

Interpreting the Results

The choice of model M8 as the best fitting model suggests two conclusions. First, group is related to reports of a telephone ringing. Computing the appropriate odds ratio indicates that simulating subjects were 3.45 times as likely to report that a telephone rang than were hypnotised subjects. Second, both the actual and suggested presence or absence of a telephone ringing are related to the presence or absence of a telephone ringing. One way to quantify this relationship is to compute an odds ratio between any two of the variables at each of the levels of the third variable. Doing so yields the following conclusions: When the telephone actually rang, subjects who were given a suggestion to hear the telephone ring were 2.70 times more likely to report that the telephone rang than were subjects who were not given the suggestion. In contrast, when the telephone did not actually ring, subjects who were given a suggestion to hear the telephone ring were only 0.15 times as likely to report that the telephone rang than were subjects who were not given the suggestion.

CONCLUDING REMARKS

The interested reader will find a number of additional resources valuable. Green (1988) offers the best elementary introduction, whereas Agresti (1984) and Wickens (1989) provide more sophisticated yet accessible treatments of loglinear analysis. The most current and complete discussion of loglinear analysis can be found in Agresti (1990).

Although a number of investigators (McConkey, 1984; Spanos, DeGroot, Tiller, Weekes, & Bertrand, 1985) have recently reported loglinear analyses, hypnosis researchers have generally not taken advantage of loglinear analyses or odds ratios. It is our hope that this brief introduction to these statistics will increase their use by hypnosis researchers.

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Normally, a logit analysis is performed when a multivariate cross-classification table includes one or more response variables and one or more predictor variables. However, the distinction between loglinear analysis and logit analysis is an artificial one. Logit models can be shown to be formally equivalent to loglinear models.

HYPNOANAESTHESIA AND HYPNOTIC TECHNIQUES WITH SURGICAL PATIENTS

B. J. Evans

Monash University

R. O. Stanley

University of Melbourne

Hospitalisation and surgery are very stressful experiences for many patients. When their fears and concerns about what will happen to them and how they will feel after surgery are not dealt with by medical professionals, patients may face both short- and long-term psychological disturbances and poor physical recovery. Surgical procedures may cause physical suffering and chemical anaesthetics administered during surgery can contribute to delayed post-operative recovery and medical complications.

One potent source of assistance for patients experiencing surgery and its consequent anxieties, pain, and physical outcomes, is the use of hypnosis. The authors outline the rationale for the use of hypnotic interventions appropriate for patients with high to low hypnotisability and medical situations which may warrant the use of hypnosis over chemical anaesthetics. A range of hypnotic techniques appropriate pre-surgically, during surgery, and post-surgically are described, together with suggestions for their effective use.

Faced with hospitalisation and surgery, many patients experience considerable stress and anxiety, which may persist over the course of their convalescence and well into post-surgical adjustment (Hackett & Cassem, 1976; Moffic & Paykel, 1975; Nichols, 1984). These stresses and anxieties arise from patients' changed status and fears about their health and long-term recovery (Backman, 1989; Purtilo, 1984). Patients also express concern about the surgical procedures they may shortly endure and the chemical anaesthetics they will require during and after surgery (Cohen & Lazarus, 1980). Patients' psychological states before, during, and after surgery may have a marked negative influence on their recovery, typified by the likelihood of complications, longer post-surgical hospitalisation, consumption of analgesics, reports of pain, and poorer medical recovery (Ridgeway & Mathews, 1982). In the longer term, patients' fears and anxieties may contribute to psychological disturbance and poor recovery indices well after their discharge (Johnston, 1980; Nichols, 1984).

A number of studies have confirmed that hypnotic interventions in surgery can be significant in assisting many patients to cope with surgery. Such interventions may reduce patients' experiences of post-operative pain and complications and enhance recovery processes (Evans & Stanley, 1990; Finer, 1988; Teitelbaum, 1967). For some patients, hypnoanaesthesia can be used as the sole anaesthetic in surgery and for many more patients, hypnotic techniques help them cope with the stresses of surgery, post-operative processes, and longer term convalescence and readjustment. The use of hypnoanaesthesia as a sole anaesthetic is rare for two reasons. First, chemical anaesthetic agents are generally safe, easy to administer and may be less time-consuming than hypnotic interventions (Nathan, Morris, Goebel, & Blass, 1987). Second, it is estimated that only 10–20% of patients can successfully use hypnosis in surgery (Hammond, 1990; Hilgard & Hilgard, 1975; Ulett & Peterson, 1965).

However, there are a number of medical situations where hypnoanaesthesia may provide an appropriate anaesthesia. These include surgical interventions where chemical anaesthetics are contraindicated (because of the patient's allergic reactions or sensitivity); procedures during which the patient's state of consciousness must be observed or the patient must respond to questions (e.g., endoscopy); and situations where the patient's medical problems (e.g., cardiac difficulties) increase any risk associated with chemical anaesthetics (Crasilneck & Hall, 1975).

More generally, hypnotic interventions have been shown to be effective in many other medical situations. They have been used with patients undergoing repetitive procedures, such as burns dressing changes, and with neurosurgery patients where constant EEG monitoring is required (Nathan et al., 1987). Evans and Stanley (1990) summarised other uses for hypnotic interventions in surgery. They are used to help patients relax and to reduce anxiety levels, pre-surgical fear, and apprehension. This greater relaxation maximises patients' understanding of procedural and sensory information given to them, which helps them cope with what is happening (Ridgeway & Mathews, 1982). Positive suggestions given to patients during hypnosis may help minimise pain and complications, often eliminating or reducing the need for pre-surgical medication and reducing the amount of chemical anaesthetics used during surgical procedures. They also contribute to more rapid recovery to a normal functioning state (e.g., urination and reduction in bleeding) so that patients feel more confident and comfortable. There is also some evidence to suggest that hypnotic interventions lead to reduced length of post-operative hospitalisation and reduced incidence of post-operative convalescence problems (Evans & Richardson, 1988; Fredericks, 1978; Gruen, 1972). Finally, hypnosis may be useful in emergency medical situations where chemical agents are not available (Udolf, 1981), where chemical agents are contraindicated because patients have eaten (Fredericks, 1978), or when patients have refused chemical anaesthetics (Cheek & LeCron, 1968; Finer, 1988).

Hypnosis can be utilised pre- and post-surgically and also during surgery. A number of hypnotic techniques can be used during each of these stages of surgery, for different purposes. Interventions can be used selectively to meet the needs of individual patients who are more or less susceptible to hypnosis.

Patients may be given direct suggestions for relaxation and anxiety-reduction, glove anaesthesia, displacement or alteration of painful symptoms, and dissociation (Hammond, 1990). Induction and deepening techniques ideally emphasise relaxation, peace, tranquillity, and patients' control over the environment and body. In the induction process, there should be some attempt to integrate what the patient is seeing and experiencing into the trance state and efforts made to reassure the patient that what he or she is undergoing is a common experience for many people. For example, at the commencement of pre-surgical hypnosis, the hypnosis practitioner may say: "The process of coming into Hospital for surgery is a very common and routine procedure . . . But for you it may be a new experience. And so, if I may, I would like to talk with you about what we have learned about the healing process so that you may prepare yourself in the best possible way for your surgery" (Sylvester, 1990). Pre-operative suggestions usually entail ego-strengthening ideas, stressing safety and comfort throughout the procedure and quick, complete recovery over which the patient has considerable control (Finer, 1988; Hammond, 1990; Hartland, 1982). The practitioner can also teach the patient to practise cognitive reframing, with such statements as: "I will cope with this temporary discomfort and pain." All suggestions made to patients should be positive, direct, logical, and accompanied by sound reasons for their acceptance. They should be given in a calm and confident manner, ensuring that patients do not feel dominated (Hartland, 1982).

Following induction, other hypnotic techniques may be used with patients. Regression may be appropriate with patients who voice concerns or fears about their surgery, based on previous surgical experiences (Kolouch, 1962). This helps both the patient and practitioner to understand the patient's fears and concerns more accurately. Ventilation of these fears and concerns may then lead to a more realistic appraisal of the situation by the patient. Patients may be given details of the procedure they will undergo, to correct any misapprehensions and to enhance their feelings of control. Equally, they can be given information about the likely sensations they will experience and ego-strengthening and cognitive reframing statements to help them control pain experience (Hilgard, 1988).

