simply not at ease about the adequacy of the instructions for de-induction. There are no suggestions about what to do if you realise you are still in hypnosis after your de-induction. Having had personal experience of the problem (Channon, 1983, 1984) I do not believe that a quick reassurance that "there is no danger of you being 'left' in self hypnosis . . . The worst that can happen is that you allow your deep state of relaxation to drift into a normal sleep state" (p. 55) is sufficient.

Given this reservation, a problem anyway that the clinician can cover with individual patients, the rest of the book is very good. The language and concepts are simple (sometimes perhaps over-simple, but one has to remember that the target population is not one made up of clinicians). The author makes excellent creative use of metaphor and imagery to get his message across clearly and concisely.

The chapters cover stress, inducing and using self-hypnosis, work-related stress, stress in sport, coping with pain, and sections on asthma, hypertension, skin disorders, cancer, and the stressed child.

For each area the author deals carefully with possible unrealistic expectations, explains that people vary in their capacity to use different techniques, and supplies ideas and scripts. For example, for chronic pain the author describes techniques of colour change, a pain-dimmer switch, warmth, stop sign, distancing, Walker's (1982) stream imagery, and so on. Most importantly, he encourages a structured approach to self-therapy with an organised work diary.

This book would make a splendid adjunct to therapy, especially for patients who have difficulty visiting their therapist often because of time or distance.

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The February Man: Evolving Consciousness and Identity in Hypnotherapy. Milton H. Erickson and Ernest Lawrence Rossi. New York. Brunner/Mazel. 1989. x + 266. \$59.00.

The February Man is an extremely detailed case study illustrating Erickson's use of profound age regression in the treatment of a depressed young woman who suffered from a water phobia. It is the only complete verbatim record of an entire hypnotherapeutic case dating from the middle of Erickson's career when his innovative genius had not been eroded by age. In particular, it demonstrates his insistence on the careful preparation of verbal and non-verbal procedures for facilitating hypnotic experiences, thus providing a balance to those who would have us believe that Erickson's work was entirely intuitive and idiosyncratic.

In this book we can see the amount of work Erickson put into preparing his patient for changing. Although he has always emphasised that it is the patient who does the work and that all the therapist does is provide conditions in which this work can be done, Erickson obviously took great pains to ensure that such conditions were optimal. To achieve this end, he used many forms of reframing and indirect suggestion, often phrasing his suggestions as questions, seeking the patient's permission to intervene. In response to her reactions, Erickson revealed great flexibility, always being ready to change such interventions.

As the "February man," Erickson visited the woman many times during the course of four lengthy psychotherapeutic sessions, utilising classical hypnotic phenomena such as time distortion, automatic writing, and amnesia to explore the patient's entire childhood and youth. By so doing, he was able to stimulate new developments in her adult personality. However, it was through age regression that he was able to achieve the outcomes he desired.

It would appear that Erickson tended to treat everyone as a child because he believed that we are most open to learning, most curious, and most able to change while in the "child state." With patients in that state, he would use a variety of hypnotic techniques to facilitate a more complete, comprehensive point of view, enabling them to transcend the limitations and literalism of childhood. This approach was used so effectively in the "February man" that it provides a most persuasive demonstration of the value of using age regression as the dominant feature of therapy.

Rossi does not intrude between Erickson and the reader. He provides a very detailed transcript of the four therapy sessions, and, through questioning and comment, encourages Erickson to explain the thinking behind his therapeutic approaches. This is done in the form of detailed commentaries on the case which were recorded in 15 hours of discussion.

This strategy of using Erickson's commentaries on work done earlier in his career does, however, raise the question of whether the intuitive therapeutic techniques he used at that time can be understood in the light of a later cognitive analysis. As Erickson's commentaries were made many years after the therapy had taken place, it is possible that Rossi's questions may have led him into answers which were not really accurate. Rossi himself has expressed his doubts on this score, suggesting that many of the psychodynamics discussed could well have been post hoc intellectualisations used to impose a cognitive structure on behaviour which was quite intuitive at the time.

