



TEACHING HYPNOSIS: THE ANDRAGOGY AND DIRECT-TEACHING MODELS

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Educational theory has influenced the development of a five-day summer workshop in clinical hypnosis. More than a decade of evolution of the course has resulted in a blend of ideas from two major teaching models: the andragogy and direct-teaching models. Following the recommendations of the direct-teaching model, workshop participants are introduced to practical hypnosis in a gradual, step-by-step manner. Consistent with ideals of the andragogy model, the instructors have attempted to include students as partners in learning rather than as receptacles for pre-packaged information. Extremely favourable summer workshop evaluation data support the value of combining elements from both models. Attributes of the andragogy model are described for the benefit of those teachers of hypnosis who might wish to review their educational practices.

How should students learn the skills of hypnosis? Members of the Australian Society of Hypnosis might reflect briefly on their own initial training. What was good about it and what would you like to have changed? The authors have conducted a five-day summer workshop in clinical hypnosis for the past 12 years. They have had cause to reflect on issues of course design and teaching philosophy and have revised their workshop accordingly. This paper offers information and suggestions for other people involved in teaching clinical hypnosis.

A common practice seems to be for acknowledged experts in the field to meet and devise a curriculum based on the knowledge and skills thought to be important for students to master. In order to transmit this information, a series of lectures from the disciplines of psychology, medicine, and dentistry are arranged, together with lectures and demonstrations about hypnosis itself. In a typical two-year part-time course, it may be that most of the first year is devoted to theory while the second year is focused more on the practice

of basic hypnosis management and the more advanced clinical applications of hypnosis. At the end of the course students are typically assessed via written and/or oral exams plus the submission of case studies.

There is no doubt that the method described above (which we will call the "traditional method") is successful. Teaching is often done after hours by clinicians who give their time with very little or no financial reward. The purpose of this paper is to offer some alternative possibilities based on recent developments in educational theory.

The first section of the paper will provide a justification for the traditional model and emphasise ways of doing it well.

THE DIRECT-TEACHING MODEL

The method described as the traditional model is also known in the educational literature as "direct teaching," "systematic teaching," or "explicit instruction." If there is consensus about "what" is to be taught, this model offers the advantage of efficiency.

Efficient ways of employing direct-teaching techniques have been described by Rosenshine and Stevens (1986). These authors attempted to identify those aspects of teaching which are associated with, and possibly responsible for, heightened achievement in student learning. Their research has yielded a method of effective instruction, consisting of specific procedures in which instructors can be trained, and which can lead to higher student attention levels, increased involvement with the learning material, and significantly improved achievement.

This model is linked to information-processing theories, according to which humans are regarded as "limited-capacity processors." Due to the relatively short attention span of people's working memories, there are limits to the amount of information that can be processed effectively. Accordingly, whenever new or difficult material is taught, the instruction should proceed in small manageable-size steps, with frequent practice periods. This enables learners to integrate the new material with that already in their working memories. It ensures that learners do not become swamped with new information, which may result in confusion, inefficient storage, and difficulties of retrieval.

The systematic small-step approach (Table 1) in essence calls for instructors to proceed systematically, making sure that the learners remain focused on the task, understand what is going on at each step of the way, and put the newly learned material to immediate use.

Rosenshine and Stevens (1986) state that all instructors use some of these behaviours some of the time, but the most effective ones use most of them almost all the time. Their research shows that instructors trained in the "small-step approach" get better results than those who do not. This kind of teaching works particularly well when the objective is mastery of a body of knowledge, or the learning of a set of skills or techniques which the learners are expected to apply to new problems or situations.

Table 1 A Summary of the Systematic Small-Step Approach

Present new material in small steps, with practice after each step
Provide a high level of active practice for all participants
Begin practice with a short statement of the aims
Give clear and detailed instructions and explanations
Provide time for questions, discussion, and check for understanding
Guide and monitor participants during initial practice
Provide systematic feedback and corrections
Begin a new section with a review of previous learning

We have used aspects of the direct-teaching model. In the summer workshops, students practise each new element to which they are introduced. This is achieved by using a number of short practical exercises. First a brief description of the aims or goals of the exercise is given, followed by a few examples to demonstrate what is to be done. Then the participants are guided through their own initial practice. This takes place in small groups, and participants provide each other with feedback on how they experienced the skills practised by their peers.

The exercises start with guiding the "client" in an enjoyable imaginary activity, which the "client" does for relaxation (e.g., riding a bike, reading a book, jogging, baking a cake). The purpose is to learn to guide the imaginary activity, amplifying the "client's" experience by using only content-free, vague suggestions, avoiding specific ideas which might disrupt the ongoing imagery. The "client" gives feedback at the conclusion of the exercise on the helpfulness, or otherwise, of individual suggestions. Trainees also soon learn to observe the minute changes in facial expressions which accompany the clients' responses to their suggestions.

Additional components are gradually added to the exercises. These include learning to match one's voice tone and tempo to what is being observed about the "client" and learning to breathe in harmony with the "client's" breathing by adjusting one's own breathing. This is followed by introducing suggestions of well-being and comfort into the guiding commentary. The trainees first compile ideas for use in the relaxation and comfort guidance, and these are put on a board for all to note and use during the exercise. Trainees are introduced to the commonly used transition and bridging words in hypnosis, such as "and," "as," "while," "because," "when," "even as," "at the same time as," "since," and others. These help them achieve a smooth flow in guiding a partner's entry into a deeper state of altered awareness.

Ideas for deepening and alerting are introduced and similarly practised with a partner, till all components commonly used in a hypnosis session have been covered and, in the step-wise manner, added onto the previous parts. Following that, trainees are introduced to formulating therapeutic and post-hypnotic

suggestions. At this stage their extant therapeutic skills in non-hypnotic modalities are drawn upon.

Participants thus initially practise the beginning steps, the language of hypnosis; they progress to putting together their own inductions, adding deepening, comfort, and alerting suggestions. Finally they conduct a complete therapeutic session on the last day of the workshop. During the workshop participants have the opportunity to work with partners of different hypnotisability levels and are encouraged to exchange feedback so they may learn how "highs," "lows," and "mediums" respond differently.

Direct teaching is a useful approach when there is no debate about "what" is to be taught. In hypnotherapy training, however, there are many debates about what material should be taught. Students, as well as instructors, have strong opinions in these debates. Where student needs are respected, the andragogy model to be described below seems particularly useful. Furthermore, although the students may be neophytes in hypnotherapy, they are already practising professionals and their needs demand recognition. We suspect that a major source of any dissatisfaction with the traditional teaching model is its implicit arrogance and relative disregard for the value of student input.

THE ANDRAGOGY MODEL

The andragogy model has been described by Knowles in a number of publications. (1975, 1980, 1984a, 1984b, 1986). Knowles has emphasised a shift of focus in education from an emphasis on what the teacher does to what happens to the learners. He has utilised the concept of andragogy (the teaching of adults) as distinct from pedagogy (the teaching of children) to emphasise different assumptions about learners that have traditionally been made. Knowles (1975) listed four main assumptions of andragogy different from those of pedagogy.

Changes in Self-Concept. As people grow and mature their self-concept moves from dependency to increasing self-directedness. According to this model, if mature people find themselves in a situation in which they are not allowed to be self-directing, a tension between the person's self-concept and the situation occurs. Ideally, therefore, education should facilitate self-direction. One way to facilitate this point is to involve students in the design of their courses.

In our early hypnosis training, we can remember having to endure redundant introductory lectures on psychological theory. As practising psychologists we felt that this was inappropriate and time-wasting. Similarly, practising doctors were forced (by virtue of attendance requirements) to sit through lectures on introductory medicine. Of course, the medical lectures were useful to the psychologists and the psychology lectures were useful to the doctors, but the limitation on self-directedness produced the tensions described by Knowles.