Such rehearsals for surgical procedures are frequently reported in the literature, deriving from the pioneering work of Schultz (1954). In this procedure, the patient is led through the surgical experience in advance, with the practitioner detailing the steps involved and the likely reactions and symptoms the patient will experience. When using such rehearsals with patients, it is important to ensure that all steps of the procedure and all likely sensations are discussed with the patient (Finer, 1988; Nathan et al., 1987; Udolf, 1981). The experience

of unexpected symptoms during the surgery or in the recovery phase can lead to a heightened anxiety and reports of greater pain (Nathan et al., 1987). How much information about surgical procedures the hypnosis practitioner gives an individual patient should be a reflection of that patient's knowledge about his or her condition and the proposed surgery, the patient's desire to know, and the legal necessity to provide information for informed consent (Ley, 1983).

Hypnosis practitioners must be aware of difficulties that can arise when giving information about likely symptoms and their duration to patients. The first of these is that some patients given more information about their surgery and its outcomes may be more likely to experience those symptoms and negative outcomes (Cohen & Lazarus, 1980). Second, many patients may experience increased anxiety and concern when learning about side effects or symptoms of which they were not aware (Cohen & Lazarus, 1980). To control for these problems, the practitioner must utilise two techniques. The first of these is to explore with the patient what he or she knows about the operative procedure and elicit the patient's fears and concerns. Lack of knowledge can be compensated for by giving the patient specific information and concerns can be addressed by correcting the patient's misapprehensions or giving additional information (Evans, Kiellerup, Stanley, Burrows, & Sweet, 1987; Ley, 1983). Second, the hypnosis practitioner should build statements into hypnotic suggestions which enable the patient to deal positively with any unexpected surgical procedures or bodily symptoms or pain (Nathan et al., 1987). For example, the practitioner may say: "Should any part of the procedure vary from what we have discussed, you will continue to feel relaxed and at ease with the situation, knowing that you have the strength to deal with it because your body is prepared for what will happen."

A number of pain control techniques can be taught to patients during hypnosis sessions. These may include direct suggestions for pain reduction, substituting another sensation (such as tingling) for the pain, transference (glove anaesthesia), displacement or alteration of the painful stimuli, dissociation, and using neuro-physiological metaphors (Hilgard, 1988; Rose, 1990). Ideomotor and ideosensory techniques can be used with pain control, to create analgesia, anaesthesia, and muscular relaxation (Kolouch, 1962, 1964; Van Dyke, 1970). This can be done, for example, by saying to the patient: "Your finger can lift when you feel the numbness . . ." (Rossi & Cheek, 1990). When using hypnosis for pain control, it is important that the hypnosis practitioner does not suggest that all the patient's pain will be removed, as this will cause loss of confidence and disappointment if the patient is not able to do this. Rather the patient is told that the pain will lessen and perhaps not be felt at all (Hilgard, 1988). Any reduction in the degree of pain will reinforce patients' trust in the hypnosis practitioner and confidence in their own ability to control their pain. **This increases the likelihood of greater pain control over the duration of surgical convalescence.**

A concern for the hypnosis practitioner helping patients prepare for surgery is the amount of time taken by patients to achieve mastery of the particular hypnotic techniques being used. Surman, Hackett, Silverberg, and Behrendt (1974) demonstrated that a single pre-operative discussion with a patient did not provide an adequate psycho-therapeutic intervention for patients, while Field (1974) found significant recovery differences between control and hypnotically-trained orthopaedic patients who listened once to a 20-minute audiotape. Hart (1980) exposed his open-heart surgery patients to five 20-minute audiotapes. The time required to train patients may vary according to their personality characteristics, the availability of the hypnosis practitioner and the constraints imposed by the hospital routine. One way of dealing with a time problem is to provide patients with audiotaped induction material which they use as required. When using audiotapes, it is important to ensure that the content is generated during an actual session with the patient and that the material be updated regularly to ensure that it continues to meet the patient's needs (Jackson & Merrington, 1988). It must be stressed to the patient that audiotapes are for personal use only and should not be used by other patients.

A second method by which to help patients gain mastery when time is limited is to teach them how to enter hypnosis by themselves. This has the additional benefits of allowing the patient a greater degree of involvement in his or her treatment and lessens dependency on the hypnosis practitioner (Hartland, 1982; Jackson & Merrington, 1988). The easiest way to give patients this skill is to use a post-hypnotic suggestion, in which the patient enters the trance state in response to a self-administered signal. If the patient uses a predetermined word as the cue, it is necessary to teach him or her to repeat the word several times to induce the trance, to ensure that the trance state is not entered should the word be used inadvertently in ordinary conversation (Hartland, 1982). When considering the use of self-hypnosis, it is important to discuss the topic with the patient before attempting the procedure. Some patients report great difficulty in maintaining concentration when using self-hypnosis and a common fear is not being able to awaken from a self-induced trance (Jackson & Merrington, 1988). Patients' concerns and fears need to be addressed before using such suggestions in the course of treatment.

Hypnotic techniques can be used while the surgery is being performed to maintain the patient's hypnoanaesthetic state. It is appropriate for the hypnosis practitioner to repeat pre-operative suggestions as the patient is taken into the operating theatre and during pre-surgical preparation procedures. This helps the patient maintain a sense of calm and control induced as part of the preparation for surgery. As the surgical procedure unfolds, the hypnosis practitioner leads the patient through the already practised events, identifying the steps in the procedure and the likely feelings, sensations and reactions of the patient. This procedure would have already been rehearsed with the patient in pre-surgical preparation (Schultz, 1954). As suggested earlier, it is important to ensure that the patient has been trained to deal with unexpected

medical crises, changes to the operative routine, or unexpected symptoms, through the inclusion of additional suggestions during pre-surgical hypnotic preparation.

Nathan et al. (1987) highlighted the necessity for the hypnotic practitioner to work in close liaison with the medical surgical team and for the latter to be aware of the importance of verbal communication in the operating theatre. In the hypnotic state, of course, the patient is highly susceptible to what is said by people in the operating room (Scott, 1973). It is important for the team to discuss the possibility of unexpected operating procedures and how these will be communicated within the theatre. Nathan et al. (1987) argued that, should such an unexpected change in the procedure occur, the operation should be stopped if possible and the patient given a verbal or physical rehearsal for the new procedure. The hypnosis practitioner can control for the effects of such an event by preparing the patient for the possibility of unexpected routines or outcomes and by suggesting, as part of the induction process, that the patient listen only to what is said by the practitioner and not attend to the verbal communication of others in the operating theatre.

The major task for the hypnosis practitioner during the surgical procedure is to ensure that the hypnoanaesthetic effect is maintained. This is achieved through deepening techniques which the patient has practised and feels comfortable with (Finer, 1988). Ideosensory techniques are also useful here. For example, the hypnosis practitioner can induce catalepsy by stroking the patient's skin at the site of an incision and use the resultant psychological and physical effects as a means of reinforcing the suggestion of numbness, cold, or warmth (Kroger, 1990). If the patient experiences increased discomfort or pain, the surgical procedure should be stopped at an appropriate time and the hypnosis practitioner then helps the patient achieve a deeper level of trance. The possibility of this happening is, of course, part of the pre-surgical rehearsal with the patient.

Hypnotic interventions could also be used to help anaesthetised patients cope more effectively with operative procedures and post-surgical recovery. Numerous studies have shown that anaesthetised patients have some level of awareness of what is happening around them and can recall some aspects of what took place during their surgery (Halfen, 1986; Kolouch, 1962; Rossi & Cheek, 1988), leading to the conclusion that operating-theatre staff should be careful not to make negative comments or suggestions during surgical procedures (Evans & Richardson, 1988)). There is also evidence to suggest that patients may be susceptible to suggestions made to them whilst under surgical anaesthesia and do show suggested behaviours (Perry, Evans, O'Connell, Orne, & Orne, 1978), although these subjects usually show total amnesia for these suggestions when they wake. Hypnotic suggestions and cognitive reframing techniques could be used to help in the recovery of patients who had received chemical anaesthetics for their surgery.

