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EDITOR'S NOTE

At the recent annual congress of the Australian Society of Hypnosis in Auckland, the New Zealand branch became a separate national society. We wish our New Zealand friends every success in their venture and invite them to become individual subscribers to our journal. We remind them that we will always be happy to publish their papers and case notes.

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INVESTIGATIVE HYPNOSIS IN CLINIC AND COURT

Gordon Milne
Cairns

A comparison is drawn between the essential requirements for investigative hypnosis in clinical and forensic contexts. The value of the former is generally easier to demonstrate. The legal tendency is to regard hypnotically derived evidence as unsafe and it has provided grounds for appeal. In the Miranda Downes murder trial the judge instructed the jury that the defendant's accurate description of the deceased (whom he had previously denied having seen at close quarters) could be of some significance despite having been made "in a state of alleged hypnosis or possible hypnosis." The test of significance was, "if it had been something known to him before he was hypnotised." It was probable that the effect on the jury of the judge's statement enhanced the prosecution's case.

IN THE CLINICAL SETTING

In the clinic, investigation is often though not invariably followed by treatment. The simplest uncovering technique consists of a form of free association which differs from the psychoanalytic method in that the patient is hypnotised. For more complex cases, hypnotic age regression is often the method of choice.

In free association during hypnosis the suggestion is made that the subject will be able to converse easily without coming out of trance; that he or she will report without censorship whatever comes to mind.

The Case of the Lost Book

I was visited by a man who had forgotten to whom he had lent a rare and valuable book. Attempts at direct suggestion were unavailing. Then he was told in hypnosis that he should expect to have a dream that would aid his recall. That night he did have a dream which he remembered, though the details were vague. He was at his local bowls club, where he attended frequently as a playing member.

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While freely associating the details of this dream his mind switched to a tragic accident in which the club's president had been killed and his wife severely injured. Then he recalled that shortly before this tragedy he had lent the book to the president, a close friend.

In the clinical situation much more complex problems are met which require investigation followed by psychotherapy. For example, one occasionally receives requests for hypnotic investigation from women who have intimations of sexual abuse in childhood, and their primary aim is to have this uncovered.

There are many ongoing cases of father–daughter incest which persist even beyond puberty, the memory remaining all too vividly with the woman. Other instances from earlier childhood favour repression, with symptoms of recurring dreams, flashbacks, and impairment of sexual responsiveness.

Hypnosis for Intimations of Early Sexual Abuse

A woman phoned and asked could hypnosis be used to take her back to childhood? She believed that she must have been "manhandled," as she put it, when she was quite young. She was aged 20, an only child who had travelled a long way to escape an oppressive home life.

She accepted my suggestion that we should aim at returning her to what she believed to be the origin of her panic attacks, and the technique of hypnotic age regression was explained. On her next visit she was unable to regress. She said, "I'm afraid to!" as her eyes opened. She phoned to cancel further appointments.

Six weeks later she phoned again, this time crying and begging for help, and an appointment was made for the next day. The objectless fear was now much worse. Recently she had acquired an audiocassette which induced hypnosis and encouraged her to regress to childhood events. She thought she was on the verge of a breakthrough, then suddenly she became much worse, with panic attacks, difficulty in breathing and a crushing sensation on her chest.

At night she was waking up shaking her head violently from side to side crying out, "No! No!" She thought her trouble had a sexual origin because she had a boyfriend who was "special," but she had no desire for sex and her breasts were quite unresponsive to stimulation. Attempts to masturbate had only made her more anxious. There were vivid dreams and flashbacks of terror, sometimes with a man whose face she could not see.

In age regression before long she began to manifest acute fear with whimpering and head-shaking, crying out, "No! No! Leave me alone! Get away from me!" She also recoiled from me with her upper body hanging out of the reclining chair. She was told that she would remember no more than she wanted to, in order to gradualise the waking recall.

It was not until the fourth session that she was able to report being sexually molested by her stepfather. She was seven, and not long out of hospital with

a lung complaint. Earlier she had heard both parents quarrelling, then Mother had shouted, "I'm going out!" and slammed the door.

Afterwards she said, "So it *was* dad!" She said she had always hated him and knew now why she used to bring on an asthma attack to spite him. There were 16 sessions over five months, with gradual extinction of the emotionally painful effects and a good deal of integration of the experience into her total personality structure. She left to travel to New Zealand, where her male friend had gone to take up a position. She stated her belief that she was "75% cured," with the need for still more therapy where she was going.

In clinical practice, the historical accuracy of an age-regressed re-living of a sexual assault is of less importance than the relief of the painful symptoms. Nevertheless the validity of the uncovering of a father–daughter incest may become of major importance to all concerned should a charge be laid against the parent.

What is the status of the therapist in such an event? If called as an expert witness he would relate the events of the age regression as he knew them, stating that for him their significance was chiefly therapeutic and he could not swear to historical accuracy; nor would his unsupported testimony be freely accepted by the court as sufficient proof.

FORENSIC INVESTIGATIVE HYPNOSIS

Obviously there are different ground rules governing the use of hypnosis in the forensic and therapeutic contexts. In the first of these, accuracy of recall is paramount, with detection rendered difficult by the fact that the suspects or defendants may lie freely and fake grief, anger, or fear as it suits their purpose. They may pretend to be in hypnosis when they are not. In the clinic, relief of symptoms takes pride of place and it is not in the patient's interest to lie or simulate hypnosis. This may pose a problem for the mental health specialist who is used to dealing with patients, not self-serving suspects or defendants (Orne, 1979).

On the other hand, witnesses may produce pseudomemories which are honest reports of distortions due to memory reconstructions. Such confabulations are inevitable in the normal course of events, and may be increased in the forensic situation by inept questioning. In the use of hypnotic procedures and interrogation the psychologist or psychiatrist, by virtue of their professional training, are more likely to utilise a method of questioning which allows the subject spontaneously to re-experience important events.

In both forensic and clinical contexts, repressed memories sometimes need to be uncovered, and the same skills are equally important in each situation. Unskilled questioning and the clumsy handling of emotive responses may confound the process of recall. It is necessary to delay detailed questioning while abreactive effects are experienced, to allow time for uncovered memories to become crystallised (Orne, 1979).

Hypnotic Evidence and the Courts

The attitude of the Australian courts towards hypnotically derived evidence is confused and at the best ambivalent. Because of the small number of cases the impact of evidence law on hypnotically derived testimony has yet to be felt. This is especially the case because most of the law was developed before hypnosis became a reputable discipline (Odgers, 1988).

In America as early as 1897 the California Supreme Court declined to recognise hypnotism as a legitimate means of gathering evidence. Thirty years later a change occurred with the so-called Frye rule, which stated that for expert testimony to be admitted it must have gained general acceptance in the field in which it belongs. The Australian courts have yet to adopt the Frye rule (Odgers, 1988).

Today, according to Sheehan (1988), the status of hypnotic testimony in courts in the U.S.A. is well articulated though complex because of differences among different states. In some cases admissibility of hypnosis may be left to the jury to determine as a matter of fact; in others it may be generally admissible but subject to specific conditions and guidelines for minimising error; or it might be excluded because of its "inherently distorting" nature and the bias that accrues to it.

In Australa one important clarification occurred during the Miranda Downes murder trial (*R. v. Knibb*, 1987). Mr Justice Macrossan in his final address left it open to the jury to accept the significance of the defendant's accurate description of the deceased — whom in previous testimony he had denied at any time seeing at close quarters — even if they were aware of the possibility that the description was given while he was in hypnosis.

Nevertheless, the legal tendency is to regard hypnotically gained testimony as unsafe, and there is a likelihood of its giving grounds for appeal. Should such evidence be given higher status than the so-called "lie detector" or "truth drug"? A persuasive answer is that during a highly charged emotional experience relating to a criminal act, material most likely to be forgotten (repressed) is the most traumatic of what is experienced. Hypnotic regression to the event may enable the individual to relive the event, removing the blockage (Sheehan, 1988).

Such material, considered alone, does not possess sufficient reliability; but especially where evidence is scarce it may provide leads for possible corroboration by law enforcement officers investigating independently. It does seem possible that with individuals who are highly responsive to hypnosis, and where the process of recall is properly manipulated, memories may be enhanced to produce with confidence what is real (Walker, 1988).

To cite a well-known instance in the U.S.A., the Chowilla kidnapping case, 26 children were abducted in 1976 by masked men driving vans. The children's bus driver, in hypnosis, was able to recall a portion of the licence plate number of one of the vans. This with ample evidence from other sources resulted in the capture of three kidnappers (Kroger & Douce, 1979).

In certain cases evidential difficulties are sure to be compounded by the possibility that the respondent is deliberately lying for self-serving motives while pretending to be hypnotised. Sheehan and McConkey (1988) have suggested that subjects who have determined to lie may find it easier to do so while faking the hypnosis. The inference is that elements which exist in genuine trance are incompatible with an intention to deceive. Which seems to imply that the determination to lie does not readily coexist with what is (perhaps subconsciously) viewed as a "surrender" to the hypnotist. This would still leave the problem of detecting such simulation, which had to be confronted in the murder trial to be discussed now.

The Miranda Downes Murder Trial

In late January 1987, I received a phone call from John Penlington, producer of the television programme *60 Minutes*. He stated that he and his crew would shortly be visiting Cairns with a man whom the police suspected of murder. Detectives had been trailing him doggedly for the previous 18 months, giving him little peace, and he wanted to "go public." He had asked to be shown on TV undergoing hypnosis, a "lie detector" test, and a "truth drug" in order to establish his innocence before a vast viewing audience.

Penlington had already arranged for the polygraph test to be given and wanted me to undertake the hypnosis. My first impulse was to refuse; hypnotising a suspect who had a vested interest in exonerating himself did not seem to be an easy method of getting at the truth. I finally agreed because a major research project in investigative hypnosis was being undertaken at the University of Queensland. Also, if the suspect *were* innocent there was just a chance that hypnosis might free a blockage which might help his case.

A fortnight later Penlington phoned to say that he was now in Cairns with the TV crew and the murder suspect, Ernest Arthur Knibb. At a five-star motel on the Cairns Esplanade, the *60 Minutes* crew had established a temporary TV studio in a penthouse overlooking the ocean. Here I met Ernie Knibb, the murder suspect.

Ernie was a stockily built man of medium height, in his mid-forties. He walked with a pronounced limp, and never without a stout stick for support. In 1984 he had suffered a severe leg injury in a vehicle accident for which he had received substantial compensation and an invalid pension. He had bought a large, expensive vehicle, a Ford Bronco, in which until recently he had been touring the east coast of Queensland under a nerve-racking programme of surveillance from the law.

He was in a foul mood after completely failing the "lie detector" test that morning. Put to him were five questions of the most incriminating kind, and the changes in physiological indicators "told" that he was lying each time he responded.