The Role of Experience. As individuals mature, they accumulate an expanding reservoir of experience. This experience becomes an increasingly rich resource

for learning. Accordingly, in andragogy there is decreasing emphasis on the transmittal techniques of traditional teaching and increasing emphasis on techniques which tap the experience of the learners. The use of lectures, canned audio-visual presentations, and assigned reading tends to fade in favour of discussion, laboratory simulation, field experience, team projects, and other action learning techniques.

Readiness to Learn. As individuals mature, their readiness to learn is increasingly the product of the developmental tasks required for the performance of their evolving social roles. Andragogy assumes that learners are ready to learn because of their developing roles as workers, spouses, parents, leaders, etc.

The implication of this assumption is that the timing of learning experiences needs to coincide with the learner's developmental tasks. Andragogy suggests that people will be ready to learn when they confront relevant problems. In the workshops, we addressed this issue by inviting participants to suggest specific client conditions which they are currently interested in treating with hypnosis. We thus adapted to student needs rather than imposed our own ideas about which applications of hypnosis should be covered.

Orientation to Learning. Children have had a subject-centred orientation to learning imposed on them whereas adults tend to prefer a problem-centred orientation to learning. Because adults want to apply tomorrow what is learned today, the time perspective becomes one of immediacy of application. Therefore, adults engage in education with a problem-centred orientation. This assumption has implications for curriculum design. Knowles suggested, for example, that if students are subject-centred, then an appropriate approach is first to teach foundation knowledge (e.g., history, philosophy) and then to develop skills (field work, clinical skills). This approach is less appropriate for mature people, who are problem-centred in their orientation to learning. Mature students would experience the time spent on foundation knowledge as drudgery that had to be endured in order to get to the "real thing." Accordingly we recommend that theory and practice should not be separated into first and second years, but that students have an opportunity to commence practice from the very beginning.

Knowles (1975) suggested that most learning activities are planned according to *content-design* models for the efficient and logical transmission of bodies of knowledge. Instead, the andragogy model defines education not as a process of transmitting knowledge, but as a process of self-directed inquiry. This definition emphasises a *process design*. Knowles (1975) has described seven elements of this process design. A brief cover of these elements is presented so that instructors may use them in evaluation of their own procedures.

Setting a Climate. Desirable aspects include informality, mutual respect, physical comfort, collaboration rather than competition, openness, authenticity,

trust, non-defensiveness, and curiosity. An example of a non-desirable practice is the conventional grading system which imposes a relationship of competitiveness among the students and omnipotence on the part of the faculty.

The most influential determinant of psychological climate is the relationship between the teacher and the students. The teacher should act as *facilitator and resource person* in a process of self-directed learning.

Mutual Planning. People tend to feel committed to any decision or activity to the extent that they feel they have influenced that decision or activity.

Diagnosing Needs. Needs can be determined by first constructing a model of the competencies required for excellence. The second step is the assessment by the students of their present level of competencies according to the model. Too often this step is ignored, when the presenter assumes that the audience knows nothing or very little, and spends wasteful and boring time re-covering "old" material.

Students can concentrate their energies on developing those competencies in which they are weakest. Competencies may be categorised according to knowledge, understanding, skill, attitudes, values, and interests.

Formulating Program Objectives. The behavioural objectives of the programs should be described. The list should include student objectives, plus the objectives of the teacher, the institution, the profession and the larger society.

Planning a Sequential Design of Learning Activities. The units of learning should be arranged in a design that has sequence, continuity, and unity. This process should not only emphasise formal courses and field experience but also other units such as independent study, team projects, informal seminars, and telephone consultation.

Conducting the Learning Experiences. It is here that the shift in the definition of the role of the teacher away from that of transmitter and toward that of facilitator and resource person becomes operative. The andragogical teacher plans the learning experiences with the students and shares responsibility with them for executing the plans.

Evaluating the Learning. This should be a process of re-diagnosing the model of required competencies and reassessment of the current level of development.

It can be seen that the andragogy model invites the student into the learning process as a partner rather than just a recipient. The andragogy model deserves widespread attention as it may offer the potential to significantly improve student learning and satisfaction. The model has replaced the conventional curriculum in courses as diverse as undergraduate medical training and agricultural science.

The andragogy and direct-teaching models describe radically different approaches to teaching and learning. It is possible, however, to utilise elements of each in an approach which respects the resources and needs of the learner,

while still maximising the effectiveness of the didactic components of teaching. Extremely favourable summer workshop evaluation data support the value of this integrated style of teaching. It is suggested that instructors may benefit from a consideration of the merits of the two models when revising their courses.

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TIME-EFFICIENT SUPERVISION OF CLINICAL HYPNOSIS TRAINEES

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This paper sets out an effective method of supervising and shaping the practical experience of clinical hypnosis trainees. It involves the supervisor being behind a one-way screen but in communication with the "therapist" by a small microphone connected to a single earplug. This method is especially suitable for the hypnosis session, since the pace is usually quite slow and natural pauses can be used for suggestions and feedback without disturbing the client.

In another part of this journal Hawkins and Kapelis (pp. 37-43) describe the application of two training models to teaching the five-day continuing education summer workshop in clinical hypnosis at Flinders University. They are the direct teaching model of Rosenshine and Stevens (1986) and the andragogy model described by Malcolm Knowles (1975). The aim of the five-day workshop is to provide instruction in hypnotic techniques and procedures. Entry into the workshop is restricted to registered practitioners in psychology, psychiatry, or some other branch of medicine. This ensures that everyone has at least some experience in counselling and knowledge about psychological disorders and their treatment.

A similar philosophy is followed in the semester-length topic taught as part of the clinical Master of Psychology program. As in the summer workshop, besides covering the relevant research, theories, and history of hypnosis, students learn practical hypnosis in a gradual step-by-step manner, similar to the breakdown used in the five-day workshop. In contrast to the workshop, however, there is a major emphasis on supervised practice and the use of hypnosis with clients.

The importance of supervision and practical training in teaching hypnotic procedures has been emphasised in a review article by Wickramasekera (1992), who wrote: "Because hypnotic techniques, particularly in people of high hypnotic ability, have a potential to influence a wide range of physiological

(e.g., neuroendocrine, etc.) and psychological functions in health and disease, I have grave reservations about training technicians to perform hypnotic procedures without supervision" (p. 687).

Adequate supervision, unfortunately, is very time-consuming, as the units of supervision time have to be multiplied by the number of class members. The traditional model of supervision, which has been practised since the early years of psychoanalysis, requires that trainees meet individually with their supervisor, to whom they describe the session with the client, after which plans for future therapy sessions are made. Such supervision contains inadequacies. First, as has been shown by studies comparing the contents of a taped session with trainees' verbal accounts of the therapy, the verbally transmitted accounts tend to suffer from omissions and distortions. Second, the moment of therapy, when a particular intervention suggested by the supervisor could have been put into effect, has passed. Although the supervisor's advice can be filed away in memory for future use, for that specific client on that occasion, the benefit of the suggestion is lost.

Basing supervision on video or tape-recordings overcomes the difficulty of inaccurate recall, but it does not solve the problem of putting new learning immediately into practice. Also, replay of whole therapy sessions, interspersed with discussion, is time-consuming.

Over the years the writer has experimented with devising more time-efficient direct supervision and has developed two innovations which to some extent overcome the problems described above.

SUPERVISION OF TRAINEE PAIRS

After completing the formal theoretical requirements of the course, students undertake the practical component and are assigned to work in pairs. From the very first contact with the client, two students are present. They meet the client, take the history, plan the hypnotic induction, deepening, therapeutic suggestions, and conduct the therapy and debriefing. Although the therapy is planned jointly, and both are always present in sessions with the client, it is designated beforehand who is going to take responsibility for which part of the session. One might be in charge during the history-taking, while the other takes responsibility in preparing the client for hypnosis. Similarly, they take turns in guiding the client into and throughout the hypnosis, one acting as operator, the other observing and being ready to take over as prearranged, thus proceeding through relaxation and deepening, perhaps, switching again at the start of the therapeutic work, and so on. In addition, they are encouraged to shift the responsibilities in subsequent sessions, so each experiences the whole range of therapeutic work.