Post-surgically, hypnotic suggestions can play a major role in helping patients deal with the immediate effects of the procedure and help ensure more rapid recovery (Evans & Stanley, 1990; Finer, 1988; Hilgard, 1988). These can be given when the patient is still in the recovery ward and continue the rehearsal process commenced pre-surgically (Schultz, 1954). The patient is told that the operation has been completed, that the wound is healing, and the body working to ensure that there is a speedy recovery with no infections. As a result, the patient feels comfortable and relaxed. Positive suggestions regarding the resumption of normal bodily processes and functioning are also included (Fredericks, 1978). The patient is told that there may be little or no need for analgesics or pain-killing medication, as the recovery process is proceeding so smoothly (Gruen, 1972). As with all suggestions, these are communicated in a positive and confident manner. It is also important that the hypnosis practitioner does not suggest that all the pain and symptoms of the medical procedure will be removed, for the reasons mentioned earlier. Telling subjects that many patients experience less pain and greater comfort using hypnotic techniques is a powerful suggestion which helps many patients cope with post-operative recovery (Evans & Richardson, 1988; Finer, 1988; Kolouch, 1962). Suggestions made by the hypnosis practitioner should be reinforced by medical and nursing staff with whom the patient comes in contact pre- and post-surgically. These are also a powerful source of influence for many patients, increasing their confidence in their own ability to control what is happening to them and decreasing reported pain and complications (Fredericks, 1978).

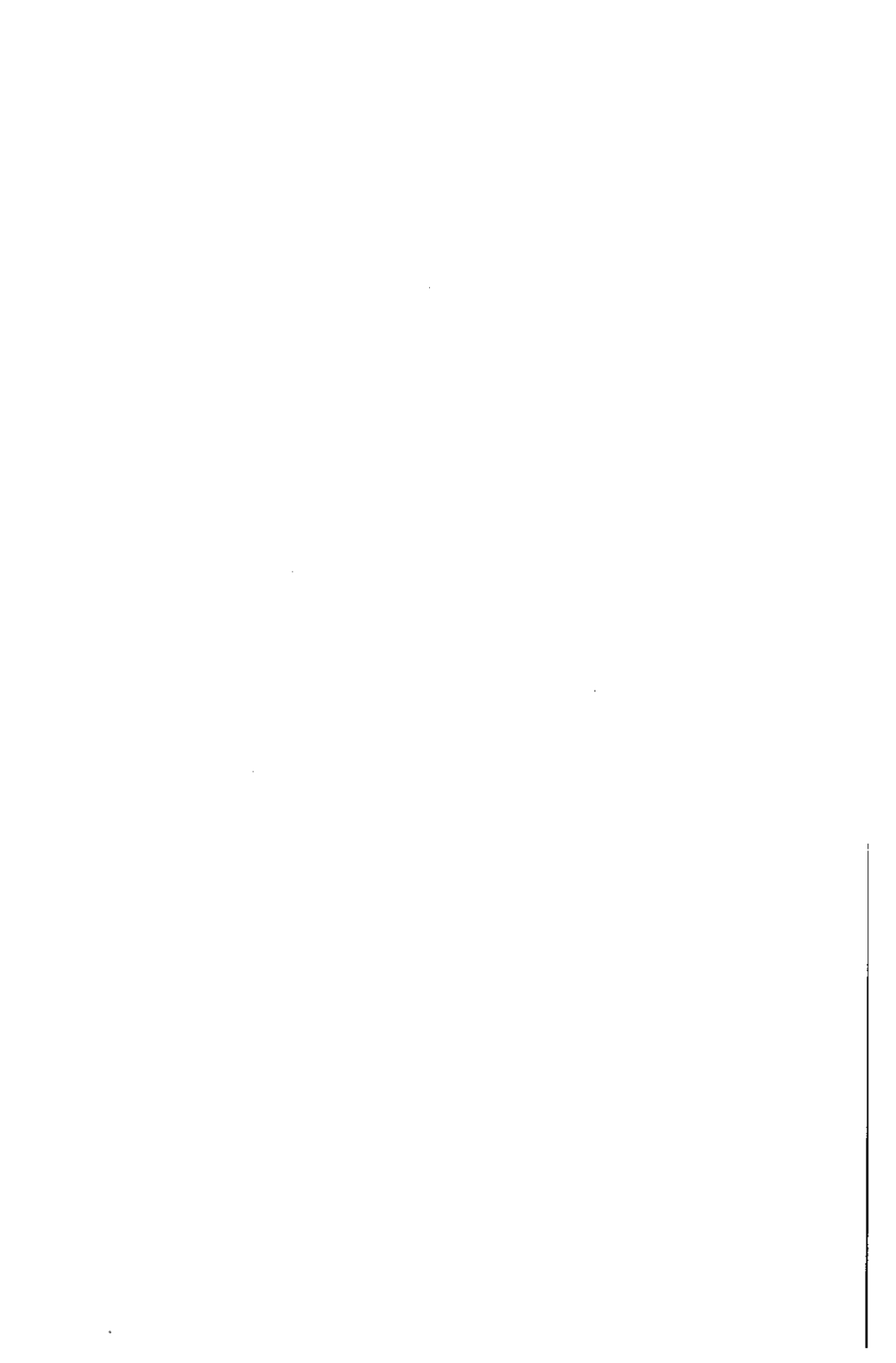
Patients with special needs in the post-surgical phase of medical care can also be assisted using hypnosis. Where the surgical procedure results in specific bodily symptoms (such as cramps or swelling in the area of the incision), the hypnosis practitioner should acknowledge that these sensations may be experienced, but that they are common reactions and are, therefore, a normal part of the post-operative process. The suggestion can then be made to the patient that these symptoms are not as great as he or she expected or that the patient has the ability to speed up the recovery process so that these symptoms disappear sooner rather than later. Similar suggestions can be made when the patient has any tubes or drips attached to the body.

The studies which have examined patients coping with surgery have demonstrated that hypnotic interventions can be a powerful mechanism to help patients deal with surgical procedures and their aftermath. For a limited number of highly susceptible patients, hypnoanaesthesia may be used as the sole anaesthetic, demonstrating the capacity of the human mind to control bodily processes. For the majority of patients, simpler hypnotic interventions described in this review, together with careful attention to patients' information and emotional needs, can provide the resources needed to speed post-operative recovery processes, lessen the pain and discomfort felt by many, and maximise, in the longer term, the personal resources needed to enhance post-surgical adjustment.

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OVERCOMING FEAR OF PUBLIC SPEAKING WITH THE DIAGNOSTIC TRANCE

Harry E. Stanton

University of Tasmania

Twenty-four male executives drawn from three large business firms were matched on their Fear of Public Speaking Thermometer scores, one member of each pair being allocated at random to either an experimental or a control group. The latter read articles describing how performance anxiety might be overcome while the former had two treatment sessions learning the diagnostic trance procedure. The Fear of Public Speaking Thermometer was administered on two further occasions, one immediately after completion of the second training session and one as a follow-up three months later. On these two occasions, subjects also completed Anecdotal Reports outlining their impressions of the experiment. After the first stage of the study had been completed, control group subjects experienced the same two treatment sessions as had the experimental group. Results indicated that fear of speaking in public was significantly less both immediately after use of the diagnostic trance and at the three-month follow-up.

It has been suggested by Frank (1972) that people seek assistance from therapists when they are unable to cope with life situations which they, and others, believe they should be able to handle. He labels this situation demoralisation, suggesting that the therapist's role may be conceptualised as that of morale restorer, assisting patients to feel that, within themselves, they possess the resources which will enable them to cope effectively with their environment.

One approach to the fulfilment of this role may be through the use of the trance state. Kuriyama (1968) has claimed that being in a trance is very valuable in itself, irrespective of any therapeutic suggestions which might be given to patients who are in that state. Erickson and Rossi (1977) have supported that position, affirming that hypnotic induction techniques are simply mechanisms providing people with opportunities for an intense self-absorption which permits them to access their inner experience more fully.

As people in a trance state often adopt the role of a passive observer, they find it easier to become aware of their own unconscious sources of potential

information and guidance. They are able to focus their attention, in a detached manner, upon thoughts, images, or sensations that would ordinarily be overlooked or denied. They are also able to experience the events they imagine with great clarity, acting as if they were in the actual situation, experiencing many of the same changes in learning, performance, and belief as they would in real life (Havens & Walters, 1989).