Whatever the merits of this qualification, *The February Man* is an excellent illustration of Erickson's use of five typical stages of trance and suggestion. He begins by (a) focusing the patient's attention on the topics he introduces, then (b) uses confusion techniques to depotentiate the patient's own habitual mental sets. Once he has done so, without her realising it, he sends her on (c) creative inner searches within her own mind, these (d) activating unconscious processes, which (e) establish a readiness for creative hypnotic response.

The February Man provides a multitude of detailed examples demonstrating how Erickson progresses through each of these stages. This wealth of detail is both the strength and the weakness of the book. For those relatively unacquainted with Erickson's work, it will be a source of fascination, whetting their appetites to learn more about this master clinician. For those who are more familiar with his methods, it could well be extremely tedious. Every word, every nuance is reported, commented upon, explored and dissected. However, as a definitive example of Ericksonian therapy in action, *The February Man* deserves consideration by all those who seek a deeper understanding of the techniques he pioneered.

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Trance on Trial. Alan W. Schefflin and Jerrold Lee Shapiro. New York. The Guilford Press. 1989. xiv + 338. \$33.95, paper. (Available from Astam Books, 162-168 Parramatta Rd, Stanmore, N.S.W. 2048; (02) 550-3855)

This book is number five in the Guilford Clinical and Experimental Hypnosis Series (edited by Michael J. Diamond and Helen M. Pettinati). The two previous books in this series which dealt with hypnosis, memory, and forensic issues were the highly regarded *Hypnosis and Memory* (edited by Helen M. Pettinati) and the excellent *Hypnosis, Will, and Memory: A Psycho-Legal History* (by Jean-Roch Laurence and Campbell Perry). Thus, one comes to the present book with anticipation, and this anticipation is enhanced when one sees that the authors are a lawyer (Schefflin) and a psychologist (Shapiro). Their aim is to present "a book that could function as a practical reference handbook" (p. x) for both lawyers and expert witnesses in cases involving hypnosis. In working to meet this aim, the authors considered that "forensic hypnosis is

a volatile field engendering strong opinions" (p. xi), and tried "to present each perspective (on forensic hypnosis) as impartially and as fairly as possible" (p. xi). *Trance on Trial* has 11 chapters and an appendix, which are grouped in six parts; also, there is a provocative foreword by David Spiegel, a preface by the authors, a reference and bibliography section, and an index.

Part I overviews of the legal status of hypnosis. The authors canvass a range of issues concerning hypnosis, and the legal aspects of its use in clinical and forensic settings. The authors relate actual case examples involving themselves or others, and also present hypothetical case situations to highlight potential legal problems. The authors are provocative at times. For instance, in considering a person who was hypnotised in the clinical setting and subsequently not allowed to testify in court because of this (therapeutic) use of hypnosis, the authors ask whether "there is a duty to warn clients that they may lose legal rights in order to gain mental health" (p. 5)? Relatedly, the authors state that "the most potentially significant question for hypnotherapists" is whether "a therapist can be sued successfully for failing to fully inform a client or patient of the potential legal consequences in undergoing hypnosis" (p. 5). The authors are biased at times, and make statements that have little support. For instance, they argue that "by trying to shut out police . . . researchers [by investigating the effect of hypnosis on memory] have helped create the dilemma faced by mental health practitioners" (p. 10). This is nonsense, and has a flavour of shooting the messenger, rather than listening to the message. The authors are trite at times. For instance, their conclusion that "the differing goals and dissimilar methods of lawyers and therapists are often difficult to reconcile" (p. 17) is not one that needs 17 pages to realise.

Part II contains a case portrait of "Jennifer," and the authors present excerpts from four (therapeutic) hypnosis sessions between Jennifer and Shapiro. Jennifer was beaten and raped by a male; she identified him and he was arrested. Jennifer experienced various post-rape sequelae, including amnesia for certain periods of the time surrounding the rape. During an hypnosis session, Jennifer recalled that she had also been raped by another male; she subsequently identified him to the police and he was arrested. The judge allowed Jennifer to testify on the basis of her hypnotically refreshed memory, and both were convicted and sentenced to multiyear terms. If the judge had not allowed this, then the second male would not have been convicted. Also, as noted by the authors, some of the procedures used by Shapiro during the hypnosis sessions have been associated with rulings in other jurisdictions that the previously hypnotised person could not testify. Thus, this case highlights the variability that exists in rulings on hypnotically enhanced testimony. The case of Jennifer also highlights the potential conflict that exists between the use of hypnosis for clinical as opposed to forensic purposes. The authors overstate that conflict at times, but this overstatement is understandable given

the personal experience of the authors and the disputatious nature of discussions in the U.S.A. about forensic hypnosis.