The client knows that the therapy is shared and that the trainees will take turns. When the changeover is about to take place, the client is informed: "and now I will pause and . . . will talk to you." Clients readily accept the

two-therapist and supervisor-behind-the-screen arrangement, knowing that in addition to the two trainees, they are also in the care of a therapist expert in hypnosis — a senior university academic. Since the rooms are equipped with cameras and recording devices, those are used also, but predominantly for students' private feedback and session-planning purposes.

Having students work in pairs sharing one client has proved a very satisfactory training arrangement. It reduces a student's anxiety about having sole responsibility and control of all aspects of therapy, as well as dealing with the questions and explanations at the start and conclusion of every session. Direct supervision time is halved, while the benefits of instruction remain intact. An additional bonus is that fewer clients are required. This is an important factor, as only those persons who, on screening, demonstrate a high level of hypnotic susceptibility are accepted into the program. It is done to ensure that trainees work with highly talented clients, which leads to increased rates of therapeutic success and is reinforcing for the trainees.

SHAPING BEHAVIOUR BY MEANS OF ELECTRONIC PROMPTS

Last year an additional modification was introduced. While observing behind the one-way screen, I became aware of situations when the trainees were lost for what to do, whereas to an experienced therapist the next move was obvious. This occurred predominantly when a client introduced unexpected material, or disclosed problems not revealed earlier.

Observing behind the one-way screen, I realised the need for a special means of communication with the trainees which would not disrupt the flow of the therapy session. With the aid of our audio-visual technicians, a simple single earplug was devised, which was connected to a microphone available for use by the supervisor situated behind the one-way screen. With this device one could prompt students as required. Such prompting works particularly well during hypnosis, since the pace is usually quite slow and there are many natural pauses. Also, one can easily encourage students' efforts, without disturbing the client, by means of immediate positive feedback. Two incidents during which the prompting device proved particularly useful stand out.

Our clients for the 1992 clinical hypnosis course were music students studying at the Adelaide Conservatorium. They requested help for debilitating performance anxiety. During therapy one of them disclosed something which he had not made clear during the history-taking. He described how his anxiety was rising not only when preparing to perform in recitals, but also while on his way to his regular music lesson with his long-standing teacher. The trainees in this case were prompted to use a paradoxical intervention. They were instructed to tell the client not to try to stop the anxiety, as it could provide useful clues. The next time he prepared for his lesson he should try to remain quite anxious so he could describe his anxiety in detail at the next session. Observing the puzzled look on the client's face, both trainees were at a loss as to what to do. Although familiar with paradoxical interventions,

they lacked experience in their use. Their instructions were to offer no further explanations, as these would weaken the paradox. When at the next meeting the client apologised that, despite seriously trying, he had not been able to produce anxiety associated with the music lesson, the trainees experienced an encouraging early therapeutic success.

Another incident involved a client who was unable to go into hypnosis, explaining that although she had not mentioned it at the beginning of the session, she was suffering from a bad headache. The course had covered headache treatment, but the trainees had not prepared to work on treating a headache. Again, they were "walked through" treatment, with prompts as needed, and the client left the session much relieved, having also gained ideas for future self-help.

Besides these incidents, in almost all sessions there were short prompts regarding improving suggestions, using more repetitions, or making other small changes to the therapy. Sometimes the supervisor noted information which both students had missed, and could draw their attention to it.

Students did not take long to become accustomed to this type of supervision, and all commented favourably on its effectiveness. Clients who had provided verbal consent, and were aware of it, did not show difficulties with accepting it.

Using the electronic prompt enabled the supervisor to guide the trainees without disturbing the rapport of the treatment session by physically appearing on the scene and taking over. At times, while not in hypnosis, clients could sense the prompting, observing the concentrated look as the trainee was trying to absorb some complex set of instructions. There were also odd humorous incidents, as when the trainee had turned the volume on too high and the client could hear faint sounds, signalling impending turns or modifications in therapy. With experience, these incidents were controlled, and the prompting kept unobtrusive so that the benefits to the training were retained without undue distraction to the client.

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REMEMBERING CHILDHOOD SEXUAL ABUSE

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In recent years an increasing number of women have requested treatment with hypnosis because of intimate beliefs that during some forgotten period of their childhood they were subjected to a form of sexual abuse. Among the symptoms reported were recurring nightmares, flashbacks, and inhibited sexual desire towards male partners. Two contrasting case histories are presented.

THE INCIDENCE OF CHILD INCEST

In 1896 Freud's major concern in hypnosis was the discovery of traumatic events which had occurred during the childhood of each of his patients. He succeeded only too well, as he wrote:

almost all my women patients told me that they had been seduced by their fathers. I was driven to recognise in the end that these reports were untrue and came to understand that hysterical symptoms are derived from phantasies and not from real occurrences. It was only later that I was able to recognise in this fantasy of being seduced by the father the expression of the Oedipus complex in women. (1966, p. 584).

Freud's first finding of father-daughter incest would have been so unacceptable to the Viennese male ethos of the time that his horror was understandable, and "nowhere in his early publications did he specifically inculcate the girl's father" (Freud, 1966, fn, p. 584). In recent times he has been criticised by a number of authors for renouncing the evidence of father-daughter seduction in favour of a theory designed to defend against it (Courtois, 1988; Miller, 1984; Rush, 1980).

Since the evidence of sexual abuse of children within the home is commonly accepted today, it may be assumed that at least a number of the reports of incest elicited by Freud from his patients were factual. Such an awareness is comparatively recent. Less than two generations ago, the incidence of incest

was estimated at one or two cases per year per million of population (Weinberg, 1955). More recently, Russell (1986) has estimated from a large-scale methodologically rigorous study that approximately 20% of all women had at least one incestuous experience before the age of 18.

Christine Courtois told how she first became involved in the sexual assault scene in 1972 at the University of Maryland in a campus rape centre which was initiated to provide assistance to women immediately after a rape: "it was not long before we started to get calls from women who had been raped in the past . . . not by strangers on the street but by men they knew and by family members . . . And for some of them the assaults had never stopped" (1988, p. xiii). Ellen Bass first heard that children were sexually abused in her creative writing workshop, from a student who wrote her story "on bits of paper." Then "another woman told me her story. And then another. And another" (Bass & Davis, 1990, p. 13). Since the 1970s the topic of sexual child abuse in the home has been ventilated in the print and electronic media so thoroughly that women's collective consciousness has been raised to the issue. Many who repressed their experiences as young children have found these leaking through as intrusive symptoms at younger adult ages.

INTRUSIVE SYMPTOMS OF CHILD SEXUAL ABUSE

In recent years an increasing number of requests for hypnosis has been received from women convinced that they suffered sexual abuse during childhood. Symptoms where memories have been repressed or dissociated include inhibited sexual desire (ISD) towards partners — for whom there may exist deep fondness — frightening recurrent dreams, and flashbacks. Whole portions may be occluded from childhood memories.

A flashback is a momentary experience of the original abuse or something closely connected with it. It may be visual or a touch, smell, or sound with repulsive connotations. It may be the frightening figure of a man, dark and unrecognisable or invisible, as when a child in bed is staring at a door as footsteps stop outside.

The man may be recognised, as in the instance of a young woman who, on her wedding night, hallucinated seeing her father near the door of the hotel bedroom. One woman could reach climax with her husband only if she fantasised that he was a large black dog — which was traced to seduction by her father during which she had shameful orgasm. Recurrent dreams may be nightmares: a 35-year-old woman said that during adolescence she dreamt that her father came into her room and changed into a wolf. She never connected it with sex until years later.

