

## **DIFFERENCES IN HYPNOTISABILITY OF DUTCH PSYCHIATRIC OUTPATIENTS ACCORDING TO TWO DIFFERENT SCALES**

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Data on the hypnotic susceptibility of 183 psychiatric outpatients (obsessive-compulsives, agoraphobics, speech anxiety patients, and tension headache patients) and 82 normal control subjects were compared. The mean scores of agoraphobic and speech anxiety patients on the Stanford Hypnotic Clinical Scale (SHCS) and Creative Imagination Scale (CIS) did not differ significantly from the mean score of the control subjects. The hypnotisability of patients with an obsessive-compulsive neurosis as assessed with the SHCS was significantly lower than that of normal controls and patients with another diagnosis. In this patient group, fear of losing control or insufficient dissociative abilities may negatively interfere with successful hypnotic responding.

In 1974 Frankel (1974) proposed that the capacity for spontaneous self-hypnosis may be causally related to the development and maintenance of phobic symptoms. This proposition has renewed the discussion about the relationship between hypnosis and psychopathology which dates back as far as the famous disagreement between Charcot and Bernheim in the nineteenth century (Ellenberger, 1970).

Existing standardised hypnotisability scales have rendered this question subject to empirical investigation and, especially during the last decade, a

number of studies have investigated levels of hypnotisability in various groups of patients. Restricting ourselves to the diagnostic categories which have been investigated in the present research, in several studies elevated hypnotisability scores have been observed in phobic patients in comparison to different reference groups (Foenander, Burrows, Gerschman, & Horne, 1980; Frankel & Orne, 1976; John, Hollander, & Perry, 1983). However, Frischholz, Spiegel, Spiegel, Balma, and Markell (1982) found no differences between the hypnotisability and absorption scores of phobics, smokers, and chronic pain control patients. Moreover, Owens, Bliss, Koester, and Jeppsen (1989) reported that phobics obtained significantly lower hypnotisability scores than controls. Levels of hypnotisability of patients with chronic pain syndromes did not differ from those of smokers (Frischholz et al., 1982) and normal controls (Bliss, 1986). In comparison to "expected" scores of normals, the hypnotisability scores of obsessive-compulsives were found to be low (Hoogduin, 1988; Hoogduin & De Jong, 1984, 1986).

In most studies, hypnotisability scores of a specific diagnostic group have been compared to different reference groups using only one particular test of hypnotisability. Only a few studies have involved investigation of the hypnotisability of multiple diagnostic groups using different measures of hypnotic responsiveness or its components (Frischholz et al., 1982; Pettinati et al., 1990).

As has recently been suggested by Pettinati et al. (1990), there is a need for more studies of hypnotisability in a variety of different clinical populations by using different standardised scales. The question addressed in the present study was whether reported differences in hypnotisability between diagnostic groups depend on the type of standardised hypnosis scale used.

## METHOD

### Subjects

The sample consisted of 265 subjects: 183 outpatients and 82 normal control subjects (35% males and 65% females). Their mean age was 34.4 years ( $SD = 12.7$ ; range = 17–68 years). The sample comprised five groups: (a) obsessive-compulsive disorder, according to DSM-III criteria ( $N = 39$ ; 56% female); (b) agoraphobia, according to DSM-III criteria ( $N = 64$ ; 86% female); (c) speech anxiety (i.e., an item score of 4 or 5 on the 5-point ordinal scale for "speaking in public" of the Fear Survey Schedule; Arrindell, Emmelkamp, & Van der Ende, 1985) ( $N = 25$ ; 80% female); (d) chronic tension headache, according to the referring neurologist ( $N = 55$ ; 51% female); and (e) normal control subjects drawn at random from a Dutch population ( $N = 82$ ; 57% female).

In all five groups, standardised psychological measures were used in order to obtain independent corroboration for the diagnostic classification of our study sample. In the group of obsessive-compulsives, high scores on the

Inventory of Daily Activities, a self-report inventory for obsessive-compulsive behaviour (Kraaiaat & Van Dam-Baggen, 1976), corroborated the diagnosis. In the group of agoraphobia patients, high scores on the Marks and Mathews scale (Marks & Mathews, 1979) and the Watson and Marks scale (Watson & Marks, 1971), rating scales for agoraphobic anxiety and avoidance behaviour, corroborated the diagnosis. In the group of patients with speech anxiety, high scores on the S-R Inventory of Anxiousness (Endler, Hunt, & Rosenstein, 1962) and the Personal Report of Confidence as a Speaker (Paul, 1966), self-report inventories for speech anxiety, corroborated the diagnosis. In the group of chronic tension headache patients, high Headache Index scores (Budzynski, Stoyva, Adler, & Mullaney, 1973), a measure for the average level of pain, confirmed the severity of headache pain. Finally, the scores of normal controls on the Symptom Checklist-90, a self-report inventory for level of psychopathology (Arrindell & Ettema, 1986; Derogatis, Lipman, & Covi, 1973), fell within the expected range according to norms for a normal population.

### **Instruments**

The Dutch version of the *Creative Imagination Scale (CIS)* (Van der Velden & Spinhoven, 1984) as developed by Wilson and Barber (1978) is a 20-minute, 10-item scale, which can be administered with or without formal trance induction both to individuals and to groups. The range of items guides the subjects' thinking to creative imaginings. The test includes both motor and cognitive items, but is foremost cognitive in nature. Although the CIS is related to traditional measures of hypnotisability such as the HGSHS:A, the CIS appears to tap primarily the processes of imagery and imagination which are only partly related to performance on traditional hypnotisability scales (Hilgard, Sheehan, Monteiro, & MacDonald, 1981).

CIS scores relate solely to subjective experience and range from 0 to 40. According to Barber and Wilson (1978), a score of 0 to 10 indicates low hypnotic capacity, 11 to 20 low medium capacity, 21 to 28 high medium capacity, and 29 to 40 high capacity.

The Dutch version of the *Stanford Hypnotic Clinical Scale: Adult (SHCS)* (Oyen & Spinhoven, 1983) as developed by Hilgard and Hilgard (1975) is a 20-minute, 5-item scale that is administered individually to the patient. A hypnotic relaxation induction is followed by one ideomotor and four cognitive items modified from items on the SHSS:A, B and C (Weitzenhoffer & Hilgard, 1959, 1962). Data for the validity of the test show that the shorter SHCS score correlates as highly with the longer SHSS:C ( $r = .72$ ), as the longer SHSS:A does (Morgan & Hilgard, 1979).

SHCS scores are based on the assessment of both overt behaviour and reported experience and range from 0 to 5. According to Hilgard and Hilgard (1975) a score of 0 or 1 indicates low hypnotic capacity, 2 or 3 medium capacity, and 4 or 5 high capacity.

## Procedure

The assessment of hypnotisability was conducted individually at different settings. It was emphasised that the testing was for research purposes only and that the results of the tests would have no therapeutic consequences. After fully explaining the procedure, informed consent was obtained. All assessments were preceded by a short discussion to establish rapport and were followed by a discussion of the patients' experiences during the session. The CIS was administered without prior hypnotic induction and presented as a test for imaginative capacity. The SHCS was presented as an opportunity to experience hypnosis and to react to different suggestions. The research assistants who conducted the hypnotisability assessments were not blind to patient diagnosis. However, they were not aware of the research question of this study.

In the obsessive-compulsive patients the CIS and SHCS were presented before treatment, with the administration of the SHCS preceding that of the CIS. In the group of agoraphobia, speech anxiety and tension headache patients, the CIS was given prior to treatment, while the SHCS was administered at the end of treatment.

Agoraphobia patients were treated in a psychiatric outpatient department for nine weeks with future-oriented hypnotic imagery and graded exposure in vivo (Van Dyck, 1986). Students with speech anxiety were treated at a psychology department for two weeks with future-oriented hypnotic imagery. Tension headache patients were treated in a psychiatric outpatient department of a university hospital for seven weeks with autogenic training or future-oriented imagery not defined as hypnosis (Van Dyck, Zitman, Linssen, & Spinhoven, 1991). In the group of normal controls, the assessment of hypnotisability was part of a larger psychological investigation, with the administration of the CIS preceding the administration of the SHCS. In the patient groups, patients with tension headache received hypnotherapy. Because some of these patients presented themselves for hypnotic treatment, sampling differences between these three patient groups and patients with an obsessive-compulsive neurosis may exist.