The next morning I joined Penlington and his interviewer Ian Leslie for breakfast. Ernie Knibb had not yet come down, and they told me that he

no longer wanted the Pentothal test, evidence from which was also inadmissible in court. He was obviously pinning his hopes on the hypnosis which was to be videotaped that morning.

Murder at Buchans Beach

On Saturday, 3 August 1985, a Sydney television scriptwriter, Miranda Beverley Downes, arrived in Cairns with two friends. At this time Miranda was working on a screenplay for a television mini-series, *Fields of Fire*, a story of life in north Queensland's canefields. The series was eventually completed and shown on TV several years later.

Cairns is a popular seaside resort town in far north Queensland. From the airport the party proceeded to an area known as Buchans Beach, 25 kilometres north of the city. The beach is overlooked by a headland, Buchan Point. Here the Captain Cook Highway rises steeply from the north and the road widens to form a lookout where vehicles often pull over to admire the scenery; nude bathers may sometimes be glimpsed on the sand or in the water below.

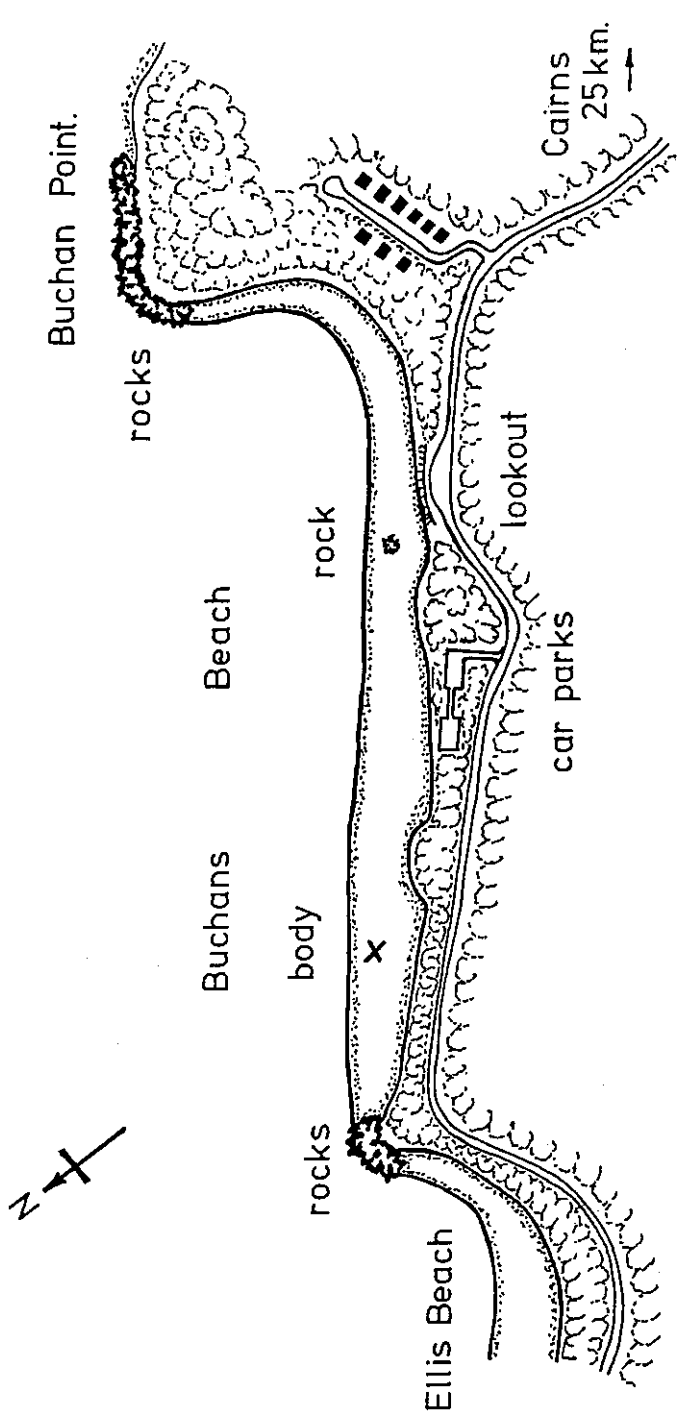
The beach itself is a little more than a kilometre long, stretching from large rocks which surround Buchan Point at the southern end to a smaller rocky mass which separates Buchans from Ellis Beach at the north.[1] The highway is lined with trees, and there is but one entrance through which vehicles can turn in to a car park. From here a vehicle track extends through to another open area which in the trial came to be called "the second car park."

The nature of the beach — its relative seclusion — attracts nudists who tend to congregate (illegally) at the southern end beneath the elevated highway and the headland. The nudist area appears to be bounded by a large rock, a conspicuous landmark set in the sand about 150 metres from the headland.

A winding, narrow foot-track leads down to the beach from the point road where, at the home of a friend, Miranda Downes and a London doctor and his wife had arrived to spend a beach holiday in the warm northern winter.

It was shortly after 6 p.m. — less than an hour after arriving — and dusk was already beginning to fall when Miranda, captivated by the view below, announced her intention of going for a jog along the beach. She was an attractive woman of 35, very tall and slim. Her friends watched her disappear in the fading light. When she had not returned within a reasonable time they searched the beach without success, and then contacted the police. At about 1.50 a.m., a Senior-Sergeant Walsh found her naked, battered body at the northern end of the beach.

A government medical officer who examined the body reported that it was partly buried in the sand and wave-action over it was evident. She had apparently been dumped in the sea and the tide had washed her ashore. There were multiple injuries due to blows to the head, face and body, and bruises to the neck. There was some blood still oozing slightly in the pubic region.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A Brisbane pathologist who performed the post-mortem examination said that death was due to drowning, but strangulation could have caused loss of consciousness. Injuries were consistent with her having been struck by a vehicle, and a Y-shaped bruise on the left shoulder could have been due to an impact with a rear-vision mirror. A slight injury to the vulva suggested the possibility of sexual interference. Although salt water had washed away vital clues, slight traces of spermatozoa were found inside the vagina. The victim's clothing had been found scattered about the beach area and Dr Harman, the forensic scientist, "expressed the opinion that the spermatozoa observed on the slide had been deposited in the deceased's vagina after her panties had been removed" (*R. v. Knibb*, 1987).

It was about half an hour before Miranda's descent onto the beach that Knibb turned off the highway in his four-wheel-drive Bronco. About an hour earlier two visitors from Victoria, a Mr Murphy, aged 76, and his wife had pulled into the parking area in their bright red Mercedes sedan after failing to gain accommodation in a caravan park. Later their sworn statements were to provide valuable evidence. They watched Knibb's vehicle drive through from the highway and disappear over the sand dunes so quickly that Murphy exclaimed to his wife, "It's gone into the sea!" Murphy estimated that the time was then about 5.40 p.m.

Shortly afterwards Knibb came back and borrowed some rope. About 5.45 p.m. the "old couple," as they came to be called, went for a walk along the beach. The driver of the Bronco was helping some young men free their vehicle which was bogged in soft sand near the grassed area off the beach. The couple walked about 200 metres towards the southern end of the beach and saw a young woman dressed in (what appeared to be in the failing light) a sort of jumpsuit, and carrying a pullover. She was walking smartly towards the northern end of the beach.

As they returned to their car the vehicle which was now freed drove through to the highway, and Murphy reclaimed his rope from Knibb, who drove off the soft sand area onto the beach. It was at least a half hour later that Knibb returned to the car park, and with lights still on got out and appeared to examine first the bull-bar on the front, and then the passenger side of his car. He then drove onto the highway.

The Bronco is a distinctive looking vehicle, so rare in the far north at that time that Knibb must have often since regretted buying it. On the Monday, two days after the murder, he phoned the police and said he was the owner of the vehicle they were seeking. Later he came to the station and made a statement in which he said he was on the beach for only two to three minutes. He then proceeded to Hervey Bay, about 1,300 kilometres to the south, where he took up residence in a caravan park.

The police were far from finished with him. Two undercover detectives posing as bikies visited the park, became friendly with him, and during a drinking session tried to coax him along by confiding about various "crimes"

they had committed, including rape, but he gave away nothing. Two women police posing as tourists played beach ball with him; they claimed that he forgot to use his stick, and he is said to have proposed to one of them. Eventually, to his chagrin, the Maryborough police took his vehicle away to make scientific tests on it.

Everything was going wrong for Ernie Knibb. Apart from the polygraph test, which had no bearing on the trial, his interviews with the police and Ian Leslie revealed him as a querulous equivocator. In his final interview with Leslie he first admitted then denied that he was on the beach for half an hour, then stated, "I wouldn't fuckin' know, mate, I'm not a computer . . . that's your answer. I don't know how long I was on the beach."

He knew that if his gamble failed and he was arrested the prosecution's aim would be to have the video recordings of the interviews with Leslie and the hypnosis screened before the jury. All his hopes lay with the impression he made during the hypnosis session.

Before proceeding to the hypnotic evidence it is important to note that at the time when Miranda Downes was murdered — presumably while she was walking or jogging towards or from the northern end of the beach — the only persons *known* to be in that circumscribed area (apart from the elderly couple) were Downes, Knibb, a young American woman named Janice Cunningham who was a prime witness, and three overnight travellers camped in the second car park. Each of this latter trio reported sightings at the material time of a vehicle sufficiently resembling Knibb's Bronco to satisfy the jury as to its probable identity. The car was even reported being seen by a driver and his passenger from the highway above.

The almost deserted state of Buchan's fine beach at the height of the holiday season was not unusual. Locals say that on winter days it was generally warm to hot, with numerous visitors; but after the sun went behind the mountain range to the west it became quickly deserted, with a cool breeze blowing in from the sea.

The witness Janice Cunningham had walked down from the northern end of the beach and had passed a woman walking north whom she identified as Miranda. The appearances of the two women were in sharp contrast, a point which was to become of major significance.

Miranda was aged 35, 178 cm (5 ft 10 in) tall, of slim build with brown hair. She was wearing grey tracksuit bottoms, a light pink top, and a pullover was tied about her waist.

Janice was about 10 years younger, blonde-haired, 160 cm (5 ft 3 in) tall, and of medium build. She wore baggy cotton pants of very bright colours, pink, black, green and orange in a geometric design, and a baggy white T-shirt.

She stated that she had arrived near the southern end of the beach at about 6.20 p.m. Shortly after passing the deceased, when somewhat north of the large rock, she saw a vehicle on the beach which passed her on three

occasions with its headlights on; first travelling north, then south, then again travelling north. On the last occasion the driver of the vehicle, which she identified, stopped and spoke to her reassuringly near the rock, then continued north.

THE PRE-TRIAL HYPNOSIS

Ernie Knibb had explained earlier that his request for hypnosis was an attempt to arrive at the truth. He thought that his memory was blocked, and he wanted it cleared whatever the consequences (the nature of this "blockage" will become evident during the final portion of the transcript).