TREATMENT

The motivation of such women is so strong that they invariably agree to hypnotic age regression. Children who are regularly abused typically adopt

a defence of trance dissociation in which their bodies go numb or they are "not there." A woman at the clinic recalled that while she was being sexually molested she was "up there," pointing to the corner of the ceiling. It is not remarkable that the responsiveness to hypnosis of these women is usually of a high order.

Those who were able to reconstruct their abusive experiences in hypnotic recall, with repeated, attenuated abreactions, have developed therapeutic behaviour changes. Such a case is presented below.

Rhonda, an attractive secretary aged 23 years, had asked a Lifeline counsellor to refer her for treatment with hypnosis. When she was 19 Rhonda's mother had reminded her of incestuous assaults by her stepfather whose memory she "adored." These had begun at the age of six and continued until she was eight when she had informed her mother.

The family comprised the stepfather, the mother, Rhonda and a sister who was two years older. As soon as the mother knew that *both* daughters had been molested she and the girls moved out. Rhonda quickly blocked all memories relating to the incest and wondered why daddy didn't come too. She said that she missed him so much that she wept for days.

She developed very negative feelings against men in general, and would become enraged to hear of a sexual assault against a female. She feared for her own safety so much that she consulted a psychologist and discussed whether she should take a self-defence course.

At 15 she began to suffer a recurrent nightmare of the dark figure of a man whom she could not recognise standing in the doorway, then moving towards her, but never reaching her. Less frequently she had night terrors from which she awoke screaming. The nightmares continued about weekly, then became less frequent after she turned 18.

She had intercourse first at 21 in two casual affairs, each of them pleasurable, before meeting Peter, her present lover. It was not until they became "committed" and began living together that a serious problem occurred. There were times when sex was satisfying, but just as often their lovemaking was interrupted by what she described as "A black cloud comes over me and all desire for sex immediately vanishes. It is a horrible fear which grips me." To make matters worse, Peter believed that the fault was his.

She still had feelings against men, and sometimes found herself shouting at her partner for no good reason. She was still in love with the memory of her stepfather. She recalled that at 19, when her mother reminded her of his abuse of her — the memory of which she had completely blocked out — it meant nothing to her emotionally: it was as if she was hearing of some everyday events from the past. However, once she realised the true origin of the nightmares and the "black cloud" she had sought help, *though her feelings towards her stepfather did not change*. During discussions with Peter it became clear that their relationship was seriously affected by the black cloud and the strange ambivalence she sometimes displayed.

AGE REGRESSION

Rhonda willingly agreed to relive in hypnosis events with the stepfather which she believed had been repressed from memory. She was asked to experience the black cloud vividly, to strengthen the feeling, and go back through the years to its origin — the first time and place. She was told that she would be able to speak without affecting her hypnosis.

After a minute her finger rose. She said that she was six years old, and he was in her bedroom. The quotes are from a recording:

He's showing me his body . . . I've never seen it before . . . It's strange . . . He says, "Daddy loves you, come over here and touch it and see what it feels like." And I did. Then he's asking me to get up on the bed because he says I've got one too . . . I said no I haven't . . . and he said he's going to show me . . . Then he was looking at me and touching me . . . and he says, "That's it, that's the one you've got."

Asked how she felt when he looked and touched her:

"I didn't like it, it felt horrible, yucky, I didn't like it because it didn't feel right."

"What about when you touched him?"

"That didn't seem so bad. I hadn't seen anything like it before. I guess I was curious the first time. But it was different him looking and touching me. I remember feeling sort of frozen."

"You said you adored your stepfather. Did you still feel the same way after him touching you?"

"Yes, I still loved him, but I think I was a bit confused."

She explained that although she really experienced herself as a six-year-old (and she spoke like one) she sometimes felt the presence of her adult self. She recalled further molestations, but they were mostly exposing his penis and asking her to feel it, which she didn't want to do, but always did. They occurred only when the mother was not home. Finally, after the last time he touched and looked at her, when she was eight, she told her mother. She explained: "I think I had just had enough and I decided I was just going to tell her because I figured she would make him stop and he wouldn't stop for me."

Most noteworthy was her composure while she related these events. She said that she never cried or told him she didn't like it. The deeply repressed anger was displaced elsewhere, while the idealised concept of the stepfather continued, presumably as an ego defence against the guilt from her betrayal. It seemed that for treatment to succeed the anger had to be brought out and directed towards its proper target.

The emotional impasse was continued in the next session when the child-self was asked did she love grown-up Rhonda. She replied "yes," but declared

that what Rhonda and Peter did was yucky. Yet when pressed, stated that daddy had behaved like he did because he loved her, and asked, "Don't you think that I should forgive him?"

During the next session in hypnosis the need to forgive a father who has abused a child sexually was discussed with Rhonda. It was pointed out that in order to make peace with her past and to move on to a normal life she had to discover her real feelings about her stepfather. She did not have to love him or hate him or forgive him, just see him as he really was, a child abuser whose influence was still ruining her happiness.

On her next visit she was visibly distressed. Things were worse, she said, and "I've been shouting at Peter for no reason." She had also written of her own accord a poison pen letter to the stepfather (who had died three years earlier).

"RAGE RELEASE"

During the next regression the question was raised of the anger which had led to her telling her mother of the stepfather's abuse. She agreed that it would have been right for her to have shown anger the first time she was molested, and to have told her mother then.

At this stage a procedure devised by Helen Watkins (1980) was adopted. The author described this as "a dynamic technique designed to break through an emotional impasse [which is] particularly efficacious when repressed anger is being focussed upon" (p. 109):

One such method I use is to walk the hypnotised patient down a hallucinated stairway into a room with a glass panel. The patient and I sit on one side of the glass panel while we watch the action on the other side. We view the patient-as-a-child interacting with a significant person-of-the-past who has mistreated her (usually a parent). She first visualises through the glass panel . . . an especially traumatic episode, one which at the time left her with repressed anger because of her fear of expressing it.

I then say, "Watch now as the child acts out all the angry thoughts she has had about this person. She can beat him up . . . or she can kill him over and over again." (p. 109; the pronoun "he" in the original is replaced with "she")

Watkins called her method "silent abreaction," the patient's excitement being expressed subvocally within the imagination. In the situation below Rhonda was encouraged to express herself freely, and it is better described as "rage release." The quoted passages are from a recording made while Rhonda, accompanied by the therapist, visualised her final traumatic interaction with her stepfather. "Now watch while the child turns on her molester. See how she has become suddenly strong, and is attacking him, beating him up, she can do what she likes with him, she can kill him however she likes, as many times as she likes."

Suddenly Rhonda, who was becoming more and more agitated, called out:

"Horrible man, I hate you! Every part of you . . . leave me alone! I wanna stake him . . . (crying) He's not gonna do it any more! Bugger-off! (After a long pause) I've killed him . . . cut his head off!"

"How do you feel now?"

"I feel proud of myself . . . Mum's proud of me."

"And grown-up Rhonda?"

"She's proud of me too . . . I'm strong like her."

The scene was then changed to the tranquillity room. In relaxed hypnosis, the imaginary destruction of the stepfather was interpreted as being justified because of the years of victimisation of the helpless child. She had been right to reverse this helplessness, getting rid of the immense anger she had stored up. Killing the stepfather was proper and effective, but it was in the imagination and far removed from real life.

The result was a breakthrough after eight hours of therapy. Two more sessions were needed to consolidate the favourable outcome. The test consisted of her being able to view the stepfather objectively as a child molester who had earned punishment. The child-self then became integrated with the personality of grown-up Rhonda.

Rage release was not undertaken lightly. It is often adequate for the child to confront her abuser and verbally express her anger and disgust. However, Rhonda had shown that she was no weakling. It is an heroic act for a child to inform on an incestuous parent after years of submission. The cost was heavy: the need to repress everything connected with the stepfather except her idealisation, with years of destructive symptoms to follow.