## RESULTS

### Hypnotisability Scores

The mean CIS score was 16.9 ( $SD = 8.7$ ; range 0–39) and denotes a (low) medium hypnotic capacity. The mean CIS score of the patients ( $M = 17.2$ ;  $SD = 8.6$ ) was not significantly different from that of the normal controls ( $M = 16.3$ ;  $SD = 8.9$ ) ( $t = 0.75$ ,  $df = 263$ , ns).

The mean SHCS score was 2.0 ( $SD = 1.4$ ; range 0–5) and denotes a medium hypnotic capacity. The mean SHCS score of the patients ( $M = 2.1$ ;  $SD = 1.4$ ) did not differ significantly from that of the normal controls ( $M = 2.0$ ;  $SD = 1.4$ ) ( $t = 0.75$ ,  $df = 263$ , ns).

The Pearson product-moment correlation coefficient between CIS and SHCS scores was .47 ( $p < .001$ ).

### CIS and SHCS Scores in the Different Groups

A chi-square analysis indicated significant differences between groups with respect to gender ( $\chi^2 = 23.0$ ,  $df = 4$ ,  $p < .001$ ). However, no significant differences between males and females with respect to CIS ( $t(263) = -1.21$ , ns) and SHCS scores ( $t(263) = 1.29$ , ns) were observed. Moreover, a one-way analysis of variance indicated significant differences among the groups with respect to age (see Table 1). Since age was significantly and negatively correlated with both CIS scores ( $r = -.24$ ,  $p < .001$ ) and SHCS scores ( $r = -.18$ ,  $p < .01$ ), all subsequent analyses were done with age as the covariate.

Subsequently, a multivariate analysis of variance was conducted, with age as the covariate, that included simultaneously the five groups' mean scores on the CIS and SHCS. The mean CIS and SHCS scores (both observed and adjusted for age) can be found in Table 1. The results were highly significant ( $F = 3.23$ ,  $df = 8$ ,  $p = .001$ ). However, the main effects from the multivariate analysis of covariance for the CIS were not significant ( $F(\text{observed}) = 1.74$ ,  $F(\text{adjusted}) = .89$ ,  $df = 4$ , 259, ns). Only the main effects for the SHCS proved to be significant ( $F(\text{observed}) = 7.06$ ,  $F(\text{adjusted}) = 6.46$ ,  $df = 4$ , 259),  $p < .001$ ). These results indicate that, among groups, only levels of hypnotisability as measured with the SHCS are significantly different.

**Table 1** Scores on Two Hypnotisability Scales for Four Patient Groups and for Normal Control Subjects

Item	Groups <sup>a</sup>					Analysis		
	I	II	III	IV	V	<i>F</i>	<i>df</i>	<i>p</i>
<i>Age (years)</i>								
Mean	36.7	40.1	20.0	34.3	36.0	15.9	4,260	<0.001
<i>SD</i>	11.7	14.3	1.9	9.7	11.0			
<i>CIS Score</i>								
Observed mean	14.9	16.3	19.7	17.8	18.4	1.7	4,260	ns
<i>SD</i>	11.1	8.9	6.7	6.9	8.7		4,259	
Adjusted mean <sup>b</sup>	15.4	17.5	17.5	18.0	18.7	0.9		
<i>SHCS score</i>								
Observed mean	1.1	2.0	2.3	2.3	2.5	7.1	4,260	<0.001
<i>SD</i>	1.0	1.4	1.2	1.4	1.4		4,259	
Adjusted mean <sup>b</sup>	1.2	2.1	2.1	2.4	2.5	6.5		

<sup>a</sup> I = obsessive-compulsive; II = normal controls; III = speech anxiety; IV = agoraphobia; V = tension headache.

<sup>b</sup> Adjusted means were corrected for age by multivariate analysis of covariance.

Using Duncan's multiple range test (Kirk, 1982), comparisons between the five groups were made for the observed and the adjusted means of the SHCS. In the analysis of differences in SHCS scores between patient groups and normal control subjects, Duncan's multiple range test revealed that only the mean (observed and adjusted) scores of the obsessive-compulsive patients were significantly lower than the (observed and adjusted) means of the normal controls. Analysing differences in SHCS scores among patient groups by comparing all patient groups with each other using the Duncan multiple range test, it was found that (observed and adjusted) means of the obsessive-compulsive patients were significantly lower than the means of all the other patient groups.

## DISCUSSION

The finding that patients with agoraphobia or students with speech anxiety achieved CIS and SHCS scores comparable to those of normal controls does not support the hypothesis of Frankel (1974) about a positive relationship between hypnotisability and phobias. The current results are more consistent with the findings of Frischholz et al. (1982), who found no difference between phobics, smokers, and chronic pain patients when they used the Hypnotic Induction Profile (HIP) as a measure of hypnotisability. Moreover, our results are more nearly consistent with the findings of Owens et al. (1989), who found that phobics obtained lower hypnotisability scores as assessed with the Stanford Hypnotic Susceptibility Scale, Form C (SHSS:C) than comparison groups. The fact that in the present study the hypnotisability testing was not incorporated into the therapeutic process and that not all patients presented themselves for hypnotic treatment may explain the absence of elevated hypnotisability scores of phobics in the present study (cf. Owens et al., 1982). Moreover, as in the study of Frischholz et al. (1982), increasing age was negatively correlated with measured hypnotic responsivity and previous studies in which differences in hypnotisability between phobics and controls were observed (Frankel & Orne, 1976) failed to control for the confounding effects of age.

Only patients with obsessive-compulsive disorder had significantly lower SHCS scores than normals and patients with another diagnosis. However, average CIS scores were not significantly different among groups. The SHCS may be a more difficult scale for obsessive-compulsive patients than the CIS. In order to obtain a high score on the SHCS, one must be able to experience some degree of dissociation (e.g., posthypnotic behaviour). Obsessive-compulsive patients will experience difficulties with these tasks either because they will become anxious when asked to give up some control or because they lack the dissociative capacity thought to underlie successful hypnotic responding on these tasks. On the other hand, to score high on the CIS may be easier for obsessive-compulsive patients because the test is not defined as a hypnotisability test but as a test for imaginative capabilities and the wording of the suggestions of the CIS explicitly stresses patients' voluntary control

of their own thoughts and imaginings. This hypothesis is in accordance with the results of the study of McConkey, Sheehan, and White (1979), who suggest that the CIS measures more the processes of imagery and imagination than involuntariness of responding or dissociative ability.

The present study has some obvious methodological shortcomings: (a) interrater reliability for the diagnostic categories was not assessed (however, standardised psychological measures independently corroborated the psychiatric diagnoses); (b) no statistical control for the moderating effect of medication was used; (c) the fact that the research assistant was not blind for patient diagnosis may have biased the study in favour of finding higher hypnotisability scores for phobics (however, this expected difference was not found); (d) the CIS and SHCS were not presented in counterbalanced order; (e) there was little time to build rapport between subjects and tester; and (f) in three of the five groups the SHCS was administered at the end of hypnotherapy, while comparable pretesting hypnosis plateau experiences (Shor, Orne, & O'Connell, 1966) were not provided in the groups of obsessive-compulsives and normal controls (however, SHCS scores of patients assessed after hypnotherapy did not differ from SHCS scores of normal controls without previous hypnotic experience and existing studies indicate that SHCS scores of obsessive-compulsives (Hoogduin, 1989) and chronic tension headache patients (Spinhoven, Linssen, Van Dyck, & Zitman, 1990) assessed after hypnotherapy do not differ significantly from pre-treatment scores).

Notwithstanding these limitations, the results of our study give an indication that the detection of differences in levels of hypnotisability between patient groups and normal controls depends both on the patient's psychiatric diagnosis and the nature of the hypnotisability scales used. After hypnotherapy, phobics achieved no higher SHCS scores than normal controls, while obsessive-compulsives obtained significantly lower SHCS scores than normals, with both groups having an equal amount of experience with hypnosis. On the CIS, on the other hand, which was administered in all patient groups before treatment, no differences were observed in a test which measures at least one of the components of hypnotic responsiveness. The finding that obsessive-compulsives score significantly lower on the SHCS though not on the CIS in comparison to other patient groups and normal controls adds to our understanding of the cognitive mechanisms that mediate hypnotisability in different (patient) groups. Although obsessive-compulsive patients seem to possess the imaginative capabilities necessary for responding to hypnotic suggestions, fear of losing control or insufficient dissociative abilities may negatively interfere with successful hypnotic responding. These findings are consistent with the model of Spiegel and Spiegel (1978) in which the relationship between hypnotisability and psychopathology is viewed on a continuum, with the least hypnotisable patients including those with schizophrenia, obsessive-compulsive disorder, and/or paranoia.