The hypnotic session took about an hour to complete, and the full transcript consisted of more than 6,000 words, almost all of them spoken by Knibb — an incredible feat of word-spinning from a subject presumed to be hypnotised. Only those segments considered to be of significance are reproduced. Circumlocutions and repetitions have been omitted in the interests of readability, but many of the crude expletives from the legal transcript are retained.

Once the cameras were set up, no-one else was to be in the room, which presented no problem as the recordings were controlled from an adjacent room where police were present and made their audio recording for the official transcript. Fifteen minutes were allowed for briefing and the induction, as I did not wish this to be televised. However, some of the induction had to be repeated on camera when he became talkative and restless.

Knibb was asked to take himself back in time to the moment when he drove his car off the Cook Highway and through the parking area, over the sand dunes and onto the beach. After a while, in one of his confused statements, he described two persons jogging up the beach:

> . . . if it was a woman it would have been a very pretty one because it was around five feet ten, five feet eleven, very slim, if it was a man it would have been a very muscular man, like very well built . . . and then I saw this other figure running behind . . . I just thought there was a male and female . . . husband and wife jogging on the beach.[2]

Asked about clothing, he said: "she had blue on the bottom, I think, and light on the top, ahm I'm not sure what the top was." He appeared confused about which had blue bottoms on and which was the man and which was the woman. Then he said: "I saw this woman walking down. I thought it was the same woman who was jogging up." (This was obviously Janice Cunningham who had reported passing Miranda running north alone.)

Knibb then drove up towards the northern end, switching on his headlights which shone on the rocks separating Buchans from Ellis Beach. He then made a U-turn: his observation was, "I thought, shit, they're in front of me, I'd better watch myself." He then drove south past the entrance to the car park, passing Cunningham. He said:

And then I saw this big rock, and I thought, shit, I'm up the end of the beach again. So I did a U-turn and here's this woman standing no more than 50 feet in front of me and I didn't see her till my lights shone on her and I thought, fuck, that was close.

Q: This was the woman you saw running up the beach?

A: I don't know . . . so if she come from the other end and she was walking down what the fuck happened to those two joggers, where did they go, they've vanished, in other words they're gone in fresh air, they just disappeared so . . . I saw no-one up that end of the beach . . . going north . . . I saw nobody come back and I definitely didn't hit anyone . . . it's obvious she gets in the water and walks out just after I go past.

Q: [Reverting to the woman caught in the headlights] How do you describe her?

A: I just recognised her as a woman sort of thing and she was only 50 or 60 feet away from me at the most . . . She's looking frightened, and I thought, You poor bastard, you're scared stiff, and I stuck my head out and said, Don't worry love, I'm just trying out my new car, and she smiled and waved back.

Q: You stayed in the car. You didn't touch her.

A: I gotta admit I'm not interested in girls taller than myself, and she was standing there and I'm looking straight at her. Her head was well above the bonnet — my head — my chest.

Q: You could tell without getting out of the car that she was taller than you?

A: Oh, she was definitely a tall woman, a tall woman, yeh she was a tall woman.

Q: How old is she?

A: Oh, about thirtyish, I'd say.

Q: Well, you visualise her now. See her face.

A: She's got blonde hair, light shade blonde.

Q: Pretty?

A: I don't see her as pretty. To me she looks plumpish. She's got something round her waist, it might be a jumper or something tied around her waist. The back of the jumper's behind her and tied in a knot in front. She had what I think it was a gym suit bottom on, I don't know what the top was. It was something light, you know. She had something light on the top.

Q: She went away then?

A: Oh, no. She's standing about 60 feet in front of me. I went left to go around her. She started walking, and I drove straight off the beach.

Comment

Knibb begins by seeing two people jogging up the beach "like man and woman, husband and wife." One of these, the man, is an invention — doubtless a

potential murderer in the scenario he has prepared. There was no evidence that such a man existed on the beach at that time. He drives up as far as the rocks at the northern end, ostensibly to test out his tyres on the loose sand, but he doesn't see them. "They vanished into thin air."

In this last scene with the witness Cunningham, he sees her near the large rock, and she also had reported this meeting. She is in the glare of his headlights looking scared and frightened, 50 or 60 feet away. Then as if by magic a different woman, a very tall woman is *in front of the bonnet* of the car. She was taller than himself because, standing there and he's looking at her, her head is "well above the bonnet — my head — my chest." (Downes was 18 centimetres — 7 inches — taller than Cunningham.)

When asked to visualise the woman, Knibb describes her as blonde and plumpish, but she is dressed like Miranda with a gym suit bottom and a jumper tied around her waist. She is once again 50 feet back from the bonnet of the car.

This perceptual confusion beginning with what seemed to be a hallucinated image of Miranda, then switching to a composite picture of the two women, was of great interest to the prosecution because of Knibb's previous denial that he had ever seen the deceased at close quarters. He had never provided such details to the police or to Ian Leslie, the *60 Minutes* interviewer.

According to Knibb he drove straight from the meeting with Janice Cunningham to the car park (where the old couple were camped for the night in their Mercedes). According to the prosecution, before turning off the beach he would have proceeded to the northern end where he ran down and murdered Miranda Downes. Janice Cunningham did not look back to observe whether he turned off the beach or drove north.

Returning to the hypnotic recall, Knibb has just arrived in the car park on his way out from the beach:

> There's a car there, it's got all its lights on high beam. I've just pulled up and it's gone reversing back real fast into the bush, real fast, it wasn't necessary. If it was the old couple why should they be afraid of me? Why doesn't he turn those lights off . . . Oh fuck him anyhow . . . I gotta check me tyres . . . I'm going to go and ask him if he's got a pump he can lend me. No, fuck that, if I walk over there this cunt's going to run over me. No, fuck you . . . I can go over and ask him I suppose. No, something's wrong, no, fuck this . . . This cunt starts that car he'll run over me and I can't run out of the way . . .
>
> *Q*: You are concerned now . . . You feel there's something wrong . . .
>
> *A*: This is all wrong . . . I felt someone . . . as if something was touching me . . . like as for instance me mum was touching me but she's not there, you know what I mean . . . there's something wrong there . . .
>
> *Q*: Could you describe the car?
>
> *A*: Oh it's a light brown station wagon, a Ford, about a 1964 or 1965 model . . .

Q: The number?

A: No, I can't see the plates . . . lights are full on . . .

Q: What do you feel now?

A: There's something wrong out there. If I go out there he's going to kill me . . . Fuck him, no I should go over. If it's the old couple they might be in trouble, no, fuck you, I'm not going over you cunt, I can't run out of your way if you try anything . . . It looks like he might have a blanket or something round the windows, why the fuck don't you turn those lights off you cunt . . . If I could run I would have gone over to that car . . . I can't run. If I try to run away he's gonna kill me . . . He knows I'm on to him . . .

Q: You have bad vibes, as they say, about this car?

A: There's something wrong with that car . . . There's no way in a hundred million years somebody's going to tap me on the fuckin' shoulder, sending bloody chills through me . . . Look, I've been in gaols all my life mate. I've seen worse crimes than what you've ever dreamed about . . . handled dead bodies in hospital . . . where they'd left the fridge off for two bloody weeks and it stunk, the poor bloody bitch . . . I'm not afraid of dying either . . . when I leave here and this is all over . . . I'm going to kill myself, whether I come out innocent or not makes no difference . . . I'm just sick and tired of this fuckin' world . . . all this bullshit and lies . . . a man tries to go straight . . . huh, what's the fuckin' sense of it . . . after 20 fuckin' years of being a good little boy you bring me out in the public so that I can be called a criminal . . . you didn't give a fuck that I was innocent, you persecuted me, you slandered me, you stole my car . . . you shoved me out of the way, you cunt, so that I nearly went over . . . you're just fuckin' persecuting me you cunt, look at the fuckin' statement you put in the paper, Miranda Downes murderer been found, you didn't tell them I was a cripple, did you, just a pensioner . . . Go out there and have a talk with that cunt in the car, eh . . .

Q: Going back to the car you've had such bad feelings about. Have you thought of what purpose he might have had in leaving those lights on?

A: So I can't see in the car! . . . Where'd that other jogger go? There was two joggers on the beach . . . where the fuck's that other one? I wonder if she's in there . . . he doesn't want me to see in that car . . . The cunt's got a knife, it's got to be a knife . . . something with lights flashing on it . . . and that cunt's leaning forward over the steering wheel . . . what are you fuckin' watching me for you cunt . . . You're not the old couple, you're too fuckin' young . . . keep looking at me and I'll ram you with this car you cunt. I'll fuckin' push you right over the edge . . . [*Pause*]

Q: I want you just to let these impressions fade from your mind now. Just let your mind become perfectly blank. When your eyes open you'll feel relaxed and okay.

[*Dehypnotising suggestion added*]

Comment

In the final scene in the car park a lonely, frightened observer views a man armed with a knife, crouching behind a steering wheel, with car lights on high beam to hide what's inside the van (perhaps a murdered woman). Now the reason for the early perception of the *man* and woman jogging up the beach becomes clear.

Knibb's diatribe against the police was probably motivated by his belief that the video was to be shown Australia-wide (which it was, but without that portion of the script).

The scene impresses as a prepared, desperate gamble, and a foolish one, since the police were able to show that the only vehicle in the car park at that time was a red Mercedes sedan owned by the "old couple".

THE TRIAL

On 6 February 1987, not long after the end of the hypnosis session, Knibb was arrested and charged with the murder of Miranda Downes. The trial commenced seven months later, a little more than two years after the murder, with Mr Justice Macrossan presiding. Almost one month later Ernest Arthur Knibb was found guilty of murder as charged and sentenced to life imprisonment.

The 18 months of determined police surveillance paid off the moment Knibb agreed to cooperate with the *60 Minutes* show. In Penlington and Leslie he may have expected to find confederates who would help his case. Instead he found that the interviewer Leslie was a relentless questioner, concerned only with facts, and the facts all too often told against Knibb.

The polygraph test alone might well have destroyed him, had its results been admissible. The evidence from the hypnosis was a boon to the prosecution. Mr Justice Macrossan in his summing-up to the jury read to them the portion of the hypnotic transcript covering Knibb's meeting with the witness Cunningham at the large rock, stressing how it contradicted his earlier evidence of not having seen the accused at close quarters. It might have sounded like the tolling of a bell for the defence.