Discussion with both partners three months later confirmed that the remission of symptoms had been maintained.

Where adequate investigations of symptoms with the stamp of unremembered child abuse is possible, one is usually convinced of a genuine basis for the complaint. The case which follows has unusually bizarre elements, which pointed to the possibility of sexual abuse of a child by her doctor.

Clara, aged 36, a highly qualified nurse, had phoned and expressly requested hypnotic age regression. Later she cried as she told of 16 years of frustration with Roger, her *de facto* husband. Although orgasmic with masturbation, Clara had never enjoyed sexual foreplay or intercourse. For more than a year this had become much worse — ever since she and Roger had watched a film on the theme of child sexual abuse. Since then she said she had had a recurring dream of a man bending over her. She also had flashbacks of being painfully penetrated. Intercourse became possible only if she consumed sufficient alcohol. Then she stopped drinking, and intercourse became so painful that they agreed to abstain.

Although Roger drank a lot, he was not unkind to her and her four-year-old son, and she felt fondly towards him. As a child she recalled good

relationships with both parents, and was now especially close to her mother. Her childhood was marred by two surgical operations to correct a congenital defect of the urinary system. She has bitter memories of having to suffer through many painful procedures, as well as surgery, with inadequate relief from pain. (To this day, she stated, doctors fear prescribing adequate pain relief for children.)

The first session lasted two hours. Following the lengthy discussion, hypnotic age regression was induced: she was asked to recall the terrifying dream, and to strengthen it as a bridge to the past, to a time and a place of the source of her symptoms. She was told that she could talk while still in hypnosis. After several minutes she said that she was nine or ten years old; she was lying on a table and a man was interfering with her. She recognised him as Mr M. She became distressed as she told how he was doing something "down below." "He's hurting me, and I don't like what he's doing to me. I don't like him being down there." Mr M was the surgeon who had operated on her. Then she complained of a heavy weight lying on her so that she couldn't move and could hardly breathe. After a while she said that he had gone, but she could still feel the weight on top of her.

Asked if this had happened before, she said that it always happened, as her mother had taken her to the surgeon many times. She had cried and said that he hurt her, but her mother made her go. She was comforted and told that she would remember only what she wanted to, and could talk about it if she wished.

Afterwards she wanted to know if things that were remembered in hypnosis were always true. It was explained that memories of events could alter over time, whether in hypnosis or not.

At her next appointment five days later Clara immediately said that she had misgivings about what appeared to be a sexual assault by the surgeon, and was keen to return in hypnosis. She also said that she had actually felt that she was herself at that age with no presence of her adult self.

Soon she was nine or ten again, lying on the same table. She could see surgical instruments and Mr M was preparing her for catheterisation. She was complaining in a whining voice: "I'm frightened. Why can't I do it for him my way? I keep asking him and he won't let me. He says he needs a clean specimen each time, and I don't like what he does down there. I'd sooner do it my way." This time there was fear and pain, but no hint of sexual interference.

Later she told of treatments extending over several years for recurring infections of the urinary tract, and how she dreaded those visits to the surgeon. She remembered the pain as very real, possibly enhanced by fear. Nowadays a child would be permitted to pass her urine into a clean receptacle.

One point remained to be cleared up. This was the experience she had of the surgeon lying on top of her even when he was no longer present. She had thought about this and connected it with a most unpleasant post-surgical

experience she had undergone as a child while she was in the recovery room. She believed that the anaesthetist would have injected a curare-based blocking agent to increase muscle relaxation, and that she had received an insufficient amount of the drug to reverse the paralysis. When she regained consciousness the effect was terrifying — as she had experienced it in hypnosis, but much worse. It was like a large rock resting on her, and she could hardly breathe.

She did not think further age regression was needed.

How, it might be asked, could medical procedures — which did not appear to be in the least bit sexually oriented — have inhibited Clara's sexual desire and performance for a total of 16 years with her husband?

Five months later a phone call announced that a letter which she had promised to write, expressing her views on this vexed question, was on the way. Since her purpose in requesting hypnotic age regression had been to determine whether she had been sexually abused as a child, she had been asked at the denouement to consider whether she might have had a fantasy. The suggestion was given short shrift in her letter, a portion of which reads as follows:

I did not ever, and still don't think it was fantasy. It was my reality as a six-year-old girl (the age of her first treatment). I would call it a misunderstanding or perhaps a misperception of what was going on. With my child's limited understanding of the body perhaps I did not yet understand the difference between "therapeutic procedures" on my urinary tract (passing urinary catheters in particular) and forbidden things with regard to the same area. I experienced it as I perceived it, as a frightening, bizarre (to me) experience involving the forbidden area of my body. The treatment was probably ethical by the standards of the time. I do not believe there was any malicious intention, merely ignorance of the deep rooted psychological effects many "therapeutic procedures" can have on a child.

It is instructive to compare Clara's comments with an observation by a male sex therapist: "Some mothers are so insistent about regularity that they force enemas on their children. [Because the] insertion process can be painful, it is not surprising when a girl grows up associating this pain with insertion of the penis into the vaginal barrel" (Runciman, 1976, p. 123).

Clara kindly included in her letter an assessment of the process and outcome of her treatment with hypnotic age regression which provides a valuable insight into its mechanism and a welcome feedback:

It has worked for me. It seems that the simple act of bringing these memories back to my conscious mind (through hypnosis) so that I could reassess the experiences with the understanding of an adult has enabled my mind to realise which feelings and emotions belonged to the past and were no longer relevant or useful in my life now. This was sufficient to create a state of release for me.

I feel like a completely healthy person now... I feel balanced and comfortable with my sexuality *and my body image* (also thanks to hypnosis)

now. I see my sexuality as a normal, natural aspect of living and not as something separate and full of shame, fear, pain and anxiety as it was for so many years. (Writer's emphasis)

Clara's case was the only one of its kind seen. The fact that she was able to salvage her sexuality from the wreckage of so many years duration in two 2-hour sessions was due to her very good intelligence and the robustness of her personality in its other dimensions.

The two cases were chosen because of their brevity and the contrast they presented. They were also among those most successfully treated, which was due in no small measure to the strength of their personalities. There are some, of course, who respond less favourably even after months of treatment. Least promising are those who though highly motivated — at least for a while — have severe personality problems and horrendous histories of childhood abuse even involving both parents.

INHIBITED SEXUAL DESIRE

Experience with women who have been sexually abused suggests that often their most demanding problem is ISD with their male partners. A review by Hammond (1990) suggests that ISD (context unspecified) has increased to the extent that it is now the most widespread of sexual dysfunctions, responsible for 50% or more of treatments. Hammond quotes a consensus of opinions from therapists that it is "perhaps the most complex and least successfully treated sexual complaint" (p. 350).

If ISD is increasing (in America, and it would probably be the same in this country), the cause among women may well be an increase in male sexual sociopathy, both within the family and wherever women are exposed to sexual assaults. An increase in child incest could be partly related to the increase in divorce and remarriage and the incidence of live-in lovers, since the incest taboo applies less stringently when the child and adult are not blood-related.

Hammond stresses the value of hypnosis in sex therapy, recognising that it is unduly neglected. He quotes a survey (Kilman, Boland, Norton, Davidson, & Caid, 1986) which revealed that only 7% of certified therapists in the sample used hypnosis in treating sexual dysfunctions. The indication is that the potential of hypnosis in sex therapy — probably the most effective modality for treating ISD — is largely untapped.

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EGO-ENHANCEMENT FOR POSITIVE CHANGE

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The use of generalised ego-enhancement suggestions is related to a three-level model of therapist directiveness. A specific approach to ego-enhancement is then described. This makes use of Hammond's (1990) serenity place metaphor, extended to emphasise the concepts of changed perspective and communication with the unconscious mind. A two-session application of the approach to 17 patients expressing a sense of dissatisfaction with their lives is outlined. Happiness, operationalised as scores on the happiness thermometer, showed improvement immediately after treatment and further improvement six months later.