Future studies of assessment of hypnotisability with different hypnotisability scales in various clinical populations can enlarge our knowledge of different cognitive processes underlying hypnotic responding and may be helpful in the development of a more empirically-based theoretical model of hypnotisability and psychopathology that includes a broad spectrum of psychopathology.

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## INDIVIDUATION IN A VOYEUR RECIDIVIST

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Using Wilber's "Spectrum of Consciousness" as a model, the author describes an eclectic approach in the psychotherapy of a case of voyeurism in a prison setting. Jungian and Gestalt dreamwork, hypnosis, meditation, cognitive, and behavioural methods are utilised as complements. A natural history of the therapeutic alliance is provided session by session.

Voyeurism is defined in the DSM III (American Psychiatric Association, 1980) as "the repeated observation of unsuspecting persons who are naked, undressing, or engaged in sexual activity." Dwyer (1980) reports that it is generally believed that almost all voyeurs are male and that no attempt is made to form a relationship with the victim. Various explanations of the causes and treatments of voyeurism have been postulated, including those within the models of psychoanalytic theory and structural theory of automata (Spencer Smith, 1976).

Although there is a relative lack of material in print, a recent report (Dwyer, 1980) advocates that the treatment of voyeurism needs to be multi-dimensional. Multimodal therapy (see Kee, Deuivenvoorden, Trijsburg, & Thiel, 1986-1987) approaches behavioural dysfunction through a broad spectrum of interventions with empirically proven techniques, for which effectiveness can be explained in terms of social learning. This, however, may be limiting. Dennerstein and Burrows (1979) comment that where an underlying cause is present, or where intrapsychic conflict persists, behavioural techniques alone may be ineffective for treating sexual problems.

The University of Minnesota Sexual Offender Treatment Program for voyeurism/exhibitionism (Dwyer, 1980) outlines 16 goals of treatment, including the understanding and integration of sexuality into the intellectual, social, and spiritual self: "In order to accomplish these goals numerous therapy modalities are used, including psychoanalytic theory, structural and strategic family therapy, social skills modalities, behavioural techniques, and cognitive restructuring to name but a few. Always an eclectic approach is maintained" (p. 111).

Patterson (1989), in reference to eclecticism in psychotherapy, comments on two different views of human beings giving rise to two different kinds of therapists: the manipulators and the enablers. He reports that current eclectic approaches and attempts of integration in psychotherapy have not been successful because of an irreconcilable difference in paradigms of human and emotional disturbance.

The enabling approach is central to the treatment program discussed in this paper, in that its underlying philosophy is consistent with that of Jung (1972), for whom the core of psychotherapy is regarded as work which facilitates the individuation process. Jung (1972) states that "the natural process of individuation served both as a model and guiding principle for my method of treatment" (p. 110). The process is directed by the unconscious, mainly as expressed in dream images. Jung believed that the unconscious compensation as revealed in these images could effectively correct the one-sidedness of the conscious mind if understood and integrated. Individuation, then, is defined by Jung (1972) as "coming to selfhood" (p. 173). This is a holistic notion in which there is a recognition of an autonomous centre in the psyche which is goal-directed towards a sense of personal completeness, connectedness, and harmony.

It is the author's contention that the self-respect, thus induced, translates into a capacity for more socially responsible behaviour even in recidivist clients. This process can be supported and empowered by an eclectic approach that includes a range of other therapeutic modalities including more manipulative strategies.

Wilber (1982) provides a model which is helpful in directing a coherent multidimensional eclecticism in psychotherapy. He outlines a model of consciousness in which there are different levels of awareness, each potentially productive of a certain type of alienation from oneself. He contends that each of the major but differing schools of psychotherapy is simply addressing a different level of the spectrum of consciousness. Wilber defines the bands of consciousness in terms of *Senses*, *Shadow*, *Existential*, *Transpersonal* and *Mind*. He maintains that a true synthesis of therapies is one that can allow approaches leading to a sense of successively higher-order unities and integrations and hence target the whole person. Multimodal (or eclectic) therapies do not meet this aim if they do not address different levels within the "Spectrum of Consciousness."

Many authors describe therapy in terms of models, without giving a sense of the flow of material in the natural history of a therapeutic alliance. In what follows, a broad spectrum therapeutic process is described in a case of voyeurism. It purports to illustrate the use of different but complementary approaches to facilitate the unfolding of a particular individuation process underlying the resolution of a number of problem behaviours. In the discussion following the case history, the therapeutic strategies utilised are related to the definition of the different bands making up Wilber's "Spectrum of Consciousness."

## **CASE STUDY**

### **Background of Client**

The client was a 27-year-old male prisoner. Before the commencement of therapy the client, "John", presented as dishevelled and worn in appearance, but with buoyant mood. His manner was appropriate and thinking was clear, rational, and without bizarre ideation.

He expressed appropriate concern for dealing with his problems in order to allow him to feel confident about not returning to prison in the future.

He was the elder of two children. His mother, to whom he was close, had died 12 years earlier and his father, with whom there was little communication, was retired.

John left school at the age of 15 years. He left home aged 16 years and had had a large number of jobs, mainly associated with cooking, in different states. His nomadism and interrupted job history were largely due to behaviour which brought him in conflict with the law. John was single. Since 1970, he had had a criminal history which included housebreaking, theft, indecent assault, smoking cannabis, drunkenness, illegal interference, attempted rape, loitering, aggravated assault, disorderly conduct, and breaking and entering at night with intent.

### **Presenting Problems**

John had a long history of voyeuristic behaviour and since 1977 had had several previous psychiatric hospital and prison admissions. His chief presenting complaint was the need to overcome his urge to peep at women. This urge led him to peep through windows at night at females undressing; to break into premises in order to masturbate on females' clothing; and to follow females in the streets if they were scantily clad. John told me that alcohol consumption and drug taking were other problem areas. At the root of these problems was a general sense of inadequacy and associated anxiety, low self-esteem, lack of self-confidence, particularly with women, and personal frustration. The latter seemed to reflect the under-utilisation of his natural intelligence which impressed as above average. This was reflected in his verbal competency, although his literacy was poor. In addition, his frustration appeared to be related to affectional deprivation, which had given rise to dependency in personal relationships and was acted out by the use of alcohol and drugs. At the same time the possibility of obtaining nurturance from the two meaningful female relationships that he had experienced as an adult had been sabotaged by his own violent, rejecting behaviour when closeness could not be tolerated.

### **Therapeutic Strategy**

A psychotherapeutic approach was seen as appropriate to deal with John's personality problems because of his adequate intelligence, good verbal skills, good contact with reality, apparent affectional capacity, and keen motivation.

At commencement of therapy John had about three months to serve prior to possible parole. Hence, due to the history of seriously deviant behaviour, a strategy was devised to be as wide-ranging as possible, enlisting a variety of approaches to John's problems. These approaches, in addition to hypnosis, included dreamwork using psychodynamic as well as Gestalt techniques, remedial education, cognitive and behavioural techniques. The latter included masturbatory reconditioning and aversive therapy to voyeuristic fantasies using an elastic band on the wrist. John also attended a meditation group concurrent with his individual psychotherapy.

The use of hypnosis supported other work done. This was relevant and appropriate because of John's dependency and high suggestibility, his lack of ego resources and his need for ego-strengthening techniques, the shortage of therapeutic time to achieve the latter, and John's interest in hypnosis due to previous pleasant trance states experienced whilst meditating.

The decision to use hypnosis was based on the need to deal quickly and positively with John's sense of hopelessness. The latter seemed, in part, due to his experience of having previously not benefited sufficiently from therapeutic contact in other settings.

Dennerstein and Burrows (1979) underline the benefits of hypnosis as an aid to behavioural treatments and psychotherapy in cases of sexual dysfunction, particularly where there is a component of anxiety. Koadlow (1979) advises that hypnosis be used with caution in psychosexual dysfunction, particularly where there is seductive behaviour or the possibility of psychotic depression. This is to guard against accusations of sexual misconduct by the therapist. These were not relevant concerns with John. Brown and Chaves (1980) outline five distinct strategies for the utilisation of hypnosis in sex therapy: (a) as a diagnostic tool; (b) for the direct removal of symptoms; (c) as an adjunct to behaviour therapy; (d) to facilitate the resolution of neurotic conflicts; and (e) to improve self-confidence. The last three strategies were employed with John.