Such changes tend to occur spontaneously as a function of people's entering into trance and, in a state of relaxed involvement, examining the thoughts, memories, or images associated with their inner sources of physical and mental pain. Through use of the trance state, they learn how to make use of these inner resources to solve the problems causing the pain and discomfort.

THE DIAGNOSTIC TRANCE

One method of demonstrating to people that they have, within them, unconscious resources capable of assisting in problem solution has been described by Havens and Walters (1989). Their approach, the diagnostic trance, begins with having people close their eyes, relax, and concentrate upon the unpleasant sensations or feelings associated with their problem. As they do so, they usually drift into a light trance, turning inward in order to focus on internal events.

As part of this internal focusing, people mentally observe the unpleasant sensations, reporting whatever thoughts or images come into their minds. They are encouraged to observe their discomfort in a somewhat detached manner, simply allowing associated memories or ideas to spring spontaneously to mind. When they report on what is going on inside them, they usually reveal a pattern of thinking, a series of images, or even a specific memory which is creating the problem. One person may hear a voice repeating a particular phrase while another may recall a previously forgotten incident.

The final step in the diagnostic trance procedure involves asking people to find a thought or image which removes or displaces their unpleasant feelings. At an unconscious level, many people know quite precisely what they need to do to solve their problem. Others actually have all the resources required to work out what is needed but they do not know that they have this knowledge. Given the opportunity provided by the diagnostic trance, they often find solutions occurring spontaneously.

SUBJECTS AND METHOD

Many business executives suffer from a fear of public speaking, yet, as a function of the position they hold, they are often called upon to address groups, both large and small. Twenty-four male executives working in three large business firms, ranging in age from 34 to 53 years, comprised the subjects of this study. These men responded to an offer to help with public speaking made in the context of seminars on management techniques being conducted within the firms.

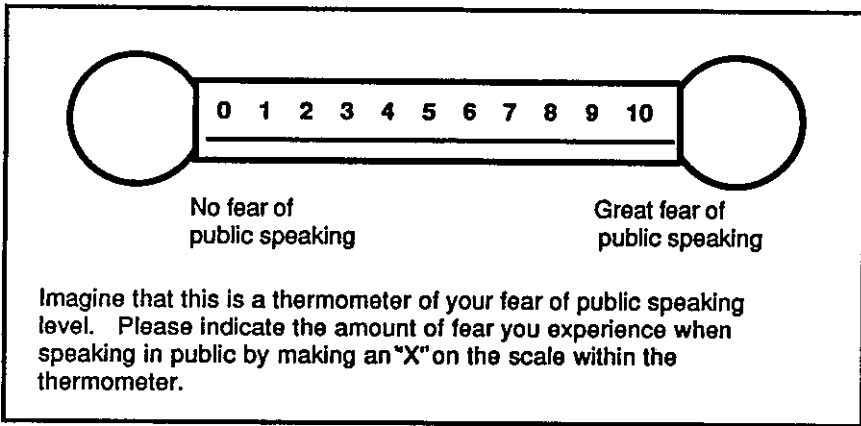


Figure 1. Fear of Public Speaking Thermometer.

The executives completed an adaptation of the Fear of Public Speaking Thermometer (Francis & Stanley, 1989) which was termed the Fear of Public Speaking Thermometer (see Figure 1). The thermometer format has a number of advantages including high face validity, familiarity, ease of administration, and satisfactory reliability and validity (Hornblow & Kidson, 1976; Luria, 1975; Price, McGrath, Rafti & Buckingham, 1983). As the Francis and Stanley study demonstrated adequate reliability and validity for a thermometer defined by scale extremes such as "No fear of public speaking" and "Great fear of public speaking", this form was employed in the present study.

In the first stage of the experiment, the executives were paired on their Thermometer scores, one member of each pair being allocated at random to either a control group or an experimental group. Two 30-minute sessions were used, spaced one week apart. Control group subjects used this time to read articles on coping with the anxieties engendered by public speaking while the experimental group subjects were shown how to use the diagnostic trance procedure.

Sessions for both groups were conducted in a thickly carpeted, well curtained office furnished with comfortable upholstered chairs. This provided a pleasant environment for the control group's reading and for the experimental group's relaxation as they learned how to use the diagnostic trance to solve problems. It was suggested to the subjects in the experimental group that it would be helpful for them to use the positive images generated by the procedure whenever negative thoughts about public speaking entered their mind. It was also impressed upon them that these positive images could be used to counteract feelings of fear in the actual situation itself.

The Fear of Public Speaking Thermometer was administered to both experimental and control groups immediately after completion of the second session and again three months later. Anecdotal reports, in which the executives

recorded their thoughts about the two sessions, were also completed on these two occasions. Subjects were asked simply to write down their thoughts about the experiment in the form of an anecdotal report.

In the second stage of the experiment, the control group experienced the same two treatment sessions as had the experimental group. In this way, they functioned as their own controls, providing further data pertaining to the effect of the diagnostic trance technique.

RESULTS

Stage 1

Data derived from Fear of Public Speaking Thermometer administrations are set out in Table 1.

A repeated measures analysis of variance indicated the existence of a highly significant difference between Experimental and Control groups ($F = 9.48$, $df = 5$, $p < .01$). Comparisons of the immediate after-treatment scores of the two groups revealed a significant reduction in fear of public speaking on the part of the former, as compared to the latter, this being operationalised in terms of scores on the Fear of Public Speaking Thermometer (Scheffe $F = 3.88$, $df = 11$, $p < .01$). Consideration of the three-month follow-up scores of the two groups indicated that the lower fear of public speaking level of the experimental group had been maintained (Scheffe $F = 2.78$, $df = 11$, $p < .05$).

A comparison of the experimental group's pre-treatment score with that recorded immediately after treatment (Scheffe $F = 4.39$, $df = 11$, $p < .01$) and three months later (Scheffe $F = 2.36$, $df = 11$, $p < .05$) indicated a significantly diminished fear of public speaking. No such diminution was displayed by the control group.

Table 1 Mean Scores and Standard Deviations for Two Groups of Executives on the Fear of Public Speaking Thermometer Administered Before, Immediately After, and Three Months After Treatment ($n=24$)

Group	Before treatment	Immediately after treatment	Three months after treatment
Experimental	60 (19.7)	33.4 (19.1)	36.8 (18.3)
Control	59.3 (18.4)	58.4 (18)	58 (19)

Table 2 Mean Scores and Standard Deviations for Control Group on the Fear of Public Speaking Thermometer Administered Before, Immediately After, and Three Months After Treatment ($n=12$)

Group	Before treatment	Immediately after treatment	Three months after treatment
Control	58 (19)	36.9 (20.2)	38.3 (20.8)

Stage 2

Table 2, which presents the data pertaining to the second phase of the study, when control group subjects experienced the diagnostic trance procedure, confirmed the presence of the same improvement pattern.

For the control group, the three-months follow-up score from Stage 1 of the experiment was used as the pre-treatment score. When this was compared to Fear of Public Speaking Thermometer scores, by means of a repeated measures analysis of variance, immediately after (Scheffe $F = 5.19$, $df = 11$, $p < .05$) and three months after (Scheffe $F = 4.51$, $df = 11$, $p < .05$) the two treatment sessions, a significant reduction in fear of public speaking was apparent ($F = 6.48$, $df = 2$, $p < .01$).

DISCUSSION

It would appear, from the results presented above, that the executives in both the experimental group of the first stage of the study, and the control group of the second stage, were able to reduce their fear of public speaking level significantly through use of diagnostic trance procedure. Three months after conclusion of the experiment, this improvement had been maintained.

The anecdotal reports of the executives provided information on their use or lack of use of the technique after leaving the experimental situation. Approximately half of them continued to employ the procedure as a means of handling the various problems which arose in their lives, their comments indicating that they derived considerable benefit from behaving in this way. Many of these executives taught the procedure to members of their families and to friends as an effective approach to problem solving.

However, there was no significant difference between those executives who made more extended use of the procedure and those who restricted their use of the technique to handling their fear of public speaking alone in terms of the number of speaking engagements undertaken. Over the group of 24 who took part in the experiment, there was an 83% increase in the number of speaking engagements undertaken during the 12 months following the experimental treatment compared to the 12 months preceding this treatment.

Thus it would appear that two treatment sessions occupying a time period of 60 minutes were sufficient to assist the executives in reducing their fear of public speaking, both in terms of Thermometer scores and number of speaking engagements.