Havens and Walters (1989) have suggested a three-level model of hypnotherapy using the criterion of therapist directiveness. The first level affirms that effective hypnotherapy may, on many occasions, be accomplished solely through the elicitation of a relaxed trance state in which patients learn whatever their unconscious minds have to offer.

With most patients, Havens and Walters believe, it is necessary to go beyond such an induction and to utilise the trance state. A gentle focusing upon problem areas, possibly through the use of techniques such as ego-enhancement, may be conceptualised as a second level in which the therapist, while providing some stimulus toward an understanding of the presenting problem and/or its solution, still places considerable emphasis upon patients' own initiative and resources. The metaphors used at this level are sufficiently specific to provide conscious guidance messages, yet they are also directed toward the unconscious mind.

For most patients, the permissive, indirect approaches of levels one and two enable them to develop new skills, conclusions, and solutions. However, a minority of patients require the more straightforward or direct approach of level three, in which specific therapeutic instructions are used. Havens and Walters believe such suggestions are more likely to be accepted and acted upon if communicated to patients when they are in a trance state. Even at

this more directive level, ego-enhancement suggestions of a wide-ranging nature may still be employed.

Since the days of Hartland, ego-enhancing suggestions have been used to help patients feel better about themselves. Hartland (1965, 1971) has claimed that patients tend to improve under the influence of generalised ego-enhancing suggestions which make no attempt to deal with specific symptoms. These standardised suggestions, delivered to the patient after a hypnotic induction, are designed to eliminate tension, anxiety and fear, and to gradually restore the patient's self-confidence in his ability to handle his problems. My clinical experience echoes that of Hartland and I have often been amazed at the improvement patients make over a wide gamut of problems when exposed to generalised ego-enhancing suggestions. More objective experimental evidence supports this subject view.

Using psychiatric patients attending a community mental health centre as subjects, Calnan (1977) investigated Hartland's approach and concluded that virtually all his subjects reported feeling more relaxed and self-confident. It was noticeable that patients reported the changes they experienced in exactly the same words as those of the Hartland suggestions, yet they displayed no awareness of the origin of these descriptions.

A comparison of patients' belief in the efficiency of Hartland's ego-strengthening technique with a series of positive suggestions derived from Ellis' rational-emotive therapy also produced positive results (Stanton, 1977). Even when these suggestions did not deal directly with their symptoms, patients indicated a strong belief in the value of suggestive therapy.

Equally positive was the outcome of an experiment designed to investigate whether the use of generalised ego-enhancing suggestions could increase internal control as defined by scores on Rotter's Internal-External (I-E) Scale (Stanton, 1979). The script used in this study (Stanton, 1975) included suggestions derived from Hartland, Ellis, and Coue (1922) designed to produce increased calm, relaxation, and self-confidence, with considerable emphasis falling upon the power of individuals to effect change within themselves.

AN APPROACH TO EGO-ENHANCEMENT

In the present paper, an ego-enhancement procedure which builds on Hammond's (1990) serenity place metaphor is outlined. This is, in most respects, the conventional "special place" metaphor used so widely in hypnotherapeutic work. However, it does have two useful additions, the first of these involving the concept of perspective. In Hammond's words; "in this place of serenity and security, things can come into perspective. You can be aware of actual feelings, with a correct sense of proportion, free from the distortions of a mood set or set of circumstances" (p. 131). To this suggestion, I add the concept of a scale. One end point, 0, marks the worst possible thing patients can imagine happening to them, and the other end point, 10, marks total peace and contentment. Patients' current problems may then be placed on the scale

where it seems appropriate, most people realising the problem with which they have been so involved may not be worth the importance they are attaching to it.

The second of Hammond's additions involves the establishment of communication with the unconscious mind. His suggestion is:

And in this special place, independent of anything that I say, you can receive what you most need right now. Your unconscious mind knows what you most need. And I don't know exactly how you'll receive that . . . before awakening, you'll receive from your unconscious a special gift, or an experience or memory . . . or perhaps you might hear what you need. (p. 131)

Within this framework, I add an exercise suggested by Rosanoff (1988) which goes as follows:

Imagine a traffic light in your peripheral vision, red at the top for stop, yellow in the centre for caution, green at the bottom for go. Place the traffic light on one side of your field of vision; do not let it be in the middle. Make sure that you can sense it clearly. Think of a current situation you are involved in. Check the lights. Which light is on? Try other situations and identify which light is on . . . the lights are there to help you define your intuitive feelings. You may never spontaneously see a light but you will get the feeling associated with the lights. And the lights will help you define that feeling more accurately. (pp. 104–105)

Should some patients be unable to use the traffic lights as a means of communication with the unconscious mind, they might:

Remember a situation when things did not go right. What did it feel like? Now, listen. Your intuition will produce a sound or word . . . Now, remember a situation which required you to wait and be patient. Remember what that felt like. Let your intuition produce a sound to go with this feeling . . . it may be a tone, a tune, a familiar phrase or word, or a noise. Now, remember a situation when you needed to keep going, or get going, where continued action or new action was required. Remember what that felt like? Let your intuition produce a sound or word to link with this feeling . . . think of a current situation in your life. Listen to the sound that comes with it. Reflect on what the sound and your intuition are communicating to you. (pp. 106–107)

Rosanoff's term "intuition" corresponds reasonably well with Hammond's "unconscious," as may be observed in a further alternative which may be used to focus on feelings rather than sounds and mental pictures:

Remember a situation when things did not go right. What did it feel like? Your intuition is going to exaggerate this feeling. Where do you feel it in your body? What does it feel like? Have you ever experienced this feeling before? Soak in this sensation. Let it be imprinted in your body. Let it

go. Now, think of a situation in which you had to wait and be patient. What did this feel like to you? Again, let your intuition exaggerate this feeling. Soak in the physical sensation. Then, let it go. Repeat the exercise with a situation that required you to keep going, take action, or proceed as planned. (pp. 108-109)

THE STUDY

Two sessions were involved in the treatment of patients using the above ego-strengthening enhancement approach. The first occupied 50 minutes and included case-taking, establishment of rapport, and guiding the patient through the serenity place metaphor. One week later, a second 30-minute session provided an opportunity for patients to talk about their experiences of the previous week and for repetition of the metaphor.

Patients were not selected in any way but came for therapy in the normal way, expressing both a dissatisfaction with their lives and a desire to effect change of some positive kind. Five of the 17 patients experiencing the serenity place metaphor were referred by a medical practitioner (3 males, 2 females), while the other 12 (4 males, 8 females) were self-referred.

A face valid scale which asked patients to rate their present level of happiness was administered as part of the case-taking procedure. Choice of this subjective form of measurement was influenced primarily by the work of Allport (1960) and Combs and Snygg (1959), who have emphasised that the most important element in personality measurement is a person's own perceptions of the way he or she is functioning. If people say they are unhappy, they are likely to behave in a manner reflecting the same.

That particular form of face valid scale chosen was the Thermometer (Francis & Stanley, 1989), which is easy to administer, has high face validity, and is reliable (Price, McGrath, Rafii, & Buckingham, 1983). Francis and Stanley have demonstrated adequate reliability and validity for a Thermometer Scale bounded by marker phrases, and this form was employed in the present study, being administered before and one week after the two treatment sessions. Figure 1 represents the scale.

Figure 1: Happiness Thermometer

0 1 2 3 4 5 6 7 8 9 10

Miserable **Happy**

Imagine that this is a thermometer recording the level of your happiness.
Please indicate whereabouts you usually are on this thermometer by circling
the appropriate number.

RESULTS

No sex difference was apparent, nor was there any significant difference between patients referred by a medical practitioner and those self-referred. Therefore all data is recorded in Table 1, which sets out scores derived from three administrations of the thermometer, one before commencement of the two treatment sessions, the second one week after their completion, and the other six months later.