THE APPEAL

The principal ground on which the appellant relied was that the "verdict of guilty was unsafe and unsatisfactory." In support of that ground the appellant relied on a number of particulars, the most relevant in the present context was the following:

> 4. The trial judge wrongly admitted into evidence:
> (G) The video recording of the hypnosis session conducted in relation to the accused and the evidence in relation hereto of Dr Milne, Professor Sheehan and Dr McConkey. (*R. v. Knibb*, 1987, p. 4)

The appeal was dismissed. Mr Justice Williams, of the Queensland Court of Criminal Appeal, presented the major analysis of the evidence which included the following statement:

> The prosecution relied in particular on the fact that during the "hypnosis" session he was able to give a very accurate description of what the deceased was wearing on the beach. If the jury, as they were invited to do so, concluded that the appellant was able to recall precisely what she was wearing, then they could attach significance to the fact that in other statements, particularly statements to the police, he denied seeing at close quarters, any person other than the blonde to whom he spoke — the witness Cunningham. Further, in the "hypnosis" session and in other conversations in February, 1987 the appellant made much of another vehicle — said to be a Ford station sedan — in the car park as he left the beach; something was wrong, he was alarmed by its lights and its movement — and further there was a knife on the dashboard. But he only made passing reference to such a vehicle in his statement of the 5th of August, 1985: "As I drove from the clearing there was a car which I took to be the one containing the old couple reversing back into a place to my immediate left."
>
> I will not expand at length on other matters the jury were invited to take into account when considering whether the appellant, by his conduct and by the statements he made, manifested consciousness of guilt. It is sufficient to note what he said about the height of one of the women he saw on the beach; he referred to the "taller" woman and gave in one of his statements a height of five feet ten or five feet eleven — the height of the deceased who was much taller than Cunningham.

As noted earlier, the trial judge also dwelt on the accused's accurate description during hypnosis of what the deceased was wearing in spite of his denial that he had ever seen her at close quarters.

WAS KNIBB GENUINELY HYPNOTISED?

The three expert witnesses for the prosecution, mentioned in the appeal, were asked during the trial whether Knibb was genuinely hypnotised. The answer given by each was "no," though each qualified his denial by conceding the possibility that the defendant was passing in and out of hypnosis during the session. However, the major impression given was that he was overplaying a role, engaging in rational debate.

This was the case even if one allowed for the special circumstances which existed in his being a police suspect, battling for his freedom. Knibb was virtually a non-stop talker, averaging more than 100 words a minute with a variety of expressive movements over a session lasting about an hour.

How did the court accept the consensus by expert witnesses that Knibb may, on occasions, have been drifting in and out of trance? The trial judge clarified this issue by addressing the jury as follows:

> But if he says, in a state of alleged hypnosis, or possible hypnosis, that he observed something, or knows of something which he could only know of, if it conforms with true events, real events, which he could only know of if it had been something known to him before he was hypnotized, then there may be some significance in the remarks he makes under hypnosis. (*R. v. Knibb*, 1987, pp. 42–43)

There was one period when I am certain that Knibb was in a genuine state of trance. This was during the scene at the rock when he hallucinated the dead woman standing tall at the bonnet of his car; and then, 50 feet back again, the blonde-haired Janice wearing Miranda's clothes. This was a gift to the prosecution, perhaps the final link needed in the chain of circumstantial evidence, stemming from who knows what unconscious motivation — conceivably his guilt.

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[1] The area described has always been popularly known as Buchans Beach, though still officially part of Ellis Beach.

[2] Quotations from the police transcripts of hypnosis.

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BRAINWASHING, HYPNOSIS, AND THE CULTS

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It is an interesting anomaly that the issue of cults and coercive persuasion can be studied for 20 years and generate scores of papers and studies without the question of hypnosis by cults being seriously investigated, nor have specialists in the study of hypnosis become involved in the study of cults, despite serious and repeated allegations of abuse of hypnosis by cult groups. This anomaly is here explained as being the result of the uncritical a priori assumption of volitional decision-making by cult devotees on the part of most social scientists studying the issue, who tend to be apologists for cult groups under the rubric of pluralism and religious freedom, and the almost equally uncritical acceptance by opponents of cult groups of either the "brainwashing" model of coercive persuasion or allied social psychological models, to which all people are held to be vulnerable given sufficient stress. Both sides of the controversy share the assumption of little variation in important psychological variables between those who leave cults of their own initiative and those who leave through the intervention of parents or other significant others. The measurement of hypnotisability as a possible variable predicting successful cult recruitment of the prospective devotee has been ignored to date, despite intriguing hints in published cases, and the study of hypnotisability in ex-cult members provides a promising avenue for further research.

The past 20 years have seen the growth of a serious controversy within the social sciences regarding the use by cults of techniques for conversion and maintenance of membership. These techniques have often been described as thought reform or brainwashing. The debate about whether or not religious movements have, in fact, been using techniques of conversion that are analogous to techniques that the Chinese used on prisoners has polarised the social sciences. The prevailing opinion among sociologists is that thought-reform techniques have not been used, that in fact members of new religious movements joined them out of their own initiative, leave in larger numbers than remain, and stay in them of their own free will. They cite studies showing a high attrition rate to bolster this claim, as well as discrediting the brainwashing hypothesis by pointing out that conditions in cults are nowhere near the limits of human endurance, as they often were among American prisoners of war in Korea.

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Stories of ex-members who allege that thought reform techniques were used on them tend to be dismissed as atrocity stories out of which persecutions are made.

The psychological community has been split on this issue. Many psychologists have documented symptoms resembling post-traumatic stress disorder in ex-devotees of religious cults, both among those who exited the group voluntarily and among those who were deprogrammed. Ex-members exiting cult groups, for example, often show symptoms of what is colloquially called "floating", which is a state of mind in which the individual alternates back and forth between the state of consciousness they exhibited while in the cult and their pre-cult personality.

Other psychologists, such as addiction specialist Marc Galanter (1980, 1989), take a more positive view of the cult experience. Galanter, who is well-known for his study of zealous self-help movements such as Alcoholics Anonymous, draws comparisons between groups like the Unification Church and AA, claiming what he calls a "relief effect" for neurotic symptoms and abnormally high scores on standarised tests among populations of current cult members, as well as decreased drug use. Galanter mentions dissociative symptoms in his book but does not comment on them.

One dimension of the cult issue that seems to be ignored by almost all concerned is the question of whether cult groups might be deliberately or inadvertently using some analogue of hypnosis and/or selecting for highly hypnotisable members. Authorities on hypnosis such as Ernest Hilgard or Herbert Spiegel have been conspicuously absent from forums where the cult issue has been discussed, despite regular allegations by ex-members and cult exit counsellors, of misuse of hypnotic or quasi-hypnotic techniques by cult groups. Despite 20 years of study of this issue, there have been no clinical studies, let alone experimental studies on hypnotisability in cult groups by either side. Even the anti-cult psychologists have, until very recently, eschewed hypnotic explanations for goings-on in cults. They have favoured social psychological studies, based more or less on the original work on brainwashing done by such people as Edgar Schein (1961) and Robert Jay Lifton (1961), despite the seeming tendentiousness of comparisons with patients who, after all, had been prisoners of war kept in near isolation. Why both sides of the debate have ignored hypnosis with such tenacity, how this tenacity of position is beginning to break down under the impetus of the progress being made in the study and treatment of dissociative disorders, and what I expect my current research in this area to add to the study of hypnosis in cults shall be the topic of this paper.

Brainwashing emerged as a subject of popular concern in the late 1950s and early 1960s, at a time when hypnosis was just beginning to emerge as a serious subject from the eclipse that it had endured throughout the early twentieth century. This eclipse and discrediting was the result of overenthusiastic claims made of hypnosis in the nineteenth century, leading to charges that

hypnosis was somehow "unscientific," and the reluctance of Sigmund Freud to use hypnosis in psychoanalysis (Laurence & Perry, 1988).

The early twentieth century was also, of course, the beginning of the Age of Ideology. In contrast to the previous century, when large numbers of people, at least in the West, were rallied in international conflicts for essentially nationalistic reasons, the twentieth century has seen the rise of the transnational ideologies of Communism and Fascism. Being transnational, these ideologies could spread across national lines when properly inculcated. As the Great Depression gave way to World War II and World War II gave way in turn to the Cold War, military and ideological questions increasingly dominated and shaped the agenda of the social sciences, from the issue of the proper psychiatric treatment of war neuroses to the reasons for authoritarian personalities that would be inclined toward Fascism and Communism to, increasingly after the Korean War, questions of loyalty, how it was fostered, and what psychological techniques could change it. The germ warfare confessions of Korean POWs came as a total shock to the American public, although not to U.S. intelligence or policy analysts who had been following the issues of thought reform since the Stalinist purge trials of the 1930s.

As early as 1948, G. H. Estabrooks (1948) had speculated on the possible uses of hypnosis in intelligence by using hypnotic amnesia to create interrogation-proof couriers. Even earlier, building upon prewar experimentation in the induction of antisocial acts through hypnosis by Wesley Raymond Wells (1939), an experiment had been conducted by the United States Army in which a soldier subject, upon suggestion that a fellow soldier was a Japanese soldier, attacked the "Jap soldier" with a pocket-knife the observers had not been aware he possessed (Watkins, 1947). The behaviour of many returning POWs appeared to vindicate these concerns over Communist methods of indoctrination, as well as relate their ill effects to the syndromes of "battle fatigue" (now post-traumatic stress disorder). As Robert Jay Lifton (1954) states: "The average repatriate was dazed, lacked spontaneity, spoke in a dull monotonous tone with markedly diminished affectivity" (p. 735).

Continuing research by Lifton (1956, 1957), Edgar Schein (1961), and William Sargant (1957, 1966), qualified and debunked many of the early fears about the mass creation of brainwashed zombies. However, they did broaden the definition of brainwashing to include many more prosaic forms of social influence and mobilisation that did not necessarily involve holding people prisoner. Robert Jay Lifton, for example, went on to study thought reform of Western civilians in China (Lifton, 1956), as well as the thought reform of Chinese intellectuals attending "revolutionary universities," often without any obvious compulsion. Edgar Schein, although not discounting social psychological theories of coercive persuasion, emphasised the psycho-physiological stress as the variable in effective coercive persuasion. And in Great Britain, William Sargant not only concurred with Schein's findings on psychophysiological stress, drawing upon 15 years of research and treatment

of war neuroses, but applied Schein's model (which he traced all the way back to Joseph Pavlov) to a cross-cultural study of the use of psychophysiological stress in religious conversion and rituals.

The model of psychophysiological stress is valid, if somewhat reductionist, for understanding religious and political conversion. The idea that every man has his or her breaking point, which was the consensus of the 1950s and early 1960s brainwashing research, is a valid one. Politically, it had the valuable and humane effect of enabling the United States to forgive its POWs who were forced into compromising acts by their captors, rather than prosecuting them for treason. However, the idea of every man having a breaking point is, in many respects, an oversimplification of the work on the subject. Sargant, in particular, was always careful to point out there there were marked differences in the susceptibility of individuals to stress, which he related back to Pavlov's four types of temperament Sargant, 1957, pp. 20–55. Unfortunately, in the late 1940s, when Sargant was doing most of his war neuroses work, standardised tests for dissociation and hypnotisability had yet to be developed. The measurement of reactions to stress was in its infancy. For this reason, but also perhaps because of the divisiveness of susceptibility studies, differential susceptibility to stress was not followed up at that time, and Sargant's caveat did not become part of the conventional wisdom regarding coercive persuasion, although it may have paved the way for Hilgard's (1977) work on hypnotic responsiveness in the 1960s.