It is easy, on initial acquaintance with the diagnostic trance, to believe its simplicity precludes its being of any real value as a problem-solving method. This is an assumption which, unfortunately, often remains untested, for many people never actually try out the procedure to find if it could be useful to them. Yet, should they wish to test its applicability to their own situation, it is most unlikely that they would come to any harm. Either it helps people solve a problem or it does not. If it does not, they will need to look for another solution, but they will be able to move on without having suffered negative side effects. Diagnostic trance is a gentle, non-intrusive procedure which most people enjoy and, having once learned it, use repeatedly as a problem-solving method.

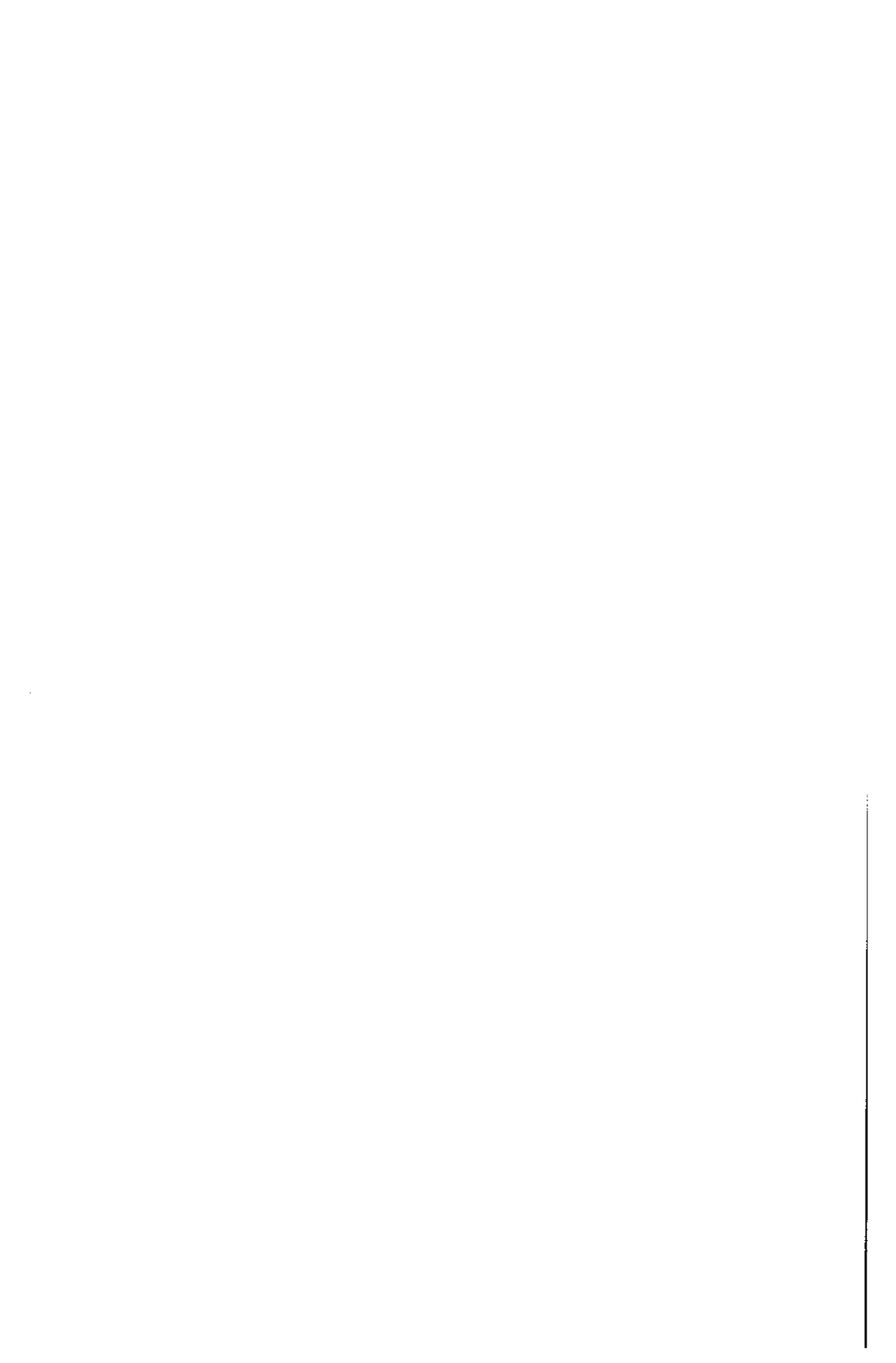
This is not to claim that the diagnostic trance will solve all problems. It will not produce the desired result every time. However, it is able to assist many people on many occasions. Children and adults alike find it of value. My own records show that of 103 cases drawn from a general population, approximately 70% reported discernible improvement in their handling of the specific problem which had been causing them trouble. This percentage did not appear to be related either to age or sex, possibly because of the nature of the technique. In its simplicity lies its strength, for it is easy to teach the technique to people who, once they have gained confidence in using it on their own problems, can then demonstrate its effectiveness to others, such as family members and friends.

In addition to being effective, the diagnostic trance is pleasant to use, even in the processing of unpleasant experiences. However, despite the positive virtues of the technique, it could arouse some apprehension due to fears about trance states themselves. Yet such an attitude is really unfounded. Trance states are quite natural. It is normal for people to daydream, drifting into a world of their own making while they are physically present in another environment altogether. It is also not uncommon, while driving, for us to arrive at some town without any recollection of what has transpired over the previous 10 or 20 kilometres. Similarly, we can become so immersed in a book or a television show that we are unaware of a knock on the door or a ring of the doorbell. This can be explained to a client.

With the diagnostic trance method we are teaching people how to use this capacity to enter trance more systematically, employing it as a means of solving problems such as the fear of public speaking. That we are able to do so in such a pleasant and effective manner would suggest that the process deserves wider use.

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HYPNOTISABILITY IN POST-TRAUMATIC STRESS DISORDERS: IMPLICATIONS FOR HYPNOTIC INTERVENTIONS IN TREATMENT

Barry J. Evans

Monash University

Post-traumatic stress disorder (PTSD) is a syndrome characterised by a number of debilitating symptoms which may follow exposure to a psychologically traumatic event and which overwhelm the individual's ego-adaptive mechanisms. Symptoms may include recurrent and intrusive recollections of the event, numbing of responsiveness or reduced involvement with the world, sleep disturbance, guilt and attentional difficulties. Researchers have shown that sufferers of PTSD typically show high levels of hypnotisability.

Hypnosis provides an appropriate and powerful treatment modality for post-traumatic stress disorder. It is an effective hypnotherapeutic technique, allowing the patient to regress to or recall the traumatic experience and abreact the emotionally charged content of the event. Additional material pertinent to the aetiology of the patient's disorder may also be elicited during this process. Hypnosis may be used as a means of helping patients reintegrate the psychic split caused by the trauma and to redevelop a sense of mastery over their lives. For the competent and experienced hypnosis practitioner, hypnotic techniques should always be considered as a possible modality in the treatment of post-traumatic disorder.

The modern study of hypnosis and hypnotisability has seen many attempts to understand the relationship between the trance state and psychopathology. Recent studies relating hypnotisability and psychopathology have shown that most psychiatric patients have lower hypnotisability levels than non-psychiatric controls and that, the more severe a patient's disorder, the lower is that person's level of hypnotisability (Spiegel, Detrick, & Frischolz, 1982). There are, however, a number of disorders which are characterised by patients' high levels of hypnotisability. These include diagnoses of hysteria and multiple personality (Bliss, 1983, 1984), anorexia and bulimia (Pettinati, Kogan, Margolis, Shrier, & Wade, 1989), phobic disorder (Frankel, 1988), and post-traumatic stress disorder (Spiegel, Hunt, & Dondershine, 1988; Stutman & Bliss, 1985).

This paper examines the relationship between subjects' level of hypnotisability and severity of post-traumatic stress disorder and details implications for treatment of patients suffering from this disorder, using hypnotic interventions.