The aim of hypnosis was to give John a sense of mastery over his environment by instilling seeds of self-appreciation and self-worth together with an understanding that hypnosis was to be learned as an ongoing self-help resource. The objective here was to give him the resolve to immediately feel hopeful about the work to come and, hence, lessen his anxiety. Hypnosis was to be used also to integrate and consolidate knowledge gleaned from dreamwork and to facilitate the production and remembering of dreams.

Naranjo (1974) regards self-rejection as being behind all the psychological symptoms, particularly anxiety and depression, just as self-acceptance is the basis for the enjoyment of life. He believes that "dream symbolism expresses us better than concepts can ... it is a message from our depths but only when we understand its language and recognise it as our own expression" (p. 212).

Dreamwork was carried out primarily within the framework of the Jungian theory (Jung, 1972). Gestalt therapy techniques were also utilised to aid dream

exploration. The latter is an experiential method in the here and now in which enactment of different elements of the dream plays a prominent part (Perls, 1969).

Kanfer and Phillips (1979) state that "building up a verbal and visual fantasy repertoire and skills for interactions with socially acceptable partners seems a basic precondition for the treatment of patients who lack success in normal relationships" (p. 119). Masturbatory reconditioning was used throughout the treatment strategy on the basis of fantasies made up to involve only women with whom there was a developing relationship and where consent was given. The fantasies were to be constructed and written and masturbation carried out whilst speaking the fantasy as often as desired. There was to be no masturbation with any other stimulus. The elastic band was to be used if deviant fantasies appeared. Fantasies were to be produced weekly for monitoring.

In this case study, as a general principle, the direction and therapeutic modality of each individual session depended upon the interaction between the client's presentation and the arising foreground in the author's own awareness. In this sense the therapeutic work presented here was structured by the evolving underlying process of the *I-Thou* encounter.

### **Therapy Sessions**

These were approximately bi-weekly. Earlier sessions had been devoted to history-taking and discussion of overall strategy to be followed, including preparation concerning the role and nature of hypnosis.

*Session 1.* Hypnosis was induced using an eye fixation technique with distraction because this was the method with which I felt most familiar. John was instructed to watch the tip of a pen held above his head whilst counting backwards from 100. Suggestions of heaviness in arm and eyelids were given and instructions re trance (deep state of relaxation) development as hand reached lap with eye closure. Deepening was achieved by progressive relaxation, arm heaviness, arm catalepsy, and the descending stair technique allied with pleasant imagery of own choice re garden scene. A medium-depth trance was achieved evidenced by slowness of breathing, body and muscle stillness and reports on awakening of profound relaxation and altered perception of time. Dryness of mouth was reported.

*Session 2.* The hypnotic induction and deepening procedures were followed as in Session 1, with instructions to go deeper still. In the trance state, which again appeared to be at least medium depth, ego-strengthening instructions from Hartland (1971) were given. These involved feelings of relaxation, self-worth, self-reliance, optimism, and good health. Imagery of walking through a field was given with a progressive counting technique linked to different nature experiences and culminating in self-analogies to a tree with strong branches, firmly grounded and drawing its energy from the soil and sun, etc.

In order to test trance depth, a post-hypnotic suggestion was given to pick up a pen from the floor and place it on my table. Instructions were also given to remember a significant dream and bring it to the next session. On awakening, the post-hypnotic suggestion was carried out.

*Session 3.* John brought dream material concerning a situation where he was drinking with Bob Hawke when a drunken Aborigine came in and was ostracised by Hawke. John then met a disabled couple in wheelchairs. Gestalting out this dream led to an owning of two particular polarities in John and dialogue between them: (a) a powerful, talented, achieving part (Bob Hawke); and (b) a handicapped, underprivileged, alienated, and self-abusing part (wheelchair couple and drunken Aborigine). Consciously the latter side was more prevalent and the session concentrated on developing more integration and tolerance between these separate aspects of self.

*Session 4.* Hypnosis was induced with deepening, using additional techniques of arm lightness and levitation. Ego-strengthening was carried out as before, including acceptance of the idea of owning the strength and power of Bob Hawke to achieve his goals and overcome his handicaps. Further suggestions were made to bring a significant dream to next session before awakening.

*Session 5.* John brought a dream concerning an anti-social clown being burned to death in a fire while John aged 12 years and his brother aged 8 years looked on. John was able to identify the anti-social clown as the role of his adult life. This was discussed in terms of the beginnings of the transformation into his anti-social self, the roots of which were to be found in decisions made by John at 8 years and later at 12 years to adopt rebellious and anti-authority stances. That decision was examined in terms of adult reality and the consequences in terms of self-destructive behaviour.

*Session 6.* Further hypnotic induction as before. Deepening by progressive relaxation, arm catalepsy, descending stairs and garden imagery. Further ego-boosting from Hartland (1971) was given, together with the consolidation of giving up old dysfunctional anti-social decisions and suggestion was made to bring a further significant dream to the next session.

*Session 7.* John brought a dream in which John was working in a carnival and peeping into a changing room where the boss's daughter was getting undressed. Although she knew that she was being watched she pretended not to notice. John then did a drug deal.

Discussion of this dream centred on the importance of relatedness to the feeling (feminine) side of his personality and the indications in the dream of possession (seduction) by her accounting for irrational mood swings. Directions were given that when the latter occurred in future he was to look at which feelings were not being acknowledged consciously. Further discussion examined a loss of contact with females and inner femininity when moving



to a boys' school aged 12 years. There was a need to act tough, consolidated at age 15 years, when John's mother died and his brother "cracked up." There was growing feeling, at this time, of disappointment with his father who was "not clever, I deserved more." This was looked at as a possible dynamic of defending against a need for attention by: (a) acting as a voyeur (i.e., looking at others instead of the wish for others to look at him); (b) having a relationship with "clever" professionals by having a problem "admission ticket"; (c) making better the relationship with Dad through the surrogate relationship; and (d) feeling different and superior to Dad because "I can talk to clever people."

*Session 8.* John brought a dream in which he was at a Pentcostal Church where he was giving the service. The congregation supported and agreed with him and gave him a tumultuous applause. This dream supported notions discussed in the previous session of John's need to "have undivided attention in the house of the father." John discussed receiving only divided attention from his father. In two-chair dialogue he expressed his feelings of disappointment, feelings of being cheated, his anger, sadness, and isolation. Paraphrased by the author he had the sense of: "If I can't share myself with you, I'll share with no one. I'll hide my needs for having undivided attention by giving undivided attention [voyeuristically] in such a way as to get a father surrogate [therapist] with whom I can share vicariously."

After some working through the re-decision was made: "I'll undo the chains. I can love you and be different to you [father] by meeting my needs differently from the past." John talked of the way he spoilt good jobs and relationships because of his feelings of inadequacy and fear of closeness because his father was incapable and his mother had died. This gave rise to: "If I get close to someone I'll be left."

*Session 9.* Hypnotic induction and deepening were carried out, as in Session 6. The ego-boosting suggestions were framed to consolidate the previous decisions to meet John's needs for achievement more directly through study of literacy skills and notions of self-confidence in social situations allowing "normal" social interaction. Imagery of mastery and of coping without anxiety in social situations with women were given. The notions given included the ability to see the power and talents of others without needing to put himself down by comparison. The suggestion of equality of worth of all people was emphasised with acknowledgment that different people do all sorts of different things with various degrees of efficiency. Hence mixing socially with comfort would now be seen as being within John's range of behaviour. Before terminating the trance, John was instructed to bring a significant dream to the next session.

*Session 10.* John informed me that he had enrolled at the prison school to study Basic Literacy and Mathematics. He said he now had a part of him telling him he could do it and could achieve success. His dream reflected his decision in that the theme was one of joining *The Professionals* (a TV series) in a daring mission. Reinforcement of self-valuing was emphasised by

drawing John's attention to behaviour likely to give rise to more self respect. This included going to bed at a reasonable hour so that he had enough sleep and keeping himself and his cell clean and tidy. Affirmation of self-worth was to be written out and placed by his bed where he could see it easily. After this session John attracted no further prison charges for sleeping in late.

*Session 11.* John began to learn self-hypnosis in this session. It was phased in by teaching him to induce trance, while deepening and further ego-boosting instructions, consolidating the work so far, were given by me. The procedure followed was from Hartland (1971, p. 184) in which John was asked to fix his eyes upon a spot on the ceiling until they wanted to close, etc. The progressive relaxation procedure and descending stairway techniques were followed with my instructions. In the trance proper, apart from ego-boosting, instructions were given that John would remember everything I had said and would be able to repeat the words to himself in the next session after inducing the trance himself. He would raise a finger after completing the procedure but before terminating the trance. John was asked to give the ideomotor signal if he felt that he understood and felt able to comply and this was done.