Brainwashing thus came to be seen as a nefarious force, to which all people were susceptible. Questions of individual susceptibility to cults and personality factors increasing vulnerability to cult involvement were ignored, and when high attrition rates were found by social scientists in religious cults, they were used to falsify what amounted to an overly brittle caricature of the brainwashing model.

By the middle 1960s, the issue of Korean POWs being brainwashed was largely a matter of historical fact. Researchers who had studied the issue, such as Robert Jay Lifton (1961) and Margaret Thaler Singer (Strassman, Thaler, & Schein, 1956), moved on to other areas, leaving the issue of brainwashing largely as the specialised concern of the military and intelligence communities. But it now appears that brainwashing may have informed the concern over the counterculture of the late 1960s and early 1970s. While I do not wish to dwell on this period, I must point out that the counterculture linked experimentation with psychoactive drugs with opposition to the Cold War in general and the Vietnam War in particular. Although few people at the time were publicly suggesting that young hippies and radicals were brainwashed, the Cold War epithets of "Communist sympathiser" and "Communist dupe" were given young antiwar protesters as their rhetoric and actions became more and more sympathetic to Hanoi. Moreover, the concerns about drugs and their effects, particularly LSD, do appear to have crystallised shortly after the CIA's MKULTRA experiments into the use of the drug

as a brainwashing tool. It is quite feasible, given the nature of the times and the bizarreness of the behaviour of young hippies, that much of the concern about drugs might well have had overtones of brainwashing about them. The question of whether there were overtones of brainwashing to the concerns of, and reaction to, the hippies remains an intriguing one.

There is nothing speculative, however, about the role that the counterculture played in the current wave in cults. Coming to the U.S. in 1965 and Australia in 1972, following liberalised immigration laws, was a wave of gurus. The interest in what is loosely called Eastern spirituality, or alternative religion, psychology, and lifestyles was initially looked upon as a constructive and socially acceptable alternative to drugs, as was the Jesus Movement. It was in opposition to the behaviourism and psychoanalytic models of psychology that humanistic psychology developed. As encouraged by such people as Timothy Leary and Stanislav Grof, psychedelic drugs were a tool for the development of human potential and for resolving problems. When psychedelics were banned, humanistic psychology began to rely on group dynamics and on the use of hypnotic means (not always labelled as such) to achieve the altered states of consciousness they had achieved with drugs. Philosophically, humanistic psychology places a great deal of emphasis on free will and choice as a given, categorically rejecting the deterministic theories of the other branches of psychology and assuming, a priori, that we all choose, in one way or another, our life conditions. Theories of brainwashing can be considered philosophically anathema to humanistic psychologists. Mixing well with Eastern traditions, humanistic psychology proved to be highly influential in the developing counterculture.

Although the Family of Charles Manson acted like what would today be considered a cult and was later found to be associated with a larger satanic cult in California (Terry, 1987), the famous Tate–La Bianca murders perpetrated by that group were not associated with cultism, and brainwashing as an issue was not raised in that case by the prosecution. It was not until 1971 that issues of brainwashing or coercive persuasion began to be raised about cults, and even then they were raised initially about one particularly outrageous group — the Children of God.

At the time, Ted Patrick — a black civil rights leader from San Diego and an ombudsman working for the then governor of California, Ronald Reagan — began to get alarmed phone calls from parents alleging that their children had been psychologically kidnapped by Children of God (Patrick & Dulack, 1976). This came about after his own son had almost been inducted by this group. Patrick infiltrated the group and then read up on brainwashing, where he found William Sargant's cross-cultural studies on religion particularly illuminating, and then figured that if he could kidnap some children out of the group and get them to tell their story, public attention could be drawn to the group and legal action could be taken against it. The abductions and the deprogrammings were successful, but neither state nor federal authorities

had any legal basis to take any action, largely because of the First Amendment to the U.S. Constitution, which guarantees freedom of religion. Finding that other parents had beat a path to his door, Ted Patrick quit his job with the State of California and the profession of deprogramming was born. Soon an underground network of parents, deprogrammed ex-members and safe houses for deprogrammings had mushroomed across the United States.

Although Ted Patrick has spoken of the use by cults of on-the-spot hypnosis, the question of the use of hypnosis was not picked up by the newly forming parents' groups opposing the cults. Lifton and Sargant and Schein got read, but not Ernest Hilgard or Herbert Spiegel, who was coming out with his hypnotic induction profile and personality profile of the highly hypnotisable person at the time. The rhetoric of the deprogramming movement concentrated on the lack of nourishing food and lack of sleep as the key variables in the cultic indoctrination process. Psychotherapists who began treating cult victims after deprogramming at this time, such as Marvin Galper (1982), John G. Clark (1979), and Margaret Singer (1978), for the most part did not use hypnosis in their practice and were not particularly up on the research in the field, preferring to rely on behavioural and social psychological models.

The year 1978 was pivotal for the cult issue in the United States. Not only was it the year of the People's Temple mass suicides at Jonestown, but it was also the year in which parental concern over wayward youth began to manifest itself in the formation of pressure groups against drug usage. One year later, the Citizens' Freedom Foundation, which had become moribund as an umbrella organisation for parents' groups getting children out of cults, received new impetus and held its first successful national convention, creating the American organisation that exists today as Cult Awareness Network. On a professional level, this was also the time of the formation of the American Family Foundation.

It did not help matters that support for the cults (or at least opposition to deprogramming) was beginning to build among social scientists, particularly sociologists. For reasons that appear to be related to pro-counterculture prejudice more than anything else, sociologists such as Thomas Robbins (Robbins & Anthony, 1982), James Richardson (Richardson & Kilbourne, 1983), Anson Shupe (Shupe & Bromley, 1978), and David Bromley (Shupe & Bromley, 1978), as well as more respected religious sociologists such as William Sims Bainbridge (Stark & Bainbridge, 1985), and John Lofland (1978), eschew recruitment models of religious conversion in favour of social drift theories emphasising choice on the part of the devotee. Deprogrammed ex-members, according to this conventional wisdom, are simply apostasising and claiming that they were temporarily driven insane by the methods of the cults in order to justify the expense and risk that their parents took in getting them out and to get themselves back into their family's and society's good graces.

These views gained momentum with the publication of Eileen Barker's work, *The Making of a Moonie* (1984). In this work, Barker surveyed ex-members and current members of the Unification Church, finding an attrition rate from initial workshop to membership after two years of over 90%, leading to an obvious conclusion that the Unification Church's much vaunted recruitment methods were not all that effective.

Psychologists studying the cults during the 1980s tended to be more critical of cult groups. Led by Michael Langone, of the American Family Foundation, they approached cultic recruitment methods from a number of angles, from social psychology to family therapy. One major result was the development of reliable methods of coaching families on how to avoid relationship-destroying confrontations with cult offspring and how to utilise what remained of the relationship with their offspring in order to get them to the point where they would voluntarily speak with an exit counsellor. This approach, inspired to a degree by the work of Richard Bandler and John Grinder (1975), was pioneered by Steven Hassan (1986) in his book, *Combatting Cult Mind Control.* Using Hassan's methods, it became possible to avoid most coercive deprogrammings, for exit counsellors to become more professional, and for the anti-cult movement to adopt a lower, more credibly professional profile. While these approaches became a practical solution to the problem of continuing to be effective in the struggle against the cults, they have offered little progress in understanding possible hypnotic potentials of cult members. Even so, most anti-cult researchers appear from their literature to have remained in the dark concerning the great strides that have been made in the past five years in understanding hypnosis and dissociative disorders.

Probably the main reason for the lack of progress on this front has been the popular misperception of thought reform or brainwashing as something that everyone is equally subject to, and a bias on both sides of the issue against exploring vulnerabilities to cult methods on an individual level. This bias is obviously more pronounced on the cult apologist side, and in Cult Awareness Network circles one gets none of the hostility towards studying the hypnotisability of cult members that one gets among most academics studying the issue. Unfortunately, studies critical of cults tend to be short of funds, particularly in the United States. The issue of separation of church and state has made the political correctness of such studies an issue in the United States, and has had a chilling effect on the willingness of grantors to fund research that might yield results critical of religious movements. As a result, the research that has been conducted has for the most part been limited to narrowly based clinical studies, while research that is uncritical or positive towards cults has received funding and patronage, sometimes from the groups that the researcher is studying.

Nevertheless, tantalising hints have emerged from cult studies, even from among those that are ostensibly favourable to cult involvement, that show possible conscious or unconscious biases in cult groups in favour of highly

hypnotisable recruits (or at least show that deprogrammed ex-members might be more highly hypnotisable than members who either leave of their own volition or are expelled). Marc Galanter (1980), who has written mostly positive studies of the Unification Church and who compares it with Alcoholics Anonymous, among other self-help groups, notes that of his Unification Church subjects, 72% report a distorted sense of time outside the prayer experience and that 50% of his total reported it "intensely."

Arthur Parsons, a sociologist who studied the Unification Church with its permission, found that it requires "conformance to the role of the child in the personalised family" (p. 148). Parsons goes on to point out that the Moonies present initiation into the Church in a series of stages, each of which elevates the initiate into a higher state of perfection as a child, passing from servants of a servant (Satan), through servant of God, adopted child, and finally perfect child. The ultimate goal, of course, is to become a perfect parent.

In practice, this results in Moonie weekend workshop participants alternating from theological lectures to children's games, such as spirit world dodge ball and relay races, something I observed doing field research on the Unification Church as an undergraduate. In comparing my experiences with Arthur Parsons' observations on the Unification Church — in which he pointed out the centrality of the role of the child, as well as the lack of responsible positions in the Church and the way that people were rotated in them, especially during the three or more years prior to marriage in the Church — I realised what Eileen Barker (1984) and others took at face value as a high attrition rate and evidence of the Unification Church's ineffectiveness, might in reality be a selection process.

The years of fundraising, going from town to town selling candy and flowers, might be a rite of passage designed to cull those who did not measure up, with the funds raised, useful as they were, being of secondary importance. If there was selectivity involved in the Unification Church, at least one of the traits being selected for might be age regression. Indeed, the Unification Church seemed to be creating an environment and social system that someone coud relate to only if he/she were able to age regress repetitively and comfortably. Anyone else would find the emphasis on ritualised childlike behaviour uncomfortable and, after a time, leave. Many Moonies might not necessarily be aware of what they were doing. And if the Unification Church were employing this method of selection, perhaps other cults were too.