Table 1 Mean Scores and Standard Deviations for 17 Patients on the Happiness Thermometer Administered Before, Immediately After, and Six Months After Hypnotherapeutic Treatment

Before treatment	Immediately after treatment	Six months after treatment
3.7 (1) ^a	5.4 (1.1)	6.1 (1.1)

^a Low scores indicate low level of happiness

A definite treatment effect emerges from an analysis of variance of these data ($F, 2, 16 = 31.69, p < .001$). Comparison of post-treatment thermometer scores with those recorded before commencement of treatment indicates a significant increase in patients' happiness level ($t = 6.06, df = 16, p < .001$). This improvement was maintained at the follow-up, with the six-months thermometer scores being significantly higher than those recorded pre-treatment ($t = 6.81, df = 16, p < .001$). When the follow-up scores were compared with those of the immediate post-treatment administration of the happiness thermometer, a further significant difference was apparent ($t = 2.4, df = 16, p < .05$).

CONCLUSION

These results are quite encouraging. Though the sample is small and no control group was used, patients appeared to feel distinctly happier one week after the two sessions than they did prior to treatment. This improvement was maintained at the six months follow-up with further increases in happiness level, as measured by the thermometer, being recorded.

The improvement was particularly noticeable for those patients who continued to use the serenity place metaphor during the six-month period after treatment had concluded. Although the difference in thermometer score between these patients and those who made no further use of the method was not statistically significant, visual inspection of the data suggests that a difference did exist. A further study involving more subjects is needed to clarify this point.

No attempt was made to measure hypnotisability or depth of hypnosis in the present study. My clinical experience in the use of ego-enhancement has

indicated that depth of hypnotic trance does not appear to exert any strong influence over the response to suggestions. However, further investigation of the approach I have outlined in this article might indicate an interaction between effectiveness of treatment and hypnotisability.

Because of their gentle and non-intrusive nature, ego-enhancing metaphors such as the serenity place, the perspective scale, and communication with the unconscious mind seem capable of use with virtually any client. Their great virtue is the manner in which they convey universally applicable messages about the nature and source of therapeutic change and their non-threatening stimulation of clients' inner resources for self-healing.

Such ego-enhancement is unlikely to cause harm and would seem likely to assist those patients finding difficulty in coping with their life situations. Certainly, in the admittedly somewhat primitive study I have reported, patients seemed to feel happier after treatment than they did beforehand. That this improvement was still apparent six months later is particularly encouraging.

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"TO BE" OR NOT "TO BE": THAT IS THE QUESTION

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This paper attempts to answer the question "what is hypnosis?" In the first part the author links hypnotic experience to the verb "to be." In the next part he links religious experience to the verb "to be." In the final part he links play to the verb "to be" and suggests that play should be the model for hypnosis.

In a survey of the words used during trance induction, Field (1973) found that there was an increase in the use of "will," "as," and the variants of the verb "to be" — "be," "is," and "are." The increased frequency of "will" is easy to explain as the use of the future tense in trance induction is important in order to instil belief and expectation into the subject. The adverb "as" can be easily understood because it gives the sense of continuing experience when used in conjunction with a verb in the present tense. More interesting, however, is the presence of the verb "to be." This, too, gives us the present tense continuous when used in conjunction with a verb. Matters become curiouser and curiouser the more one studies "to be."

The word is present in "becoming," "belief," and "behaviour," and it is interesting to speculate on why this should be so. These words are prominent in psychological and religious practice. Somewhere back in the early formation of language the verb and its additions — "coming," "lieving," and "having" — have been combined and it might tell us a lot about ourselves if we could understand why. Perhaps a linguist or philologist could provide an answer.

In hypnotic practice, "to be" allows the past and the future to be experienced as the present, and of course it is the present tense which is the hallmark of hypnotic experience. Way back in the times of proto-language, "to be" must have been one of the first words invented. We understand this point unwittingly, with the humour of recognition, when we hear the sentence, "Me Tarzan, you Jane." What is missing, of course, is the verb "to be." This might

have been followed by the world's first joke when Jane falls pregnant. "Me Bull, you Elephant." Note the metaphor and the reframing, which are also important in clinical hypnosis.

Field (1973, p. 483) got close when he talked of "the hypnotised subject who 'becomes' a child." The question one should ask, to start with, is not "what is hypnosis?" but rather, the more illuminating "what does it mean to *become* hypnotised?" Asking the question in this form emphasises that it is the *becoming* which is important and which forms the common denominator. It is the failure to address this question that results in sterile theories in the literature. We do not have a coherent model to explain the differences between being hypnotised by Mesmer in 1770 and by a hypnotist in 1993, or to explain religious "trance" and being "entranced" by a play or book.

Hypnosis can be seen as the experiencing of a story in the present tense. The story is our beliefs. Much of human mental anguish occurs when the things that happen to us do not accord with the story.

As regards religion, you may have noticed that religious literature is full of "being," "becoming," and "belief." It is the verb "to be" that gives us metaphors, of which there are more than 180 for Jesus in the Bible, and more than 145 for the Church (Cruden's, 1984). Thomas à Kempis' *Imitation of Christ* encouraged people to become like Christ (as defined by Thomas à Kempis, of course) with a lasting effect on Western civilisation. To speak of someone who has died (i.e., past tense) as though he were alive (present tense), is hypnotic, and allows one to experience the deceased. It allows dramatisation of the past and even of the future with a powerful hypnotic effect on the audience. It is no accident that the Bhagwan Rajneesh left a directive for his followers, after his death, always to refer to him in the present tense, nor that the founder of Scientology was a former sci-fi writer.

Clues to the importance of the religious/hypnotic experience can be found in the Bible itself. In Exodus iii.14 we read, "God answered, 'I AM; that is who I am. Tell them that I AM has sent you to them.'" (New English Bible). And it occurs again in John viii.57-8: "'I tell you the truth,' Jesus answered, 'before Abraham was born, I am!'" (NIV). Augustine in his *Confessions* (Book II, Chapter 20), says there are three times: "a present of things past, a present of things present, and a present of things future," the first being memory, the second sight, and the third expectation.

The Mass consists of "becoming" a participant in a meal. There is the focusing of attention on the Host, the elevation of the Host above eye level, the cue for trance signalled by a bell, and the "hallucination" of the "Real Presence."

According to Crystal (1988, p. 9): "Yahweh is a scholarly attempt at reconstruction of the divine name represented by YHWH in the Hebrew Old Testament, interpreting its meaning as part of the verb 'to be', to give the title 'the One who is.'" In Islam the world was created by God's word *kun* ("be") out of nothing (*Encyclopaedia Britannica*, Vol. 9, p. 949). In Buddhism we have the Wheel of Becoming.

Now we come to the interesting bit. Debate continues in the literature about the nature of hypnosis and what it is. On the one hand we have the believers, who consider that hypnosis is a special state, while on the other there are the sceptics who say that hypnosis does not exist. On some points there is universal agreement — that: hypnosis involves child-like experience (the buzz phrase for this among the credulous is "archaic involvement"); hypnosis involves imagination; hypnosis involves role-playing; the explanation for hypnosis, whatever it is, should be naturalistic.

As a humble medical practitioner (Special Subject — the bleedin' obvious), it seems to me that play satisfies all four criteria; and it is puzzling that no-one has suggested that this is the correct model for hypnosis. Anyone who thinks that "trance logic" is a characteristic of "hypnosis" has not recently had an argument with an 8–12-year-old. I swear that my child at play once looked straight through me. Does this not qualify as "negative hallucination"? I put it to the reader that the hypnotist and his subject are at play, and that the therapeutic efficacy of the hypnotic experience fulfils the same function in the adult that play does in the child. All that is necessary is to postulate that adults (some virtuosi more than others) retain the ability to behave like children. Just as a child *becomes* a cowboy or an Indian ("you be the Lone Ranger, I'll be Tonto"), so the patient becomes hypnotised, a native becomes possessed, and the Mass celebrant becomes a participant at a meal. Tell me what "becoming" is and I'll tell you what hypnosis is.