*Session 12.* John was asked to go through the self-hypnosis procedure, including self-induction, self-deepening, and repetition of ego-boosting instructions. After completing the task which was signalled by his raising a finger, John was told that he would practise the procedure when it was convenient and safe to do so. He was also told that he would be able to terminate his trance feeling refreshed on completion of the task or sooner if unforeseen circumstances so dictated. John was asked to bring a significant dream to the next session and then to bring himself out of trance. This was completed successfully.

*Session 13.* John was delighted with his ability to use self-hypnosis and he was full of optimism, hopes, and plans for the future. In John's dream he was talking to a mature-age woman about facilities at the beach and he heard he was to be the new inspector and one of his jobs was to steam clean the toilets. The focus of the discussion about this fell on dealing with shit (stigma) from the past with the help of his own feminine feelings and wisdom. This was to take the form of continuing his education and of joining various social organisations on his release. John reported success in the previous week in recognising and rejecting old patterns of dysfunctional thoughts.

*Session 14.* John was asked to self-induce and deepen a trance and to raise a finger when he was as deep as he wanted to go. When he did this, he was told that he would go back in time to when his mother was alive just before she died. However, he would retain his own age and memory and would be able to talk to his mother and express whatever he needed to say to her. He would then return to the present time and terminate his trance. On doing this, John became tearful; he expressed missing his mother's guidance

and care. He told her that he had been taking what didn't belong to him in order to redress the imbalance (i.e., "peeping because they can't go away as you did"). He said that he realised now that this was not a satisfactory substitute and expressed a desire for change, respectability, and legitimate satisfaction of needs through an education and a good relationship with a woman. This was discussed and reinforced after termination of trance.

*Session 15.* John brought a dream with the theme of "oil parity is the only solution to the pressing problem of low imports." As John was due for release in four weeks' time, this dream was discussed in terms of self-taxation as a way of coping with diminished therapeutic input on release. This involved a ventilation of John's fears about termination therapy and reassurance from me in pointing out that a memory of me and the work performed would be retained. Also that a referral to a therapist outside the prison could be made for further assistance and support. At the same time the reality of John's taxing himself in terms of facing the world again was confronted by looking at concrete procedures to be followed, not only in the practical sense of trying to obtain suitable employment and accommodation; but also in continuing his studies, joining clubs, and structuring time for activities by himself and with others. At this time in prison John was carrying out self-hypnosis daily and his attire and work habits had improved markedly. In his masturbation fantasies he had become focused on one woman with whom there was a deepening relationship in imagination, rather than a succession of different women as before.

*Session 16.* John brought a dream in which he was driving a Mercedes car. In Gestalting this out, John owned parts of his own drive which were stylish, reliable, and worthy.

*Session 17.* A dream was examined in which John was arguing and fighting with another prisoner. In reality John had accused this prisoner of being homosexual. In this session John identified homosexual aspects of himself in admitting his own bisexuality. John's sexual preference was to give oral sex to men. This was discussed in terms of the penis equals breast equation and John's avoidance of nurturance from women. The broader implications were examined for "look but don't touch" in his voyeurism and his fear of losing women with whom he allowed himself to be close. This feeling seemed to mirror his experience with his mother. Emphasis was placed on facing this fear by realising consciously the irrationality of this unconscious connection.

*Session 18.* In the final dream examined, John was the son of a wealthy businessman and had a personal butler. John was at the top of an escalator, 20 floors up and with only a rope to guard him from falling out. His butler helped him off safely. The theme of the discussion of this dream was the danger of ego-inflation in presenting a false self. In short, that feeling more worthy than others had dangers as did feeling less worthy. John was able

to identify judgmental and critical aspects of himself when being with people whom he believed to be less intelligent than himself. Lessons were drawn for healthy relating to others, using the model of the butler, in being of service (in a wide sense of the word) to others. The value of ordinariness and notions of a common Buddha nature were discussed, along with the implications of self-respect through respecting others. This reinforced concepts broached in a weekly meditation group, held by the author, that John had joined voluntarily.

*Session 19.* This was the final session. Instructions were given to cease masturbating to constructed fantasies. The use of the elastic band to combat the urge to think about voyeurism had already dwindled into disuse. John was induced and deepened into a trance by myself, using the same procedure as in Session 6. Ego-boosting instructions from Hartland (1971) were given, along with a recapitulation of the main points emerging from therapy. John was told that he would remember what he had learned and be able to use his awareness to deal differently and more successfully with future problems or urges that disrespected the rights of others. He was also told that he would be able to use self-hypnosis as an ongoing self-help procedure as required. After the trance was terminated, the formality of ending therapy was concluded by giving John a referral to an outside therapist for ongoing support and guidance.

## DISCUSSION

The therapeutic process described above combines both manipulative and enabling strategies. In what follows these strategies are correlated to the different levels described in Wilber's (1982) "Spectrum of Consciousness" model.

At the level of the *Senses*, directive behavioural therapy was utilised in the form of masturbatory reconditioning with imagery and aversive therapy with an elastic band.

The *Ego* level "comprises our role ... our self-image ... as well as the analytical and discriminatory nature of the intellect" (Wilber, 1982, p. 20). Hypnosis, rationalisation examining transference feelings and re-decision therapy were used as means of changing dysfunctional and irrational patterns of thought and belief. This had a direct effect on self-esteem, self-image and motivation.

The *Shadow* is defined as the "disowned, alienated, and projected facets of ego which now appear to be external" (Wilber, 1982, p. 142). In John's case his cleverness, powerfulness, and feeling and achieving aspects had been disowned and projected onto various others. It could be seen that John projected aspects of his masculinity onto professionals with whom he had been in therapy, and aspects of his feminine nature onto some women. Both categories were watched voyeuristically in one way or another. In that sense, the offending behaviour leading to his subsequent apprehension and treatment may have involved indirect attempts to be reunited with those projections of important parts of himself. Dreamwork and transference analyses were prominent awareness-raising strategies at this level.

The *Biosocial* level is defined as “a matrix of language and syntax, the introjected structure of the individual’s family, cultural beliefs and myths, rules and metarules” (Wilber, 1982, p. 133). Family therapy works at this level but was not possible in John’s therapy. Nevertheless, the therapeutic alliance was strengthened by joining with John in terms of the style of language used, including familiarity with prison argot. Modifications at this level were begun indirectly through encouragement of the development of more formal literacy skills at the prison school.

The *Existential* level is defined as that involving the “total organism, our soma as well as our psyche, and thus comprises our basic sense of existence, of being ... it’s what you feel when you mentally evoke the symbol of your self-image” (Wilber, 1982, p. 20). Existential level therapies aim to integrate the Shadow so as to reach an experiential identity with the entire organism, so “whereas on the Ego level one may receive an undoubtedly beneficial insight about one’s repressed anger, on the Existential level one becomes the anger” (Wilber, 1982, p. 252). The Gestalt enactments described throughout John’s therapy were aimed at giving expression and felt meaning to the immediacy of aspects of his existential awareness which had been blocked.

The *Transpersonal Bands* recognise “a depth of one’s identity that goes beyond one’s individual and separate being” (Wilber, 1982, p. 272). Wilber comments that “one can gain abundant personal benefits from the Transpersonal Bands by sticking to Jungian analysis through dream amplification, Tibetan or Hindu Tantra utilising visualisation techniques, and Bijamantra meditations such as Transcendental Meditation, or Psychosynthesis, Proffo dialogue, or similar exercises” (Wilber, 1982, p. 276). In John’s individuation process, analysis of his final dream alluded to this spiritual sense of connectedness with others. A word of caution is due. Skynner (1983) regards psychotherapy and sacred traditions as different dimensions at right-angles to each other with fundamental aims that cannot in their nature coincide at all. In a similar vein, Welwood (1983) states:

some therapists have introduced meditation into therapy as a way of helping clients to see through their egos, but this could be problematic ... a psychotherapist who has not had such training or testing (in one of the meditative traditions) could run the danger of confusing the two roles and becoming inflated by pretensions to a level of spiritual understanding and authority he may not genuinely possess. For these reasons I prefer to maintain a clear distinction between psychotherapy and meditation in my work with clients, seeing them as complementary, sometimes overlapping paths that apply to different aspects of human development. (p. 53).