Part III focuses on investigative hypnosis, and presents material on (a) the road to admissibility, (b) the search for safeguards, and (c) the rise and fall of inadmissibility of hypnotically enhanced testimony. The authors credit William Jennings Bryant Jr, Harry Arons, and Martin Reiser with the conception and birth of the current life of forensic hypnosis in the U.S.A. They also highlight the importance of the *Harding* case (in Maryland, 1968) in setting a precedent for the admissibility of hypnotically enhanced testimony. The authors then credit Martin Orne and Bernard Diamond with the rise of informed scepticism and the need for guidelines and safeguards in forensic hypnosis. They also highlight the importance of the *Hurd* case (in New Jersey, 1980) in recognising the need for guidelines to be followed in the conduct of forensic hypnosis sessions.

The authors then examine some of the influential court rulings and other major events concerning forensic hypnosis in the 1980s. For instance, they examine the *Shirley* and *Guerra* cases (in California, 1982 and 1984, respectively), the *Rock v. Arkansas* case (in the U.S. Supreme Court, 1987), and the report on *The Scientific Status of Refreshing Recollection by the Use of Hypnosis* (by the Council on Scientific Affairs, American Medical Association, 1985). The authors cover this material and more in detail, and these chapters contain much that is of value. The presentation of the issues tends to bounce from one extreme to the other, however, and it is difficult to get a feel of the position that the authors themselves are adopting. Nevertheless, their position does show through in a useful way at times. For instance, the authors clearly oppose "using hypnosis to shore up a sagging or inconsistent memory of a witness" (p. 73), and note that this has clearly been a motivation in a number of major cases. The *Shirley* case led to a rule of total exclusion of hypnotically enhanced testimony in California, but the authors point out the range of loopholes that have been found which allow an avoidance of that rule. In the *Rock* case, the U.S. Supreme Court ruled that a previously hypnotised *defendant* must be allowed to testify, because not allowing her to testify would be a violation of her constitutional rights. The authors note the importance of this decision, and conjecture that it is likely to begin another round of judicial debate and decision about the admissibility of hypnotically enhanced testimony in general. Current cases in the U.S.A. indicate that the authors are correct in this conjecture.

Part IV examines hypnosis and memory, and looks at (a) defining hypnosis, and (b) the nature of memory and of hypnotically refreshed recall. The authors consider a number of scientific, clinical, and everyday notions concerning hypnosis and its effects. They note that "the definition of hypnosis is likely to influence whether or not testimony is acceptable or admissible in legal proceedings" (p. 141), and state that they "believe that hypnosis is essentially a subject-oriented vehicle to reach normally unconscious mental processes"

(p. 142). What is not clear is whether their own definition leads the authors to the view that hypnotically enhanced testimony should be admissible.

The authors then consider notions concerning memory, and the impact of hypnosis on memory. They note that much of what they present is "background material" (1983), and it is presented from their "own perspective . . . of the clinical practitioner" (p. 151). Since the authors consider that "clinical writers and practitioners in hypnosis are more likely to believe in the value of hypnotic hypermnesia" (p. 154), readers should consider the substantial amount of material that the authors present with a critical eye. The authors conclude that "no hard evidence exists to prove that hypnosis *inevitably* alters memories or that it provides the *best* available recall" (p. 178; emphasis added). This conclusion conveys the way in which the authors pit extremes against one another. Moreover, the extremes of "inevitability" on the one hand, and "best" on the other are probably unreasonable criteria to set and ones that will never allow a resolution of the situation that the authors argue needs to be resolved.