All these concepts dovetailed nicely with the dissociative symptoms that ex-cult members report, what they call "floating", in which they experience a shifting back and forth between their normal state of mind and a cult state of mind. It began to occur to me that, since people who were deprogrammed had not left voluntarily and people who had left voluntarily, according to studies, did not for the most part report these symptoms (Solomon, 1981), hypnotisability might be a key variable. A study of differential hypnotisability between voluntary cult leavers and those who were removed through

intervention of family or significant others might yield significant results. This is what I am investigating in my doctoral study.

My study begins with a series of questionnaires (under the supervisory eye of Dr Wendy-Louise Walker). These comprise the IPAT Clinical Analysis Questionnaire, the Putnam and Carlson Dissociative Experiences Scale, the Tellengen Absorption Scale and the Betts Questionnaire of Vividness of Mental Imagery. Those subjects moving to the next stage of the research will be given the Stanford Scale of Hypnotic Susceptibility, Form C by an experienced clinical psychologist or psychiatrist (after appropriate screening interviews) and will then be given a detailed semi-structured interview covering details of cult experience and relating their experience of hypnosis to cult experiences.

The use of the questionnaires will replicate the unpublished study of Madeline Tobias (personal communication, 1988), who found ex-cult members to score significantly more highly on the Dissociative Experiences Scale than non-cult members. They will also provide an early warning of possible serious psychological disturbance and will permit post hoc speculation about personality variables possibly involved in cult membership. The questionnaires are also intended to compensate for an expected reluctance on the part of ex-cult members who are currently of a fundamentalist Christian persuasion to be tested for hypnotisability due to religious objections. Scores on the Tellengen Absorption Scale will provide related information.

Many factors have prevented even-handed scientific research into cult phenomena. It is time that psychology and sociology paid due attention to the area. For clinicians, especially those with hypnotic skills, there is good reason to make themselves au fait with issues related to cults. The author is still seeking ex-cult members to participate in his research.

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HYPNOSIS IN THE TREATMENT OF BULIMIA: A REVIEW OF THE LITERATURE

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Bulimia is an eating disorder characterised by uncontrolled, recurrent episodes of binge-eating followed by self-induced vomiting or purging (American Psychiatric Association [DSM III-R], 1987). Sufferers report a feeling of lack of control over eating behaviour during their eating binges and have a persistent over-concern with body image and weight. Researchers have suggested that bulimia sufferers have significantly high hypnotisability compared with normal controls and anorexia nervosa sufferers, with the latter generally showing lower hypnotisability.

Hypnosis provides an appropriate and powerful treatment modality for bulimics and compulsive eaters. It can be used as a means of support for patients during ongoing treatment and as a means of exploring the aetiology of the eating disorder. Most importantly, hypnosis may be used to enhance the efficacy of other therapeutic interventions, particularly cognitive and behavioural interventions.

Researchers and clinicians with an interest in hypnosis have sought to understand the relationship between hypnotisability and psychopathology. It is now known that most psychiatric populations have lower hypnotisability levels than non-psychiatric populations and that, the more severe the disorder, the lower is the sufferer's level of hypnotisability (Spiegel, Detrick, & Frischolz, 1982). There are, however, a number of disorders which are characterised by high levels of hypnotisability. These include diagnoses of hysteria and multiple personality (Bliss, 1983, 1984), post-traumatic stress disorder (Spiegel, Hunt & Dondershine, 1988; Stutman & Bliss, 1985), phobic disorder sufferers (Foenander, Burrows, Gerschman, & Horne, 1980; Stanley, Burrows, & Judd, 1990), and some categories of eating disorders (Pettinati, Kogan, Margolis, Shrier, & Wade, 1989).

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Why these psychiatric groups show high hypnotisability is not immediately clear. Researchers have tentatively suggested that the traumatic event experienced by post-traumatic stress sufferers may somehow enhance subjects' hypnotic potential in some way or that subjects who are highly hypnotisable are more likely to experience PTSD than are low hypnotisable subjects when both are confronted with a traumatic event (Evans, 1991). Frankel and Orne (1976) hypothesised that the cognitive processes tapped during trance may be involved in the development and maintenance of phobic symptoms, while Spiegel and Spiegel (1978) suggested that highly hypnotisable individuals may possess a configuration of personality traits that are primarily hysterical in nature. Certainly it appears that hypnotisability is related to the nature of the particular disorder in question, not the severity of disorder (Frankel & Orne, 1976; Pettinati et al., 1989; Spiegel & Spiegel, 1978).

This paper examines the relationship between the eating behaviours of bulimia sufferers and their hypnotisability levels and how hypnotic interventions have been used in the treatment of this disorder.

Bulimia

Bulimia is an eating disorder characterised by uncontrolled, recurrent episodes of binge-eating followed by self-induced vomiting or purging (American Psychiatric Association [DSM III-R], 1987). Epidemiological studies have shown that typical sufferers are white females, ranging in age from 15 to 51 years, with the majority in their twenties. Most are within their weight range or slightly overweight for their age and height (Singh & Watson, 1986). The frequency of binge-eating by sufferers may vary from many times each day to once every other week, followed by episodes of purging. The most common means of purging is vomiting, followed by ingestion of laxatives and use of diuretics (Singh & Watson, 1986). Most sufferers experience depressed mood following bingeing episodes and generally have a personal awareness that their eating patterns are abnormal (DSM III-R, 1987). It is estimated that up to 7 out of every 10 bulimics experience depressive symptoms so severe as to be classifiable as suffering from affective disorder, using the DSM III-R (1987) criteria (Hatsukami, Eckert, Mitchell, & Pyle, 1984).

The general description of many eating disorders patients is that of a perfectionistic personality, obsessively concerned with food and body proportions and excessively preoccupied with pleasing others, if necessary to their own detriment (Groth-Marnat & Schumaker, 1989). Sufferers are characterised by a number of specific attitudinal and behavioural traits. First, they suffer from some degree of distorted body image. Second, many of these patients are separated from their internal emotional and cognitive experiences, so that a major therapeutic aim in treatment is to help them become aware of and integrate their experiences. Third, many bulimic patients show high levels of immaturity, both in their understanding of self and in their relationship with others. In treatment, they will often show a reluctance to talk about their feelings and perceptions of themselves and others, usually because of

feelings of shame and self-criticism (Hornyak & Baker, 1989). Many show the traits of impulsivity and display a tendency to seek immediate gratification of needs, rather than being able to control their behaviour. Other researchers have reported that bulimics typically show strong needs for approval and have low self-esteem and heightened interpersonal sensitivity (Groth-Marnat & Schumaker, 1989).

Researchers and clinicians have speculated on the aetiology of the condition. Some have argued that the condition is an addictive disorder, with food being used for tension release, while the patient purges to avoid the problems associated with obesity (Johnson & Larson, 1982). Adopting a more psychophysiological perspective, Russell (1979) emphasised the interaction between what he considered primarily a mental disorder (overeating) and a hypothalamic response to the individual's suboptimal body weight. Despite these differences in understanding bulimia, there appears to be one characteristic common to most bulimic patients — their tendency to show dissociative behaviour (Pettinati et al., 1989).

Dissociation in Bulimic Patients

All eating disorders are characterised by the existence of a physical, somatic complaint accompanied by a gross disturbance of body image (Wooley & Kearney-Cooke, 1986). The distinguishing psychopathological behaviour of over-eating and the purging characteristic of bulimics has been likened to a dissociative experience by researchers and clinicians (Beumont & Abraham, 1983; Russell, 1979) and research has generally, although not universally, demonstrated that bulimic patients score significantly more highly on hypnotisability scales than do anorexic patients and control subjects (Griffiths, 1989; Pettinati, 1986; Vanderlinden & Vandereycken, 1990). Higher hypnotisability levels are also characteristic of binge/purging anorexic clients (Pettinati, 1986). These patients, called bulimarexics (Boskind-White & White, 1983), alternate between anorexic and bulimic behaviours. Higher hypnotisability may also be a characteristic of women in the normal population who are preoccupied with dieting and obesity concerns. In their study of the relationship between hypnotisability and attitudes towards eating in a sample of normal college females, Groth-Marnat and Schumaker (1990) reported a high correlation between level of hypnotisability and expressed concern about eating and possible obesity. They argued that extreme weight control behaviours may be similar to hypnotic-like states, such as dissociation (characteristic of bulimics during binge eating). This dissociative capacity might relate to the cognitive and perceptual distortions frequently reported by many eating disorders patients (Groth-Marnat & Schumaker, 1990; Pettinati et al. 1989). Sufferers' phobic absorption regarding their inability to control their eating behaviours and generalised anxiety may also contribute to their eating problems.

Given these research data and clinical observations, researchers and clinicians (Groth-Marnat & Schumaker, 1990; Pettinati, 1986; Pettinati et al., 1989;

Vanderlinden & Vandereycken, 1990) have concluded that hypnosis may be a most effective therapeutic intervention for many eating disorders patients, particularly bulimics, and persons with extreme concerns about eating and weight regulation, such as adolescent females. Torem (1986, 1987) argued that hypnosis may be particularly effective because patients with bulimic eating patterns or with excessive concerns about eating behaviours have dissociated ego states which are split off from consciousness. These ego states function at cross-purposes and thus cause intrapersonal conflict. Bulimics often describe themselves as becoming someone else while bingeing — they report feeling dissociated from their affective and cognitive internal experiences.

This paper reviews the range of hypnotherapeutic interventions for bulimia sufferers reported in the clinical literature. Many of the hypnotic interventions described in the literature may also be used for the treatment of obesity and weight control problems associated with other dysfunctional eating behaviours.

HYPNOTIC INTERVENTIONS FOR BULIMIA PATIENTS

Most researchers and clinicians make the observation that bulimia is a multi-causal problem and must be treated using a range of therapeutic approaches, which may vary over the course of treatment (Blainey, 1985; Singh & Watson, 1986). A number of therapeutic approaches are described in the literature and generally the most effective appear to be cognitive-behavioural and experiential therapies (Hornyak & Baker, 1989). Experiential therapies in particular are used with the aim of increasing patients' awareness of feelings and cognitions, reintegrating these into their present experience. Hypnosis, as an experiential therapy par excellence, is therefore a most appropriate treatment modality.

Hypnosis can be utilised in a number of phases of the treatment of bulimia and obesity, each one of which involves the therapist and client addressing different goals requiring different strategies, Specific uses of hypnosis are as follows: a supportive technique for clients as they change cognitions and behaviours related to their eating disorder; integration with other therapeutic modalities, to enhance their effectiveness; as a means of establishing the core reasons for the eating disorder; and helping ensure long-term maintenance of changed cognitions and behaviour.