In John’s therapy, meditation overlaps psychotherapy not only as a relaxation technique but one that serves to ceremonially affirm self-worth and self-esteem. In effect, it is saying that he is worth the dignity and respect afforded by the ceremony set up to spend time with himself. Therapy can also serve to

affirm and validate those parts of the person that find meaning in experiences arising out of this process, as in John's penultimate therapy session. It is important that the therapist does not set up himself or herself as a guru in this process and guards against subtler forms of ego-inflation that may arise.

The *Level of the Mind* is defined as mystical consciousness "and it entails the sensation that you are fundamentally one with the universe" (Wilber, 1982, p. 20). This level aims at transcending the self and may be approached through Eastern disciplines such as Vedanta Hinduism, Zen Buddhism, and Taoism. As discussed above, these practices are not within the realm of psychotherapy per se.

John left therapy needing to work through many issues including those of control, identity, power, dependency, and masculinity in a normal-life environment outside prison. Nevertheless, the Outcome of Therapy Questionnaire (see Appendix) indicates that he felt that he had achieved a great deal. Although the individuation process had merely been awakened, the rise in John's confidence and self-esteem is evident. On a more objective measure, at the time of writing approximately five years later, John had not been returned to the prison system in Western Australia. It is relevant that John had failed with many previous therapeutic interventions in which he described the focus as more narrow.

## SUMMARY

This case study takes as its point of departure the comment by Wilber (1983) that "we have seen the need for a comprehensive paradigm to include monological [empirical] sciences, dialogical [rational] sciences, and translogical [transcendental] sciences" (p. 83). When applied to psychology, Wilber (1982) states that: "using the Spectrum of Consciousness as a model ... each [of the differing schools of psychotherapy] is more-or-less correct when addressing its own level ... a truly integrative and encompassing psychology can and should make use of the complementary insights offered by each [major] school of psychology" (p. 27).

This model has been applied to a case of voyeurism in a prison setting in which there are natural difficulties in working through the gains made. Different approaches have been utilised to integrate and strengthen different levels of self-awareness in order to achieve healthier self-development and, hence, more functional social behaviour. One of the implications of such an eclectic model is that space must be found to enable the unfolding of the singular and unique individuation process of the client within therapy as well as those approaches that directly target behaviour. Such an approach should safeguard the sanctity of the therapeutic crucible not only from a wild and haphazard eclecticism but also from a focus which is too narrow to respect the whole person.

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**APPENDIX**

UNDERLINE THE ANSWER YOU WISH TO MAKE

Specify details\*  
(\* John's original spelling retained)

1. To what extent did you expect to benefit from therapy before you started?

I expected no benefit    I expected only a little benefit    I expected to solve about half my problems    I expected to solve most of my problems    I expected to solve all my problems

I have always hoped that someone would be able to sort out and help me sort out my problems

2. Has the therapy met your expectations?

Not at all    Moderately    Mostly    All of my expectations    More than what I expected

I have delt with various psychologists and psychiatrists this has been the most beneficial therapy I have ever had.

3. Has therapy enabled you to change any of your behaviour?

Not at all    A little change    About half the change I wanted    Most of the change I wanted    All the change I wanted

I have had little opertunity to experance change as I am to be released soon I do however expect and feel very conferdent that a dramatic change will show its self when I am released

4. Has therapy enabled you to feel differently about yourself?

Not at all    A little benefit    About half the benefit I wanted    Most of the benefit I wanted    All the benefit I wanted

5. Has therapy changed your outlook on life?

Not at all    A little benefit    About half the benefit I wanted    Most of the benefit I wanted    All the benefit I wanted

I now feel with continuing therapy as has been recommended that I can lead a full and proper life. I have never had this feelin before.



6. Has therapy helped you better understand and take responsibility for the way you are?

Not at all	A little benefit	About half the benefit I wanted	Most of the benefit I wanted	All the benefit I wanted	Therapy has shown me that I can change the way I was. But I shall be able to take responsibility for my future actions.
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7. Has therapy influenced your ability to choose to lead your life in a different way from the past?

Not at all	A little benefit	About half the benefit	Most of the benefit I wanted	All the benefit I wanted	Most definitely I now have the ground work set; and the confidence to proceed with my life in an acceptable way.
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8. Has therapy supported you to better cope with imprisonment?

Not at all	<u>A little benefit</u>	About half the benefit	Most of the benefit	All the benefit I wanted	I have done jail before and I have learnt to deal with it. But jail has been made easier by knowing that it's my last time.
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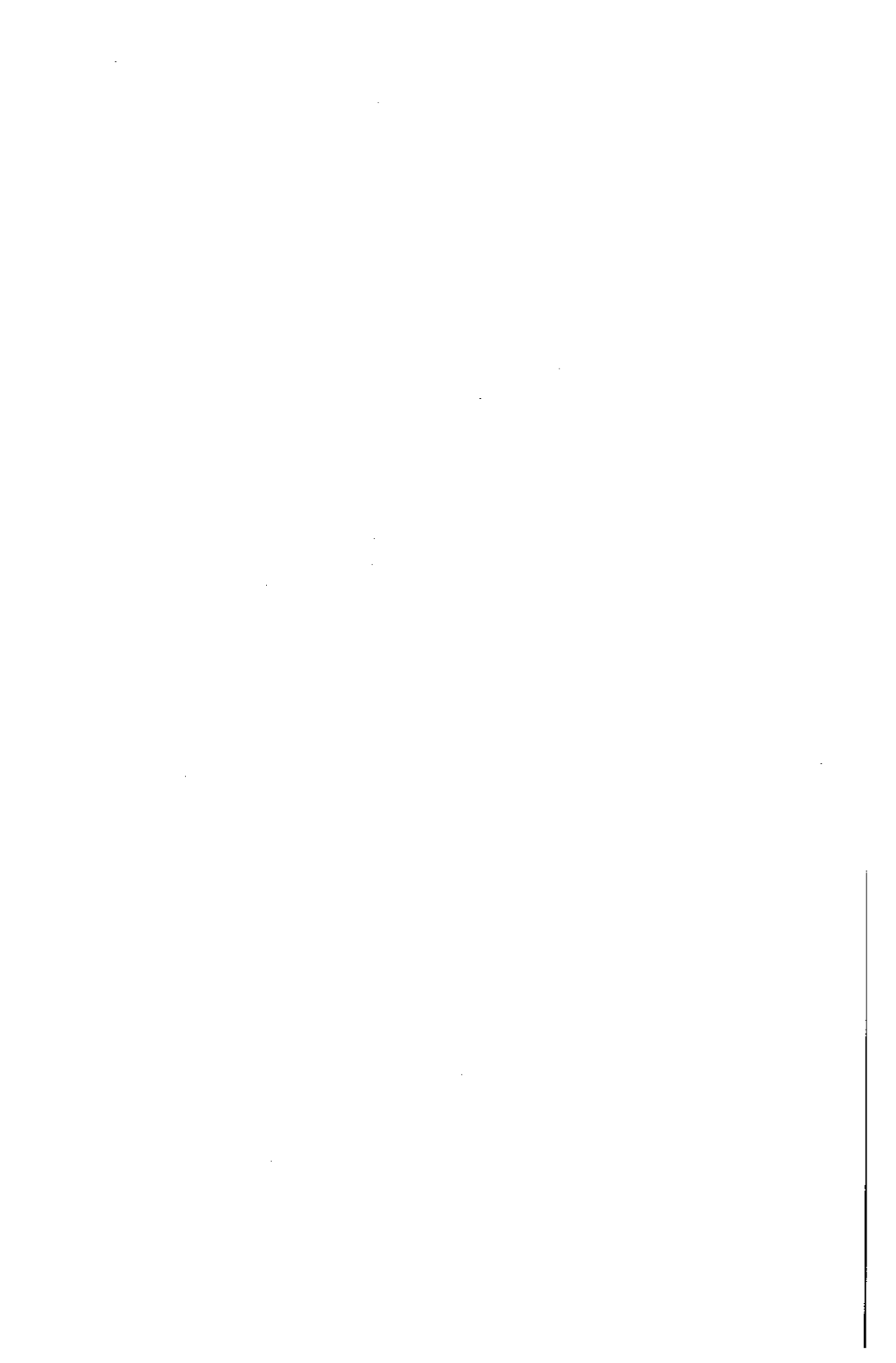
9. Has therapy harmed you?

<u>No harm</u>	Little harm	Considerable harm	Very great harm	Devastating harm	Therapy has helped me to overcome problems which I have been avoiding for 11 years. It has done only good things for me.
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General comments:

Age: 27

Alleged offence: Theft, Armed robbery, Drugs, Sexual, Murder, Motor vehicle, Violence against person, Others.