Part V considers the hypnotherapist in court, and presents material on (a) direct examination, (b) cross-examination, and (c) the psychotherapist's experience. There is much here of value to anyone going into court to testify, whether that testimony involves hypnosis or not, or whether one is in the role of expert witness or not. The advice, for instance, not to chew gum or wink at jurors when testifying would seem to be wise no matter what one's role is in court. More seriously, however, the authors' presentation of the issues and events that occur before and during testimony when one is in the role of expert witness is very useful. The basic message to come through is the need for careful and detailed preparation before going into what (for most expert witnesses) is an unfamiliar, and potentially hostile, setting. As the authors say, "only the highest level of professionalism and preparation is acceptable" (p. 258) when in the role of expert witness. The material in these chapters will be of value in that regard.

Part VI offers (a) some final comments, and (b) an appendix of law pertaining to forensic hypnosis. The appendix lists a large number of court cases involving hypnosis in Federal, State, and Military jurisdictions in the U.S.A.; it also lists cases in Canada, England, and New Zealand. The final comments made by the authors pick up again the polarisation of views on forensic hypnosis that the authors have pointed to throughout the book. A disappointing aspect of these comments is that, apart from their concern about the confusion and complications associated with forensic hypnosis and their desire for all involved in the area to "settle their differences and find common ground" (p. 265), it is not clear how the authors themselves think those differences should be settled and what that common ground should be.

Finally, Australian readers of this book should understand that the legal (if not the professional and ethical) issues surrounding the use of hypnosis in the forensic setting differ in a variety of ways from those described in this book. The rules that apply in both criminal and civil courts in this country

are quite different from those that apply in the U.S.A.; moreover, we in Australia have not had the torrent of cases involving forensic hypnosis that has occurred in the U.S.A. There has been a steady flow in this country, however. Given this, perhaps the most important message to come from this book to Australian readers is the need to avoid the mayhem that surrounds forensic hypnosis in the U.S.A.

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The Success Factor. H. E. Stanton. Sydney. William Collins. 1988. 185. \$7.95, paper.

The success factor in this book centres on how to counter the negative cognitive suggestions that people give themselves, both consciously and unconsciously. These negative suggestions, according to Stanton, hold us back in life. He makes the point that success is ongoing, a journey rather than an arrival, and that people show their fear of success by refusing to continue on that journey, instead staying stuck in unsatisfying situations.

Areas covered include definitions of success, self-awareness and self-discipline, how to sell successfully, managing stress, maintaining good health, decision making and problem-solving, and working and communicating with others. There is also a chapter on the value and misuse of meetings in organisations and how to maximise their effectiveness. A bibliography and an index are included.

In the chapter on self-direction there are many practical ideas about how to focus on one thing at a time. Achieving such focus is held to be the key to maintaining energy and peak achievement. The reader will also find a number of practical ways of handling negative emotions. Many of the ways of achieving success in this book involve hypnotic techniques, although often they are not labelled as such. Thus, people who are highly hypnotisable would probably be able to make better use of these techniques than others. The concept of "mental dieting" is a novel and useful description for a widely used cognitive technique for countering negative thoughts. To assist self-help, there are some catchy scales for measuring one's level of stress, ability to relax, and others. The chapter on health covers ways of using relaxation and imagery with self-hypnosis to deal with pain and stress, and offers some information on alternative back flower and homeopathy remedies. There is also a brief section on diet.

The book does not hold to any one theoretical viewpoint. It takes its direction from the literature on business management, Zen meditative techniques, and from Rational Emotive Therapy and Neuro-Linguistic Programming. The author unashamedly advocates a Machiavellian approach to success and manipulation of others to get what one wants, provided it is in their best interests. Readers are guided into imagining what they want to be and then

acting as if they were that person. A caution is needed here to remind people that, by using these techniques, they may well get what they think they want.

The book's strengths lie in the range of cognitive skills described to achieve self-awareness and self-discipline. The weakest areas are in interaction with others, which are too manipulative for this reviewer's taste, and lack information about conflict resolution, negotiating skills, and assertiveness, which would balance the emphasis on self.

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