Hypnosis as a Support for the Bulimic Client in Treatment

As many practitioners of hypnosis have noted, the introduction of hypnosis into therapy can have a constructive effect on the relationship established between therapist and client. This has been demonstrated with a variety of patient groups, including post-traumatic stress disorders (Evans, 1991), phobics (Stanley et al., 1990), and obese patients (Goldstein, 1981). Hypnosis strengthens non-specific therapeutic factors in the client–therapist relationship, increasing the client's expectation of change and improvement (Goldstein, 1981; Vanderlinden & Vandereycken, 1990). An important factor for the therapist

to remember in the early stage of therapy is that clients have made a decision to challenge maladaptive cognitions about body image and obesity and the negative emotions and dysfunctional eating patterns caused by these cognitions. Hypnosis can have the profound effect of creating a sense of hope in individuals that they can overcome these problems. Such a sense of hope can be easily justified. For example, Goldstein (1981) found that eliciting the phenomenon of arm levitation as a trance ratification procedure for obese women presenting for weight reduction was positively associated with subsequent weight loss. Hypnosis combined with behavioural programs for weight loss is regularly assessed as being more effective than behavioural interventions alone (Cochrane, 1987). It will also be useful for the therapist to inform clients that hypnosis may be an appropriate technique to use in their treatment, given that the great majority of bulimia sufferers are moderately to highly hypnotisable (Griffiths, 1989; Pettinati, 1986; Vanderlinden & Vandereycken, 1990).

The first session with a patient involves the therapist taking an extensive history to assess the nature and magnitude of the presenting problem, its aetiology and impact on the client's life. The client's eating behaviours are carefully recorded and the individual is usually asked to self-monitor food intake, bingeing and purging behaviours, and to record emotional states throughout the period of treatment (Holgate, 1984). The client can also be asked to record in the diary any negative or unrealistic thoughts about eating, weight, body shape, relationship problems, sexual concerns — indeed any cognition, emotion or behaviour which may be contributing to the eating problem (Vanderlinden & Vandereycken, 1988). As clinicians note, many eating disorders clients see themselves as immature, weak, and incompetent, with dependent relationships upon family and significant others (Blainey, 1985). Such negative self-messages may be introduced into the client's psyche by indirect, hypnotic-like messages, not only from the client's own thinking but in messages from family members and others, who project their own frustrations and problems on to the bulimic patient. These messages help maintain the bulimic identity, making personal change difficult. One task of the therapist is to help make the client aware of these messages from oneself and others, and to increase awareness as to how these messages lead to cognitive misperceptions which contribute to the bulimic's gross disturbance of body image (Wooley & Kearney-Cooke, 1986).

Although bulimic and obese clients present for therapy to overcome their dysfunctional eating patterns and the negative affect these cause, many consciously or unconsciously fear the consequences that may result from actual behavioural change (Blainey, 1985; Kroger & Fezler, 1976). The therapist needs to be attuned to clients' possible ambivalence and alert to any behaviours which the client may use to self-sabotage treatment. One technique used by the clinicians to control for this problem is, early in therapy, to have the client compile a list of negative consequences associated with bulimic bingeing and purging, plus a list of consequences that may result if the client were

to normalise eating behaviour. These lists can be used to confront clients with any ambivalence they may have regarding therapy and may also be used during hypnotic sessions to increase clients' motivation to change.

The eating behaviours of bulimics are often chaotic and irregular, so that one of the first goals of therapy is to help the client establish regular eating patterns. This is explained as the primary goal of the treatment program during early treatment sessions. It is important for the therapist to realise that the majority of patients commence therapy with the aim of stopping all dysfunctional behaviours associated with the disorder — that is, to stop bingeing and purging immediately and to ensure that such behaviours do not occur again. Many clinicians point out that this goal, as in many cases of obesity and weight control, is an unrealistic one which may reflect the perfectionistic nature of many sufferers (Vanderlinden & Vandereycken, 1990). The role of the clinician should be to help the client establish short-term behavioural changes aimed at controlling the frequency of bingeing and purging episodes or limiting such behaviours to specific types of food.

At each stage of therapy it is important for the therapist to educate the client as to the detrimental effects of bingeing and purging behaviours and to give information about adequate dietary intake and dietary balance (e.g. Coish, 1988). Early in therapy, the therapist and client should discuss which foods may be banned from the individual's diet later in therapy when the client has achieved greater control over eating behaviour. As Holgate (1984) noted, this is to guard against the situation where the client starts therapy but relapses and binge-eats fattening foods, then feels guilty and purges, maintaining the eating disorder problem.

Following careful evaluation of the client, an appropriate induction technique is utilised. This evaluation must include assessment of the client's possible depressive state (Hatsukami et al., 1984) and hypnosis used only when the therapist has determined that its use is not contraindicated (Burrows, 1988). The most commonly reported induction methods described in the literature are formal inductions, typically eye-fixation or its variation (Walker, 1979), Chiasson's technique (Crasilneck & Hall, 1975), followed by progressive relaxation techniques (Collins, Jupp, & Krass, 1981; Goldstein, 1981; Holgate, 1984; Vanderlinden & Vandereycken, 1990). In trance, the client is given suggestions for ego-control with the aim of reinforcing changes in eating habits, enhancing the client's control over dysfunctional eating behaviours and problem situations which cause bingeing and purging, and increasing self-esteem (Griffiths, 1989; Stanton, 1975). For example, the following suggestions in trance may be appropriate:

> As the days pass, you are going to feel more and more self-control over your bingeing and purging. You are aware of the physical and psychological side-effects and you will find that the mere knowledge of these will help deter you from bingeing and purging.

You will find that your eating will become more normal and that you will be able to eat three planned meals each day. You should not skip any meals and should try to ensure that you do not eat between meals.

You will try more and more to choose meals which you are prepared not to purge. If you feel tempted to purge after a particular meal you will engage in a distracting activity for an hour or so to prevent you from purging activity. (Adapted from Griffiths, 1989, pp. 82–83)

Early in therapy, it may be important to allow the patient to continue bingeing and purging, but at less frequent intervals, as an abrupt halt to such habitualised behaviour may cause withdrawal effects. If the person attempts total cessation of dysfunctional eating behaviours and then subsequently relapses, the resulting disgust and emotional reaction may contribute to a full return of bingeing and purging. The therapist may help the client in this context by making suggestions designed to facilitate control over swallowing. For example, the patient may be asked to imagine coolness in the throat or to imagine that food "flows from the mouth to the stomach like a waterfall" (Pettinati et al., 1989, p. 45). What are termed "paradoxical techniques" may be used to help clients control purging frequency. Instead of being taught not to binge and purge, patients may be instructed to eat, then purge at prescribed times during the day, in order to develop a feeling of control over purging behaviour or to simply visualise bingeing and vomiting (Pettinati et al., 1989).

Clients are advised early in therapy to identify, in their self-monitoring techniques, the situations or emotions which precipitate binge behaviour, and this information is dealt with in subsequent sessions to help them understand the aetiology of eating behaviour. As therapy continues and the client gains mastery over eating behaviours, the hypnotic suggestions may facilitate more specific control over dieting behaviours and social activity, together with the destruction of laxatives or diuretics which have been used to facilitate purging (Griffiths, 1989).

The aim inherent in the hypnotic suggestions quoted above is to help clients increase feelings of control and mastery over their eating behaviours. As Inglis (1982) noted, many bulimic and obese patients are in a cycle of negative expectations in which their lives seem to be at the control of their eating obsessions rather than the person feeling in control of his or her life. One aim of therapy is to help the patient change this perception. A second aim of therapy is to help lower anxiety and increase relaxation. This may be achieved by the use of guided imagery in trance. The imagery used with any particular client should reflect problematic situations and emotions which precipitate bingeing and purging episodes. For example:

Imagine yourself entering the kitchen in your flat. You notice the chocolate biscuits in the jar on the bench. You approach the bench and feel tempted to open the biscuit jar and eat all the biscuits. However, you do not open the jar. You turn away and walk out of the kitchen. You feel good and proud of your control.

> You feel very relaxed. Now just let the scene fade away and concentrate on your breathing and relax a little more with each breath. (Holgate, 1984, p. 108)

Guided imagery techniques may also be used with a coupling technique, associating what the client has been told about the health effects of bulimia with the relaxed and controlled state:

> Every time you feel the urge to binge, your unconscious mind will help you remember all the negative effects of bulimia. You are ruining your body, you are destroying your self-esteem and vitality, you become more and more isolated, you put on weight and feel very bad in your body, your financial situation becomes dramatic . . . If you binge you will feel no relief, no satisfaction afterwards; instead you'll feel bad and disgusted. (Vanderlinden & Vandereycken, 1990, p. 105)

Such coupling may also be used with positive consequences which derive from the client's control of eating behaviours:

> Each time you decide to eat normally, you will become aware of all the good things that may happen for you. You regain your self-confidence and self-esteem, you feel more energy and vitality, you develop new interests, your weight stabilises and you feel good in your body. (Adapted from Vanderlinden & Vandereycken, 1990, p. 105)

This image of the client feeling good and having greater self-confidence and self-esteem may also be used in regression to a time when the person did not suffer from bulimia or as part of a future-oriented fantasy in which clients imagine themselves without bulimia (Vanderlinden & Vandereycken, 1990). Both the negative consequences associated with bulimic behaviours and the positive consequences of changing these behaviours can be used by the therapist during hypnosis to improve the client's motivation to change. Similar age regression and progression techniques have been reported by Baker and Nash (1987).

The research and clinical literature cited above highlights the use of formal induction methods and many suggestions for trance work are directive in nature. Aetiological factors leading to bulimia and other forms of eating disorders must be considered by therapists when planning induction and deepening techniques. Bulimic behaviour may result from the patient's attempts to resist social and familial pressures, so that eating behaviour is a form of expressed rebelliousness. Many eating disorders sufferers also have distorted perceptions and feelings about personal control and may feel that the therapist is trying to control their thoughts and behaviour. In such cases, they may resist formal inductions and direct suggestions in trance and respond far more favourably to indirect induction methods and suggestions. Pettinati et al. (1989) comment that bulimic clients may see hypnosis as a threat to the control they have tried hard to maintain, so that the therapist needs to discuss such patients' prior experiences with, or beliefs about, hypnosis and deal sensitively with any concerns expressed by clients before using hypnotherapeutic techniques. In many cases it may be more appropriate for the therapist to consider using indirect and metaphorical suggestions to help patients become aware of their body and become attuned to the onset of binge episodes (Kroger

& Fezler, 1976; Yapko, 1986). The practitioner using hypnosis would need to assess each client's suitability for direct/indirect suggestions and use hypnosis appropriately.