Post-traumatic stress disorder (PTSD) is the term used to define the cluster of symptoms precipitated by exposure to a severe stressor. While the clinical manifestations of PTSD may vary considerably from one patient to another, the most frequent symptoms are emotional distress, fatigue, difficulty relating to others, self-destructive or aggressive rages, inability to concentrate, fear of losing control, feelings of guilt, phobic avoidance, and the frequent occurrence of intrusive, vivid flashbacks to the stressful event (American Psychiatric Association [DSM III-R], 1987). The disorder was initially researched in the context of the Vietnam War (Kelly, 1985; Parson, 1984) but is now examined in the wider context of people's experiences of such stressful events as rape (Spiegel, 1989), hijacking (Brom, Kleber, & Defares, 1989), natural disasters (McFarlane, 1988b) and mass shootings (Creamer, Burgess, Buckingham, & Pattison, 1989).

The etiology of PTSD symptomatology develops from the inability of the individual to cope with the actual or perceived threat evoked by the traumatic event, the impact of which overwhelms the ego adaptive mechanisms of the individual (Mutter, 1986). PTSD can show itself in both chronic and acute forms (DSM III-R, 1987). The acute form has an onset within six months of the trauma, with resolution within six months. In its chronic form, PTSD shows onset at least six months after the trauma, with the symptoms lasting for months or years (DSM III-R, 1987).

One aspect of the experience of severely stressful events to receive considerable attention in the literature has been many subjects' dissociative ability. Subjects frequently report dissociation during traumatic experiences (Spiegel, 1989), with many reporting a feeling of floating above their bodies, remaining detached from what is taking place. Such reports are particularly common in rape cases (Rose, 1986; Spiegel, 1989). Subjects' dissociation during the stressful event is a defence against the powerful negative affect associated with the experience they are enduring (Brende, 1985; Spiegel et al., 1988).

Following the traumatic event, many PTSD sufferers experience distressing flashbacks to the event (Horowitz, 1976). PTSD sufferers from Vietnam have reported auditory hallucinations of dying comrades (Mueser & Butler, 1987), innocent participants in the Queen Street incident in Melbourne in 1987 reported frequent intrusive thoughts and memories of the incident including dreams and vivid images (Creamer et al., 1989), as have patients who have undergone stressful experiences during surgery (Peebles, 1989).

These components to PTSD suggest a "psychic numbing" (Brende, 1985), which helps sufferers avoid conscious traumatic memories of the event. Many patients with PTSD experience a polarisation in which they alternate between intense, vivid, and painful memories and images associated with the traumatic experience, and a kind of pseudonormality in which the victims avoid such

painful memories, using traumatic amnesia, other forms of dissociation, and repression, with associated reduction in adaptive capacity and loss of affective responsiveness (Spiegel et al., 1988).

The phenomena associated with PTSD are consistent with the primary phenomena of hypnosis: absorption and dissociation. Just as the hypnotised subject is intensely absorbed in his or her focal experience (Tellegen & Atkinson, 1974), so too can the PTSD sufferer become absorbed in re-living the traumatic experience. One result of this intense absorption is usually a state of dissociation from one's immediate surroundings and conscious experience (Burrows, 1988). When these flashbacks occur, they quickly occupy all of the sufferer's attentional resources and result in a reduction in responsiveness to other stimuli (Spiegel, 1989). These parallels between the hypnotic state and PTSD symptomatology have been confirmed in the finding that the hypnotisability ratings of PTSD sufferers are significantly higher than those of other pathology groups (such as phobics and those with multiple personality disorder) and higher than the normal population (Spiegel et al., 1988; Stutman & Bliss, 1985). These authors have speculated that either traumatic experiences enhance subjects' hypnotic potential in some way or that subjects who are highly hypnotisable are more likely to experience PTSD than low hypnotisable subjects when both are confronted with a traumatic event.

HYPNOTIC INTERVENTIONS FOR POST-TRAUMATIC STRESS DISORDER

A number of researchers and clinicians have reported the use of hypnotic techniques with PTSD sufferers. These have included cases of PTSD following surgery (Peebles, 1989), combat (Brende, 1985; Grigsby, 1987), accidents (Mutter, 1987), burns injuries (Dobkin de Rios & Friedmann, 1987), rape (Spiegel, 1989), bereavement (McFarlane, 1989) and child abuse (Havens, 1990). Since many people mobilise what is akin to the hypnotic state during traumatic experiences, it seems sensible to use hypnosis as a means of helping PTSD sufferers retrieve their repressed or dissociated memories of the event and emotional reactions to the experience they have endured. However, the hypnosis practitioner must be aware of the high hypnotisability of many PTSD sufferers and use hypnotic interventions judiciously, to avoid the possibility of hypnosis contributing to, rather than minimising, the patient's emotional and psychological problems.

Hypnotic interventions can be used in a number of ways to treat patients with PTSD. These are: as a supportive technique when the patient requires help in controlling and minimising anxiety; as a means of uncovering repressed or dissociated thoughts and memories of the traumatic event; and as a means of reintegrating the experience into the patient's consciousness (Brende, 1985).

Hypnosis practitioners treating clients with PTSD should be attuned to the particular needs of these patients. PTSD sufferers show low compliance behaviour and a tendency to drop out of therapy (Burnstein, 1986). They

are typically difficult patients with whom to establish effective communication because of their reluctance to enter into therapeutic relationships and their perception that the majority of therapists will not be able to comprehend the enormity of their traumatic experience (Lindy, Grace, & Green, 1981; Lindy, Green, Grace, & Titchener, 1983). The practitioner should be experienced in dealing with PTSD in the therapeutic setting and needs to give careful consideration to these aspects of therapy.

An important element early in the therapeutic relationship is that the patient has made a decision to challenge his or her isolation by seeking help. The practitioner needs to provide both a sense of hope to the patient and information explaining the reasons for the emotional distress and anxiety that the patient is likely to be experiencing at the time he or she presents for therapy (McFarlane, 1989). Hypnotic suggestions for relaxation and control may be very useful at this stage of the therapy, to help the patient understand his or her feelings and reactions, to reduce anxiety, and to increase the patient's motivation to continue with therapy (Brende, 1985). A progressive relaxation induction may be appropriate, utilising the visualisation of the patient moving "energy" into his/her body (Dobkin de Rios & Friedmann, 1987). Many PTSD patients seek out treatment as a means of obtaining relief from their heightened emotional reactions to their intense absorption of re-living the stressful experience and their commitment to treatment may be enhanced if these distressing symptoms can be controlled (McFarlane, 1989). The hypnosis practitioner should utilise techniques which help maintain a sense of calmness and control for the patient, contributing to the effectiveness of therapy.

The hypnosis practitioner should bear in mind the research finding that over 50% of PTSD patients have some form of psychiatric illness associated with post-traumatic stress symptoms, with panic disorder and major depressive symptoms being the most common diagnoses (Davidson, Swartz, Storck, Krishnan, & Hammett, 1985). Hypnosis can be used quite effectively for treatment of phobic and anxiety conditions (Frankel, 1988) but is contraindicated for the treatment of depression (Burrows, 1988). It is important to ensure that any psychiatric symptomatology can be treated concurrently with the PTSD symptoms, given that the onset or increased severity of the psychiatric symptoms can increase the PTSD symptoms and associated anxiety (McFarlane, 1989).

Hypnosis may also be used in the early phases of treatment to help build trust between the patient and therapist. For example, the hypnosis practitioner may use the following suggestion:

I would like you to relax and imagine that I am helping you with the burden that you are carrying. It's been there ever since your [include exact type of trauma experienced by patient] and has contributed to all the pain/emotion you are feeling. Imagine that I am right here with you now, helping you hold up the burden. As you let me share that burden with you, it will be easier for you in the future to talk about

what is bothering you and to share your feelings with me (adapted from Brende, 1985, p. 203).

With the patient in an hypnotically induced state of relaxation, the hypnosis practitioner may explore the aetiology of the post-traumatic stress disorder. The practitioner must explore the type of traumatic event to which the patient has been subjected and consider whether the patient is experiencing acute or chronic PTSD. For example, there are considerable cognitional and emotional differences between involvement in a combat situation, being the victim of rape, and being caught in a natural disaster (McFarlane, 1989; Spiegel, 1989). These different traumatic situations cause a range of feelings regarding the possibility of one maintaining or establishing control over the situation and trust in others, factors which will also vary depending on the severity of the traumatic experience and the closeness of death experienced by the patient (McFarlane, 1989). Additionally, the practitioner must be aware of the time period between the traumatic event and the patient's presentation for therapy. With acute PTSD disorders, the majority of patients will have developed the early stages of social and personal dysfunction and these will still be amenable to treatment. In cases of chronic PTSD, the therapist's attention will be focused on remedying the patient's reduced affect and social withdrawal (McFarlane, 1988a; 1989).