## 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.

## DOUBLY DIVIDED CONSCIOUSNESS

Lorna Channon-Little

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Hypnosis can be a funny business.

Some time ago I was working on weight control with a female patient, a receptionist. While she was in hypnosis, a crowd of undergraduate students rampaged noisily down the corridor to see their examination results on the departmental noticeboard. When we had finished hypnosis and debriefing, I apologised about the interruption:

“That’s okay,” the patient replied. “I knew I didn’t have to answer it.”

“Answer what?”

“The telephone.”

“What telephone?”

“The one that rang while we were doing hypnosis.”

“I was actually apologising about the noisy students.”

“What noisy students?”

To my mind, there is a simple explanation. Many therapists find that they enter hypnosis when they are carrying out therapy in hypnosis with clients (Channon, 1985). I am certainly one of them. In what I assume to be a classic case of divided consciousness (Hilgard, 1977), my patient attended to outside information which would normally be relevant to her — a ringing telephone. I attended to an outside stimulus which would normally be relevant to me — rowdy students.

The fascinating thing is that we both remained totally unaware of the "irrelevant" input. What an example of reduced environmental scanning in hypnosis.

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## HYPNOSIS WITH MESMER'S GLASS HARMONICA MUSIC

Wendy-Louise Walker

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Dr Franz Anton Mesmer did his *magnetising* in an elegant salon and the harmonica music in the background was a glass harmonica, an unusual instrument to our ears, each note like the sound of rubbing wet fingers around the brim of a good crystal drinking glass. Leopold Mozart wrote for the instrument, as did his son Wolfgang later, and recordings of their music and that of other composers for the glass harmonica can be found (albeit with difficulty) in music shops.<sup>1</sup>

I found the music on my CD of glass harmonica pieces quite consciousness-altering,<sup>2</sup> and I paid silent tribute to the style and flair of Mesmer, even if his causal theories about the hypnotic experience were wrong. I like to share a little of the history and controversy in the domain of hypnosis with interested patients and, in this context, after telling a highly literate patient about Mesmer's use of the music, I concocted an hypnotic session with the glass harmonica music as the main pathway to trance. I accompanied this with suggested experience of being in a situation and built in suggestions which the patient himself asked to be added. The session was the result of joint planning. The session, which was judged by my maximally hypnotisable patient to be an involving and delightful experience, was tape-recorded for him to take away and add to his collection for use by himself. It went like this:

In a little while, I will start the music on my CD player. You will let the music become your moving pathway of sound that carries you into hypnosis and, as you move, a delightful scene will form itself around you

... and as it does, you will become still more absorbed in the experience ... So get yourself comfortable in the chair, close your eyes, and wait for the music to start. (*Music on.*) So let yourself settle comfortably, the body relaxing until it becomes so light it seems barely to exist ... and let the haunting music take over your mind and lead you into hypnosis ... as you move with the music, let a scene build itself around you (*tone of voice quietly involving, story-telling rather than soporific*). Imagine that you are sitting in a large and very elegant salon ... richly carpeted floors and velvet-upholstered chairs ... crystal chandeliers sometimes flashing in the long shafts of gold light of the late afternoon (*the music has a crystalline tone*) ... Imagine that and as it becomes more vivid, let yourself move further into hypnosis ... Imagine the musicians playing, but focus particularly on the young woman playing the glass harmonica, long dress, long sleeves with lace at the cuffs and long, pale fingers moving over the harmonica to produce the haunting tones ... Imagine sitting there, calm and absorbed, watching the musicians playing and becoming increasingly lost in the experience.

As the music continued, the pieces being quite long, I made suggestions of further involvement, focusing attention alternately on the shafts of gold sunlight on the crystal chandeliers, the musicians playing, and the sound of the music. After 10 minutes or so, giving time for deepening of trance, I began to weave suggestions in among those relating to becoming lost in the music and absorbed in watching the content of the imagery, timing the words to move with the music so that all strands of the experience might merge together. The suggestions, as negotiated with my patient before hypnosis, were along these lines:

As you become even more lost in this delightful experience, as the imagery and the music become even more vivid and absorbing, you will also absorb the suggestions I make ... After this session, as with every session, your self-confidence will quietly grow ... you will be aware that you are in the midst of a marvellous stage of personal growth and renewal ... as you listen to this strange but elegant music, a sense of harmony will develop that will carry on in time long after this session is over ... and later when you return to the waking state, you will feel serenely optimistic and sensitised to experiencing beauty and goodness in the world around you ...

I continued weaving words into the experience while the music played and eventually told my patient that the music would fade quietly, as would the lovely salon, that his mind would go quietly, peacefully blank (*music left playing very faintly in the background for style*), that he would remember everything of this experience, and then that he would listen as I counted back from 20 to 1.

The patient judged that he had gone a very great distance into hypnosis. He experienced the scene as suggested, and with his own vivid elaborations,

but had very incomplete recall of the content of my speech while he was in hypnosis. This did not trouble him and, in any case, he had a tape-recording of the session. He was very pleased that Mesmer's music had been added, after all this time, to his personal hypnotic experience.

<sup>1</sup> *Music for Glass Harmonica* (Vox Prima, MWCD 7150). In the accompanying notes it is written that the Mozart family became acquainted with the instrument by the virtuoso, Marianne Davies, who played an instrument of Benjamin Franklin's design. Their interest was deepened by Dr Franz Anton Mesmer, who had obtained and learned to play an instrument even finer than Miss Davies'. Wolfgang was allowed to play it.

<sup>2</sup> Wolfgang Amadeus Mozart: *Adagio and Rondo in C minor*, K. 617, for glass harmonica, flute, oboe, viola and cello; *Adagio in C major*, K. 617a, for glass harmonica; Johann Friedrich Reichardt, *Rondeau in B-flat major* for glass harmonica, string quartet and double-bass.

## WATCH YOUR LANGUAGE

### Lorna Channon-Little

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I had a rather puzzling experience which illustrates the lengths to which a patient will go in order to comply with the perceived demands of the hypnotist.

In the first session with a new patient, I used my standard de-induction instructions:

Now I'm going to count from 20 back to 1. As I count, you will feel yourself rousing up quite automatically. I'll ask you to open your eyes on the count of 5 and by the time I get to 1, you'll be feeling fully alert. You'll keep some of the comfortable, relaxed feeling you have now, but you'll be mentally fully alert. I'll repeat that ... I'll count now. Twenty, nineteen ...

As I counted, the patient's abdomen gradually lifted from the couch until he was in what appeared to be an excruciatingly uncomfortable position. I asked what was going on.

"You don't expect me to bloody *levitate* do you?"

It seemed that the patient, a businessman of Czechoslovakian origin who had been in Australia since the age of 12, had simply not understood the word "rouse." He took me to mean "raise" and he did his best to do so.

I now use the phrase "coming back to your normal waking state."