Between therapy sessions, to help control binge urges and resultant anxiety and to enhance therapeutic change, clients are urged to use self-hypnotic techniques taught during therapy, using audiocassette recordings made specifically for each individual during hypnotic sessions. The patient may be taught to induce self-hypnosis every few hours, for a period of 20 seconds, and told to focus on statements such as the following: "Over-eating and under-eating are insults to bodily integrity, in effect they become a poison to my body"; "You need your body to live", and "To the extent that you want to live, you owe your body this respect and protection" (Spiegel & Spiegel, 1978, p. 227).

Clients may also be taught relaxation techniques to use between therapy sessions. Typically, relaxation is paired with imagery engendered by the client and designed to allow the patient to feel more in touch with her feelings and bodily sensations (Pettinati et al., 1989). In her treatment of bulimia, Holgate (1984) suggested that clients should be taught meditation as a means of relaxation. This, she argued, was more appropriate than progressive relaxation training, as the former reduces tension caused by clients' bingeing and enhances cognitive centring necessary for self-hypnosis and hypnotic interventions.

Hypnosis as an Adjunct to Other Treatment Modalities

Hypnosis is often used therapeutically in conjunction with behavioural and cognitive techniques. As suggested, clients must self-monitor their eating behaviour and episodes of bingeing and purging, and should also record precipitating situations and their accompanying emotions (Singh & Watson, 1986). This record over the course of therapy is a measure of progress that the therapist and client can use therapeutically — as the individual improves over time, the therapist can use the improvement as an incentive for further mastery and increased self-esteem (Collins et al., 1981; Holgate, 1984). A range of other behavioural interventions may be used as treatment modalities for bulimia, most importantly stimulus control techniques (Kroger & Fezler, 1976). Typically these involve limiting the time and place of eating, eating only at scheduled times, keeping a variety of low calorie foods available for snacks, storing food out of sight and eating slowly, chewing and tasting food before swallowing (Holgate, 1984; Singh & Watson, 1986). Guided imagery, such as that described earlier, can be used to help the client rehearse these new behaviours. Rehearsal under guided imagery during trance can be used to help clients re-establish a controlled eating routine from current irregular and uncontrolled eating patterns. For example, clients can be asked in trance to imagine themselves at the dinner table, eating and enjoying a normal lunch. The therapist can add suggestions of eating slowly, while concentrating on tasting the food, and relaxing after the meal by reading a book or taking

a walk, introducing a response delay between bingeing and purging (Vanderlinden & Vandereycken, 1990). Another behavioural technique described frequently in the clinical literature is the therapist's use of praise as a means of reinforcement when clients achieve a pre-determined reduction in binges and purges or some other shared goal.

Cognitive techniques are also an important component of most therapeutic interventions for eating disorders. Given that bulimics frequently exhibit gross disturbances of body image (Wooley & Kearney-Cooke, 1986), it is necessary in treatment to help clients identify their thought processes which relate to their eating disturbances, so that cognitive restructuring techniques may be utilised to challenge and replace maladaptive thoughts relating to eating habits and body image. Such techniques may include thought-stopping and cognitive re-framing (Schneider, O'Leary, & Agras, 1987). Cognitive restructuring techniques can also be used to help clients challenge their misperceptions and negative thoughts about eating, weight and body image deriving from the messages received from family members and significant others, with a view to helping them change cognitive distortions to effective thoughts and cognitions. Bulimia sufferers frequently express negative views, typified in the following self-description of a young client:

> I always have the feeling that my life is worthless, that I will never be able to take charge of my own life. I think that I am not intelligent and my body size is like an elephant. No man will ever fall in love with me. I cannot do anything alone. (Vanderlinden & Vandereycken, 1990, p. 108)

This quote suggests many of the areas of negative thinking characteristic of bulimia clients: gross body disturbance, loss of control, lack of self-worth, feelings of being unloved and unwanted, all with the feeling that things will never change. One aim of cognitive therapy is to have the client challenge and change these negative perceptions and cognitions. In the case described, the clinician asked the client to write down in her diary three positive thoughts about herself. In subsequent trance sessions, she was asked to imagine herself in the near future, more aware of her qualities and better able to accept her weaknesses. As a post-hypnotic suggestion, she was told to repeat these positive thoughts whenever she started to feel disapproving of herself (Vanderlinden & Vandereycken, 1990).

Hypnotic techniques may be used in other ways to help clients change their distorted body image. Patients may be asked to draw a picture of themselves so that the therapist can gauge the degree of body distortion and to establish which parts are most distorted. Then, in trance, clients are asked to focus on these parts of the body. The client may also be asked to imagine a healthy normal-weight person and to imagine oneself weighing the same as the model, or can be asked to draw oneself on an imaginary blackboard and to re-draw the elements of the picture that are most distorted (Baker & Nash, 1987; Gross, 1982). This procedure often results in the client becoming anxious,

so that the therapist may need to tie relaxation techniques in with such a strategy.

The value in using hypnosis with behavioural and cognitive techniques is made clear in the preceding descriptions: Changing clients' maladaptive thought processes to more adaptive ones, and inappropriate eating behaviours to more appropriate ones, is typically more potent and more lasting when such techniques are used while the subject is in trance (Evans, 1991; Holgate, 1984; Stanton, 1975).

Using Hypnosis to Uncover the Aetiology of Bulimia

It was reported above that clinicians describe bulimic clients as having dissociated ego states which are in disharmony with each other (Beumont & Abraham, 1983; Torem, 1986, 1987). An ego state may be described as an organised system of cognitions, memories, and behaviours whose elements are bound together by some common principle but separated from each other by more-or-less permeable boundaries (Watkins & Watkins, 1982). The aim of therapy is to help the client 'discover' these separate ego states and bring them into harmony. Using hypnosis, this is achieved by exploring for the hidden ego state that is causing the bulimic bingeing behaviour. The therapist must acknowledge that the client's bulimic behaviour will be providing some protection or purpose, so that the aim of therapy is to ensure that the role currently being served by the "bulimic self" can be taken over by other ego-states or that the client must be helped to redefine the purpose the "bulimic self" was serving (Vanderlinden & Vandereycken, 1990).

In trance, the therapist can utilise ideomotor signalling to seek the client's permission to explore the nature of the "bulimic self" and the special role played by the bulimic behaviour in the person's psychological life. It may be important to determine when the bulimic behaviour first presented itself in the person's life, which can be explored using age regression. The therapist must be alert to the fact that the unconscious bulimic ego-state may contain traumatic memories and/or unresolved conflicts for the client, so that the possibility of extreme abreactions may occur during regression. These may result from a large number of actual events in the person's life, including childhood experiences of abuse or sexual maltreatment, marital discord, violence, and feelings of extreme lack of affection (Vanderlinden & Vandereycken, 1990). Bulimic patients often report a family history of depression, alcoholism, family violence and other forms of psychopathology and these, or specific memories of events precipitated by these, may underlie the client's trauma or conflict (Vanderlinden & Vandereycken, 1989). During the course of therapy and particularly during regression in trance, the therapist should aim to provide the client with support and understanding as part of the process of helping clients work through any painful experiences. Any emotions elicited during trance regression can be dealt with by assuring the

client of one's presence and support, followed by trance deepening and further exploration with the client of the traumatic memory (Burrows, 1988; Sacerdote, 1988). It will also be necessary to discuss fully the client's feelings and emotional state following trance termination, to ensure that the emotional abreaction experienced during trance does not carry over into the client's normal waking state.

Another technique used by clinicians to help patients access and attain mastery over painful dissociative splits in their personality is the use of the affect bridge (Watkins, 1971). During trance, clients are asked to experience how they feel when the urge to binge occurs and to use these feelings as a means of forming a bridge with specific past situations which now cause the binge behaviour. In the future, the client will remember this bridge with the past when the bingeing urge occurs and will understand why this behaviour is now occurring (Vanderlinden & Vandereycken, 1990). The affect bridge can also be used with the coupling technique suggested by Evans (1991) for trauma sufferers. The clients may be given the following suggestion:

> Whenever you feel the urge to over-eat, you will remember why this feeling is occurring, and you will add to your thoughts the idea that you can control your feelings and behaviour. Each time it happens, you will feel greater and greater control over your feelings and behaviour. (Adapted from Evans, 1991)

Using Hypnotic Interventions to Help Ensure Long-Term Change

It was reported above that many bulimia and weight control patients have the unrealistic goal of permanently stopping dysfunctional eating behaviours. Throughout therapy it is important for the practitioner to remind the client that permanent eradication of all bulimic or eating disorder behaviour is hard to achieve. Rather, the goal of therapy is the reduction of bingeing and purging episodes and the maintenance of healthy, controlled eating patterns. Clients need to know that relapses may occur, but that these do not mean that the person has not achieved much by being able to modify cognitions and behaviours in a meaningful way. The therapist should make the client aware that continued care and counselling are available, should the person require them. Initial hypnotherapeutic interventions include suggestions for growing self-esteem, ego strength, and independence (Pettinati et al., 1989; Vanderlinden & Vandereycken, 1990). These would continue to be provided in subsequent care.

In situations where the aetiology of the eating disorder is based in the individual's emotional dependence upon the family or significant other, long-term change can be facilitated with the use of trance-suggestions for independence and change. Indirect suggestions and metaphors for change, growth and freedom will also contribute to this emotional development (Pettinati et al., 1989).

SUMMARY

This review of research and clinical evidence suggests that hypnosis may well be the integrative treatment modality of choice in many cases of bulimia and weight control/obesity. Not only does hypnosis bring together and integrate what may seem to be a number of independent treatment modalities, including cognitive and behavioural strategies, but it also heightens the efficacy of these. Hypnotic techniques are easily and potently combined with cognitive and behavioural techniques, aimed at giving control for their thinking and behaviour back to these clients. Uncovering the causal factors which have led to the development and maintenance of the client's disordered cognitions and associated eating behaviours may also be best achieved using the hypnotic techniques of regression and the affect bridge. Hypnosis may also be used to help the client reintegrate the dissociated "bulimic self" into one's ego state. For these reasons, the practised hypnotherapist should always consider hypnosis as a possible modality in the treatment of bulimia and weight disorders.

The research and clinical literature also highlights the need for the therapist to be alert to possible contraindications to the use of hypnotic interventions for bulimia. Some presenting characteristics of the client may limit the efficacy of hypnosis. Where the therapist feels that a client may have borderline personality disorder, hypnosis may further fragment the client's disintegrated personality structure (Vanderlinden & Vandereycken, 1990). Should the client present in a highly anxious state or meet the criteria for depression, then hypnotic interventions should be used judiciously, to avoid the situation where the client's emotional state may be further aroused (Frankel & Orne, 1976) or depressive state exacerbated (Burrows, 1988). Clinicians also suggest that if a client has a poor understanding of hypnosis, especially considering it to be a "magical cure" and these misperceptions cannot be corrected, then hypnosis is contraindicated (Pettinati et al., 1989). Finally, hypnosis is often the treatment modality for short-term therapy and is far less effective when used in long-term therapeutic situations (Vanderlinden & Vandereycken, 1990).

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