As Brende (1985) noted, re-living events in one's life is a common experience for most people. Such re-living helps ensure control over one's life and the maintenance of a sense of personal identity and continuity with the past. However, PTSD sufferers may exhibit the symptoms of amnesia for the traumatic events, thereby lacking the sense of continuity needed to establish mastery over their situations (Horowitz, 1976). This amnesia may result from the psychic numbing PTSD sufferers experience in their attempts to keep traumatic experience from consciousness. However, the resultant instability gives rise to repetitive re-enactments of the traumatic event, which are unconscious and potentially uncontrollable attempts by the person to achieve a resolution of the intrapsychic split caused by the alternate repression and recall of the trauma (Horowitz, 1976). Hypnosis may assist in the opening up of the patient's repressed memories of the traumatic event.

In the process of helping the patient "uncover" repressed memories, it is important that the hypnosis practitioner comes to a greater understanding of what the patient experienced, as a means of comprehending the nature of the intrusive cognitions and associated feelings reported by the patient (Horowitz, 1976; McFarlane, 1989). This may not only be of therapeutic value to the patient but may also reduce the patient's feelings that the therapist is distant from the traumatic event and, therefore, unable to comprehend its magnitude (Lindy et al., 1981; Lindy et al., 1983).

It is also important for the practitioner to separate out the patient's intrusive memories and re-living of the traumatic experience (cognitions) from his or her feelings of loss, anxiety, or depression (emotions). As McFarlane (1989)

noted, there are quite different therapeutic goals between helping the patient accept that the traumatic event has occurred and helping the person deal with the range of painful emotional states evoked by the event.

Hypnotic regression can be a successful hypnotic technique for helping patients retrieve repressed memories of their traumatic experiences (Mutter, 1987; Spiegel, 1989). The most important aspect to the use of any technique which may enable patients to re-live their trauma is for the hypnosis practitioner to teach the subject to dissociate his or her mental experience from the physical experience. This serves two purposes. First, it reminds the patient that the traumatic event is not physically recurring. Second, it may prevent the subject from experiencing an anxiety or panic reaction in response to the re-living of the event. The hypnosis practitioner may use a metaphor which suggests physical relaxation, as in a bath or pool, and a sense that the subject is floating. The traumatic event may then be re-experienced by having the subject picture the event occurring on an imaginary screen (Spiegel, 1989). It is useful to have the patient divide the screen into two halves. On one side there is a re-creation of the traumatic event, while, on the other, the patient visualises any action he or she took at the time to control what was happening or to escape the situation. The negative picture on the one side is then balanced, to some extent, by the patient's attempting to provide protection, maintain dignity and, in some way, to exert mastery over the situation, as revealed on the other side of the screen (Spiegel, 1989).

Given that the hypnotic trance state intensifies the patient's focus of attention on re-living the traumatic event and reduces peripheral awareness, hypnotic techniques are useful in helping patients regain control over their thought processes. As Spiegel (1989) noted, the very discreteness of the hypnotic state helps the patient put a boundary around the trauma response. The hypnosis practitioner, rather than telling the patient not to mull over the details of the experience, instructs him or her to re-experience the events, with the suggestion that once the patient has completed this therapeutic integration, he or she can go on to other things.

The hypnosis practitioner must be alert to the fact that PTSD sufferers may be likely to experience strong emotional reactions to the re-living of their traumatic experience and may show an extreme abreaction, despite efforts to control for this possibility. Brende and Benedict (1980), for example, used self-hypnosis with a Vietnam veteran as a means of recovering the patient's memories. After several weeks, however, the patient had become more hostile and emotional as a result of opening up what had been repressed feelings of responsibility for the deaths of civilians. These reactions were so pronounced that the therapists had to terminate hypnosis and replace it with supportive psychotherapy. Similarly, Mutter (1986, 1987) and Peebles (1989) reported cases of severe abreaction when treating PTSD patients using hypnosis.

The goal of the clinician is to help the patient understand that these emotional reactions are possible and that their controlled expression is more therapeutic

than their repression (Brende, 1985; Mutter, 1987; Spiegel, 1989). Many patients express the fear that, if they attempt to recall their experiences, they will become victim to greater anxiety and fear (Brende & Benedict, 1980). The hypnosis practitioner must use suggestions of control and relaxation which will make it possible for the patient to recall the repressed event and then consolidate the memory in a therapeutic way (Grigsby, 1987; Spiegel, 1989). Suggestions that the patient can restore personal mastery and control are very therapeutic for PTSD patients, given that they have feelings of low control and perceived low ability to cope with the traumatic event and current stressors (Hyer, Boudewyns, & O'Leary, 1987). For example, Ebert (1990) uses the following suggestion for PTSD patients: "Take your time with this growing sense of power, control, and comfort because you will discover that, the more you relax with the techniques, the more the fears will simply fade away." Another of Ebert's techniques is to have the patient imagine a person whom he or she sees as having the strength to deal with the trauma and then tells the patient to: "take the strength you need from this person, store it deeply inside you and utilise it whenever you choose by recalling the image when you need to feel strong and in control" (adapted from Ebert, 1990).

A therapeutic element of treatment for which the hypnosis practitioner may utilise hypnotic suggestions is in exploration of the patient's degree of withdrawal from social contact (Spiegel, 1989). Encouragement of renewed involvement with others who may provide social support and re-engagement in relationships may be difficult with PTSD patients, given their sense of vulnerability and lack of trust in others (Kelly & Reddy, 1989; Strupp, 1972). The practitioner should include suggestions for anxiety reduction, ego-strengthening, and cognitive reframing as ways of reducing the patient's fear and anxiety and instilling the belief that social re-engagement is possible, desirable, and under the patient's control. Using cognitive reframing suggestions, the practitioner can help the patient re-evaluate the importance of social relationships in stress management, re-establish in the patient's mind his or her ability to restore social contacts, and/or help the patient re-establish trust in other people.

The hypnosis practitioner must explore the patient's fears regarding the recurrence of the traumatic event (Horowitz, 1976). Patients who exhibit an intense fear of the event recurring show an inability to develop effective coping strategies to help them deal with stressful events. This fear may result in intense feelings of vulnerability and possibly hypervigilance (McFarlane, 1989). Hypnosis may be effective in treating both these symptoms. Feelings of vulnerability can be reduced by using suggestions of control, power, and strength. Patients' hypervigilance may be reduced using hypnotic suggestions for anxiety reduction and other cognitive techniques, such as thought-stopping and cognitive reframing. One perpetuating factor important in the morbidity and treatment of PTSD is the possibility of re-exposure to the traumatic experience. Combat veterans are returned home so that the trauma is focused in their memories and imaginations, while victims of natural disasters, accidents,

and personal attacks may be often and involuntarily re-exposed to their trauma. For patients who may be faced with the scene of their traumatic experience, the hypnosis practitioner can utilise a coupling technique, such as: "Whenever a thought about this event occurs or you are faced with the scene of the event, you will add to your thoughts the idea that you can control your emotional response and that, each time it happens, you feel greater and greater control over your feelings." A posthypnotic suggestion can be tied to this coupling, to the effect that anytime a flashback occurs or the person is confronted by the trauma, the imagery would immediately be coupled with the above suggestion.

For PTSD sufferers experiencing pain or other bodily symptoms which are due to their traumatic experience (e.g., burns or accident victims), hypnotic intervention for pain control and symptom substitution can be very effective. These include direct suggestions for pain reduction, dissociation, displacement or alteration of the painful stimuli, sensation substitution (tingling instead of pain), and transference of the pain (glove anaesthesia) (Evans & Stanley, 1991; Hilgard, 1988). If patients have undergone, or are currently undergoing surgery, suggestions for rapid healing and mastery over bodily responses are also appropriate (Evans & Stanley, 1991).