## EXPERIENCING DOMINANCE AS POSITIVE: A MUSICAL FANTASY WITH HANDEL

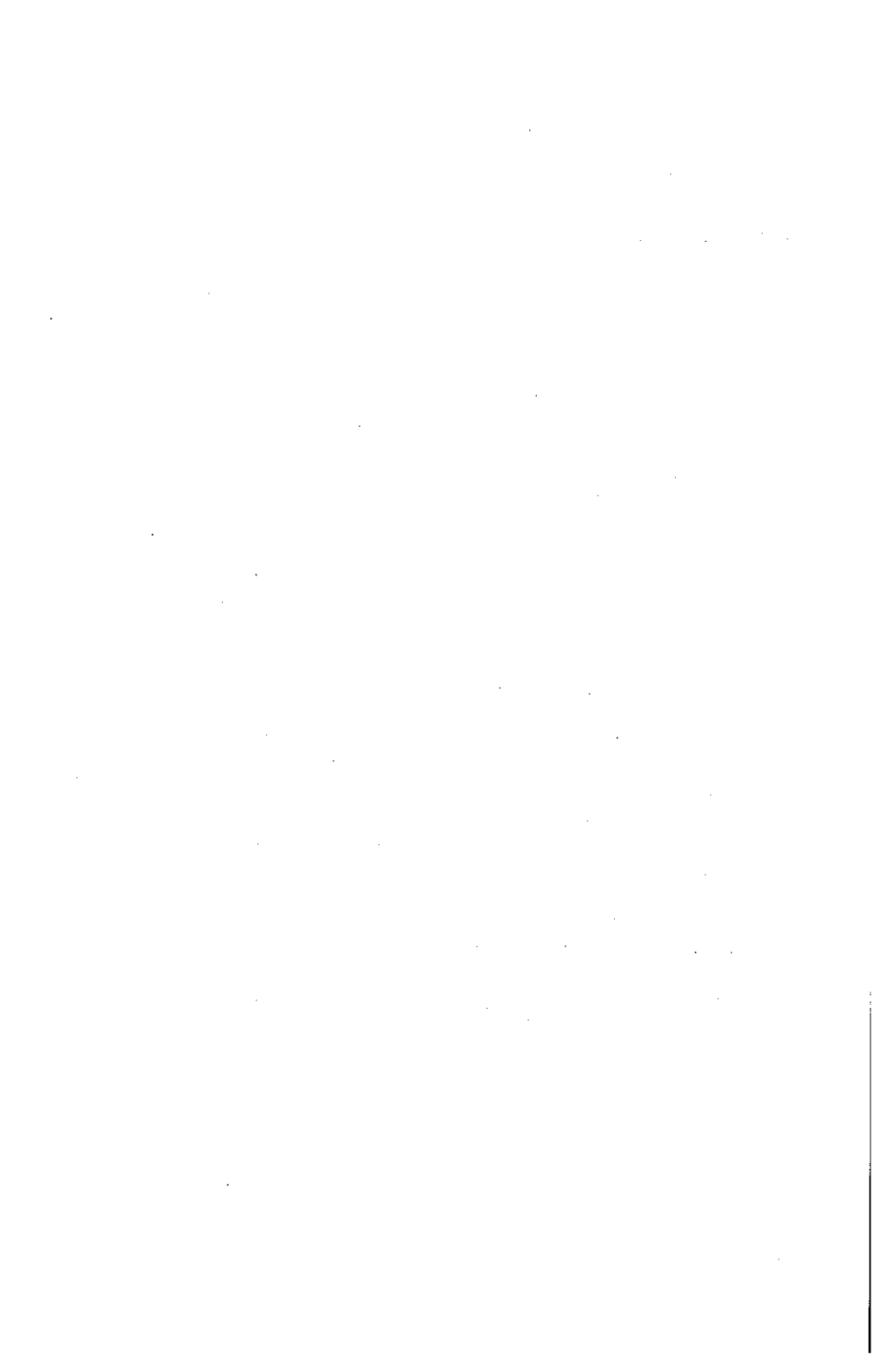
Wendy-Louise Walker

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While there is no doubt our life experience and socialisation shape our individual personalities, it seems to me most likely that dominance is a trait which has a strongly inherited core. It would also seem that those little girls who are born to rule experience increasing conflict as they are socialised into their whaleboned corset of feminine behaviours. It is not uncommon for me to find women patients with great conflict in the area of acknowledging and expressing their own dominance, even when this very dominance may have led to success in the career. Typically, of course, they have confused assertiveness with aggression and submissiveness with being sexually attractive. This confusion may be present in otherwise reasonably well coping women who attend for some non-invasive intervention such as hypnosis for stress management.

Whether or not the conflicts about dominance are in the context of neurotic disabilities or simply a difficult patch in the lifespan, if I am using hypnosis as a therapeutic modality with a particular patient, I have an enjoyable method of introducing the concept that it is quite okay to be born to rule.

Typically these days, regardless of the therapeutic work done in hypnosis, I use music along with appropriate words as a pathway in and out of hypnosis. For those women in conflict about their own natural dominance I use, as a pathway out of hypnosis (with a scattering of appropriate suggestions tailored to the patient), "The Arrival of the Queen of Sheba" from Handel's *Solomon*. The notion of coming back to the waking state proudly, calmly, like a beautiful queen (born to rule and happy about it!) is one that quite a range of women have enjoyed. When appropriate, suggestions of marvellous jewellery and robes are added. The notion of dominance as being not bad or unwomanly, simply a component of personality and probably a very basic, inborn one, can be discussed in the waking state, before the magic of the music has faded.





## BOOK REVIEWS

**The Girl Within: A Radical New Approach to Female Identity.** Emily Hancock.  
London. Pandora. 1989. x + 292. \$12.95.

Hancock bases her book on the notion that a female child is allowed to be herself until puberty. Then she encounters the crushing pressure of social forces demanding that she conform to the female sex-role stereotype. Further, the "now classic" work of Broverman and her colleagues (1972) suggests that the characteristics of the female sex stereotype are very different from the desirable characteristics of (no sex specified) an adult person. Hence a woman has the choice of being either "adult" or "feminine," but not both. A woman who makes the choice to be "feminine" must give up the experience of competence and control, characteristic of her pre-pubescent self, the "girl within."

Well, why review a patently feminist book like that in this journal?

On the negative side, Hancock's notion arose from a sudden insight and a post hoc analysis of interviews with 20 articulate American women. Hardly an impressive data base.

Also, I have always sympathised with Bannister's point that any analysis of human personality should give the reader insight into her or his own personality. "Our theories should not gainsay — though they need not simply describe and may extend — our personal experiences" (Bannister & Fransella, 1971, p. 42). I certainly didn't get a personal "aha moment" from this book.

On the positive side, though, just think of the implications for therapy. If some women actually have this experience of a "girl within" whose characteristics are repressed as she conforms to sex-role stereotypes, we have a potent force for positive change in therapy. We can re-awaken feelings of competence and self-esteem.

This is not just a supposition. The *International Journal of Clinical and Experimental Hypnosis* carried a detailed report of the treatment of a woman who had been sexually abused as a child (Miller, 1986). The therapist discovered that, as a girl, the patient had been a "feisty risk-taker." He christened this "girl within" Feisty, and suggested that his patient take her along in age regression as she worked through the sexual abuse incidents.

Looking at the adult woman, Miller noted, "I was struck with how disparate this part of her was from a part of her personality which was resourceful and competent." He used the idea suggested by Eisen and Fromm (1983) that one part of a personality could be used to help a more fragile and needy part.

There are surely a whole lot of situations where a remembered time of strength and individuality, free from the demands of being an adult (and feminine) female, could be a valuable aid to therapy.

The book, in spite of its occasional feminist polemic, is readable and interesting. Sure, one has the feeling that the author is at times cramming square pegs into the round holes of her ideas, but this kind of detailing of human behaviour is of interest to us all.

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**Teaching Self-Hypnosis: An Introductory Guide for Clinicians.** David A. Soskis. New York. W. W. Norton. xvii + 220. No price given.

This training manual is meant for clinicians who have not yet acquired any skills in the use of hypnosis. It focuses on a single technique for teaching patients to use self-hypnosis for a relatively narrow range of problems. Soskis emphasises the need for beginners to find extra training in the use of hypnosis by attending workshops, finding a supervisor, and joining a professional hypnosis society, but nonetheless the book can stand alone as a guide to a cost-effective, low-risk and almost completely fail-safe procedure.

Soskis describes two preliminary procedures (the Chevreul pendulum and hand separation) and a single scripted hypnotic procedure (arm levitation, counting with concurrent relaxation suggestions, guided imagery of a beach scene, learning the self-hypnosis exercise, and counting out). The patient also generates his or her own key phrase to use as an anchor.

The underplayed theoretical background is mildly behavioural, with a dash of neurolinguistic programming. The approach to hypnosis, as Martin Orne spells out in the Introduction, is a focus on the patient's capacity to respond and the hypnotist's ability to provide a context in which those responses may occur.

Soskis stresses the importance of recording the frequency and intensity of target symptoms as a means of evaluating treatment (something many of us are guilty of overlooking).

Soskis ends the book with guides to the practical application of the technique in anxiety, stress and dysfunctional pain, and gives pointers for more advanced applications.

Well, there's little new here. Quite frankly, most of us would consider the technique rather lightweight and find using a single imagery scene with most if not all patients a crashing bore. Nonetheless, this is meant to be an introductory manual to equip clinicians to use hypnosis with patients and it succeeds in being that.

The true excellence of the book lies in its wise and practical advice on patient selection and management. The author conveys his wealth of clinical expertise in a sensible and logical fashion. Soskis discusses so much, from patient selection (pro- and contra-indications) to how to explain your fee structure, from what to do if the patient shows no response, to how to decide on termination time. He alerts the reader to the need to spot potential problems before they become a reality.

This book represents a truly generous sharing of knowledge in fulfilling its aim to be a safe and workable introduction to the clinical use of self-hypnosis.

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