The research reviewed in this paper clearly suggests that hypnosis is an appropriate and powerful treatment modality for post-traumatic stress disorder. It is an effective hypnotherapeutic technique, allowing the patient to regress to or recall the traumatic experience and abreact the emotionally charged content of the event. The hypnotic techniques useful in this process allow the practitioner to gain a fuller understanding of what the patient has experienced, facilitating greater empathy and trust. Additional material pertinent to the aetiology of the patient's disorder may also be elicited during this process. The patient can be desensitised to their traumatic experience and have the powerful emotions of anxiety, fear, and loss of control replaced by feelings of control and mastery. The emotionally charged split that characterises PTSD symptomatology can be re-integrated using coupling and posthypnotic suggestions. At a simpler level, hypnosis can be used to alter symptoms, control pain and other bodily symptoms. Most importantly, hypnosis may be used as an ego-strengthening technique, helping patients to redevelop a sense of mastery over their lives (Mutter, 1986; Spiegel, 1989). For these reasons, hypnosis should be always considered as a possible modality in the treatment of post-traumatic disorder.

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BOOK REVIEWS

A Handbook of Hypnotic Suggestions and Metaphors. D. Corydon Hammond (Ed.). New York: W. W. Norton & Co. 1990. xxi + 602. \$US65.00.

This is a great book for the practitioner. That is, it is about doing things rather than talking about doing things. Instead of profound intellectual discussion of theories, it presents the reader with the "how to" suggestions that experienced clinicians actually use when talking to their patients during hypnotic work. These range from the highly indirect, permissive, and metaphoric, to the very direct, forceful, and authoritative.

Though it could be dismissed as just another cookbook, a collection of "recipes" permitting mindless repetition, this book is much more than that for it embodies the wisdom of many outstanding clinicians. Yet, even if it was "only a cookbook," this is not a denigration of its value for it is an excellent example of the genre. As any good cook will tell you, a recipe is only the starting point for great culinary achievement, providing a framework for the expression of creativity.

The field covered is extremely comprehensive, beginning with an overview of the principles involved in effective use of hypnotic and posthypnotic suggestion. Of particular value is Hammond's practical advice on the phrasing of suggestions. This is capable of immediate application, even by those inexperienced in the field. Also valuable is the scholarly overview of the relevant literature that provides the introduction to each chapter.

The table of contents reads like an overview of the entire hypnotherapeutic spectrum. For the practitioner of medical hypnosis, there are suggestions provided for pain, hypnoanaesthesia and hypnotic preparation for surgery, burns, emergencies, gastrointestinal disorders, cancer, chemotherapy, dermatologic complaints, obesity, smoking and addictions, childbirth training, obstetrical and gynaecologic applications, insomnia, autoimmune diseases and haemophilia.

The needs of psychologists are catered for with practical suggestions concerning habit disorders, such as nailbiting and trichotillomania, anxiety and phobic disorders, sexual dysfunction and relationship problems, concentration, academic performance, athletic performance, ego-strengthening, enhancing esteem, self-efficacy and confidence, post-traumatic stress disorders, multiple personality disorder, severe disturbances such as borderline and schizophrenic patients, and other emotional disorders.

Clinicians working with children will appreciate the chapter outlining how hypnosis may be used in the treatment of pain and hypnoanaesthesia, dyslexia,

stuttering, enuresis, Tourette syndrome, school phobia, and asthma. Dentists, too, have not been neglected: the book includes suggestions concerning bruxism, TMJ, anxiety and phobic responses, pain control, thumbsucking, vascular control, and gagging. There are also suggestions on facilitating time reorientation, age regression, age progression, and time distortion which will be of value to medical practitioners, psychologists, and dentists alike.

This handbook is the result of prodigious effort. Hammond has not only solicited many original and previously unpublished suggestions from outstanding hypnotherapists, but has assiduously searched the vast hypnotherapeutic literature of the past 30 years in search of high quality material. This he has organised into a single large volume accessible to all. Yet, despite this work, neither Dr Hammond nor any of his contributors will receive royalties from its publication. All proceeds from its sale will go to the American Society for Clinical Hypnosis to promote further research and workshop training by that organisation.

This is not a book to read once and put aside. It can be savoured and referred to time and time again, serving as an invaluable reference for every practitioner who uses hypnosis. Representing, as it does, the largest collection of therapeutic suggestions and metaphors ever assembled, the book permits readers to select material compatible with their own personal style of doing hypnosis and with the individual patients they treat. With so many excellent models provided in the book, Hammond's hope that readers will be stimulated to create their own hypnotic suggestions and metaphors is likely to be realised.

HARRY E. STANTON, University of Tasmania.

An Introduction to the Practice of Clinical Hypnosis (2nd ed.). Michael D. Yapko. New York: Brunner/Mazel. 1990. xxviii + 446. \$93.00.

I was expecting a standard "recipe book", and one with a rather magical, Ericksonian feel to it at that. This is simply not the case. Yapko is actively against the use of scripts, using which "robs hypnosis of its real potency, the strength derived from the recognition and use of each individual's unique experiences and needs" (p. 44). Instead, we are given a broad-ranging series of frameworks within which a practitioner can devise individuated therapeutic approaches.

Yapko has set himself an enormous task, with 23 chapters covering everything from hypnotic susceptibility, inductions, and deepening procedures to ethical considerations. The first section of the book looks at conceptual frameworks and the second, longer section at practical considerations. It is written in a cheery, clear, and readable style. Most chapters end up with sections on "points for discussion" and "things to do," which make the book a valuable teaching tool.

Although the approach undeniably is Ericksonian, I did not find it in any way off-putting. Yapko argues his points sensibly and thoroughly, though

one may not agree with all his conclusions. Certainly, it is one of the clearest expositions of Ericksonian theory and therapy I have read.

Whatever one's theoretical orientation, no clinician can fail to find innovative additions to the therapeutic repertoire. It's a must in every practitioner's library.

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

Children Dreaming. Brenda Mallon. Melbourne. Penguin Books. 1990. 238 \$11.99.

Here is a chatty, friendly book, written for the "many mothers" in Britain who requested it of Mallon, we read. It is also inspired by her own toddler-interrupted sleep. "I learned from my children that their dreams were not to be taken lightly." This introduction sets the tone and scope of the book.

The text begins with the questionnaire administered to children seven years and over, the answers to which make up the bulk of the text. Children from three to six did drawings and their comments were taped. There follows discussion of: the physiology of dreaming (which is presented as "the" theory of dreaming!) with brief reference to some of the theoretical literature; thence a description of age-based differences from birth through to 16 years; on to such enticing topics as dreams and childhood illness, psychic phenomena, the influence of the media, separation, divorce, death, and war. There is also a chapter on dream sharing or how to set up a dream group in which children can discuss and "work through" their dreams. For the interested lay reader there is a useful bibliography of readily accessible and digestible references. A reading list for children, with age recommendations, is a thoughtful inclusion.

Advice on the necessity of responding to the emotional problems of children as presented in their dreams is sound, restrained, and well-gearred to the average reader. Mallon points out when professional advice should be sought and continually emphasises the importance of communication between parent and child. Talking about dreams and fairy tales is a lovely opportunity for this. The warning to parents and teachers not to make moralistic judgments on dream content, "for dreams do not have a moral code," illustrates her commonsense approach. However, there are sometimes superficial comments — almost "now fancy that!" — responses which are somewhat irritating.

Some telling issues are raised but not adequately documented or pursued. For example: "Girls more frequently dream of home and show guilt feelings about inability to care adequately for others. . . Girls are being pushed into taking responsibility for others at too young an age" (p. 56).

There is a poignant comparison of the frequency of nightmares in the sample studied: 71% in Northern Ireland, 63% in the rest of Britain, and 50% in a separate study in the U.S. It is a pity that it is beyond the scope of this work to document and analyse these findings more thoroughly. On the other

hand, a diatribe on the destructive role of the media on children's psyches is overlong and repetitious, much as we may agree with many of her comments.

This book would have made several interesting articles for a women's magazine, giving enough summarised information to whet the curiosity of the average thoughtful parent. Clinicians, however, will find it of little use and limited interest except as a reference for interested parents (with warnings as to its shortcomings).

I was startled at Mallon's recommendation of three hours' duration for a children's dream group. The questionnaire quoted at the beginning was quite beyond the reading ability of those at the younger end of the age range to which it was administered. Why quote it at all in what is obviously not a research report? Careless editing, evidence of hasty writing, and too much padding with apparently irrelevant dreams mar an otherwise interesting book for the lay reader.

MARGARET KERANS, Bondi Junction.