Acting is closely related but it differs in that the actor is aware of his audience and is, in effect, "showing off." It is in fact the audience which goes into trance. As any systems analysis would show, the essence of hypnosis is that it is conducted between two (or more) participants without reference to any audience, and that it is completely self-contained. The same is true of child's play.

I first became aware of the difference between acting and hypnosis at the Fourth European Congress of Hypnosis held in Oxford in 1987. A workshop entitled "Systems Analysis Hypnosis" was conducted by two South African psychologists, David Fourie and Stanley Lifschitz. They stood at the back of the room, observing the scene. In the middle was a hypnotist facing his subject, both seated on chairs. In front of them was an audience of some 15 people. The hypnotist was asked to hypnotise his subject, which he did over a period of 10 minutes. There was then a short debriefing as to what had occurred, using a systems approach. The hypnotist and his subject were then asked to turn through 90 degrees to face the audience, and the hypnotist was asked to rehypnotise his subject. This was accomplished with some difficulty (or was it?) — much to the discomfiture of the hypnotist, subject, and audience. At the subsequent debriefing, the hypnotist complained that by the act of facing the audience, his "power had been taken away" from him. His subject complained that she thought she had been "called upon to give a performance." The audience had been quite amused, as it found itself complying with some

of the hypnotist's suggestions. What was an hypnotic session had been converted into theatre.

There would thus appear to be a connection between play in children, hypnosis in adults, and also religious experience, particularly mystical religious experience — the common link being *becoming*.

MacDonald et al. (1975) describe play and its functions. Among these are that: play is intrinsic with no awareness of an audience; it may be unstructured or highly structured and governed by rules; it is a means of acquiring the skills, attitudes, and modes of behaviour required in adult life; it takes the stress out of failure; when a task is related to play it makes success more likely because the child is less tense and anxious, gives up less easily, and is eventually able to solve the problem; the development of a child through play is greatly assisted by understanding adults.

Morris (1977) describes also how children: investigate the unfamiliar until it has become familiar; impose rhythmic repetition on the familiar; vary the repetitive pattern; select the most satisfying of these variations and develop these at the expense of others; and combine and re-combine these variations with one another.

It is not hard to see the similarity and indeed the identity between the above, and hypnotic and religious practice. The process is the same, only the cognitive content may be different. When one looks at the therapeutic uses to which hypnosis is put they are precisely the problems one would have expected the patient to have solved, in play, when a child. It has been said that we are young in order that we may play. We do not play because we are young.

So there you have it. My conclusion is that the Trinity is hypnosis, religion, and play — and the unifying principle is the present tense of the verb "to be."

"Suffer little children to come unto me, and forbid them not. For of such is the kingdom of God." Mark x:14. Luke xviii.16 (King James Version).

"Except ye be converted, and become as little children, ye shall not enter into the Kingdom of Heaven." Matthew xviii.3 (King James Version).

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CASE NOTES, TECHNIQUES, AND ANECDOTES

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

Correspondence regarding these items is also invited.

SOME OBSERVATIONS IN HYPNOSIS: A BRIEF NOTE

Ratan Singh

The observations in hypnosis that I report here are so brief that I thought they could be better grouped in one paper.

But I Was Not Hypnotised

This observation is on myself. I was hypnotised the first time when I was a postgraduate student in clinical psychology, and I still remember it vividly. The purpose of hypnosis was not clinical, but satisfaction of my curiosity. The hypnotist did not brief me about the nature of hypnosis, but proceeded to hypnotise me immediately, using the eye fixation technique. During hypnosis I was conscious of listening to the surrounding sounds. At one stage the hypnotist told me that he was going to press a blunt object on my forearm and that I would feel the touch and pressure of the object but certainly no pain. Later on, after I was brought back out of hypnosis, feeling frustrated that my curiosity about hypnosis was not satisfied, I complained to the hypnotist: "But I was not hypnotised. I was conscious of the surroundings, listening to all the sounds." The hypnotist showed me the sharp nib of a fountain pen and informed me that he had pushed about half an inch of the nib into my skin. I was then convinced that I had been hypnotised because I remembered feeling only the touch of the pen which, surprisingly, I felt to be blunt. I definitely did not remember feeling pain. Now of course it is well known that a subject may be in hypnosis yet be conscious of the surroundings.

The Patient Fell Asleep

I had hypnotised a patient having chronic muscle spasm of her right arm since childhood. Suspecting some childhood trauma, I used age regression to locate the cause. She regressed to a particular experience when she was scolded by her sister for playing outside the house until late in the evening and hurting herself during the play. She cried and went around inside the house, looking for her mother. The patient narrated this experience with much emotion during hypnosis, but then suddenly became silent. I tried to re-establish communication, but she remained silent. As I thought she was asleep, I brought her out of hypnosis after a few minutes. I took it as failure in the sense that no clinically useful material came out from the age regression. After some weeks, a relative of the patient suggested I phone the patient's sister in case she might remember anything relevant from the patient's childhood. When I telephoned her, the sister could not give any useful information. However, she could recall the day when she scolded the patient and told me that the patient, searching for the mother, could not find her and, having been tired, fell asleep. This explained to me why the patient suddenly got silent during hypnosis. This was true age regression. Instead of regarding it as failure, I should have continued further back in age regression.

Yes I Feel Pain

This observation is based on the same patient as the preceding one. Mostly, after inducing a patient into hypnosis, I test the hypnotic state by hand paralysis and needle piercing or ammonia-smell test. I did needle piercing on the patient and asked her in situ if she was feeling pain. Still in hypnosis, she replied that she did. However, she was showing no behavioural indication of feeling pain. When brought out of hypnosis, I asked if she felt pain when I pierced the needle through her skin. She replied that she had absolutely no memory of the event and could not recall even the fact that I pierced a needle through her skin. This reminded me of Hilgard's (1973) concept of "hidden observer."

We hypnotists should be willing to inquire about our patients' experience rather than jump to conclusions when carrying out hypnotherapy.

REFERENCE

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A TECHNIQUE FOR IMPOTENCE

David W. Henty

Recently I commented to a colleague that at the time approximately one-third of my private-practice case load comprised single males with erectile dysfunctions. His response that I must have an acknowledged expertise caused me to reflect upon the content of the hypnotherapy.

My private practice is part-time as I work for the state education department, where my case load involves children and adolescents. Consequently I am used to using visualisation when working with children.

Such imagery with young children involves the use of the child's favourite cuddly toy as the "therapist" at the unconscious level of cognitive functioning. In this way, for example, "Teddy" can learn how to wake the child if a toileting need arises during the night.

So with heightened awareness following my colleague's comments, I began to observe myself more closely when using hypnotherapy with my male patients and their particular sexual problems. What I saw was the linking of my techniques with small children with hypnotherapy techniques for sexual dysfunctions. The connection was the personification of the penis as an individual within its own right, just like "Teddy." Linking of the two — that is the patient and his appendage (limbic system at the neurological level and the physiological response for erections) — was made through the patient's hand and arm in order to transmit messages between these two systems.

Using information previously obtained from the patient relating to the circumstances of failures in sexual performance, reframing and conflict resolution could take place. The penis can "talk" to the brain (and vice versa) about the sexual encounter which was about to occur (in the visual imagery of memory recall) or had just occurred. These two "people" can analyse the situation, learn from their mistakes, correct the mistakes, and then re-enact the event with a successful performance. Future sexual encounters can then be fantasised, whereby successful outcomes are clearly envisaged. The real thing then seems to follow quite easily after this role-play.

There is, of course, more content than just this approach in the overall therapy program. However, as far as the actual business of obtaining and sustaining an erection in order to successfully carry out a sexual behaviour involving the male genitalia is concerned, then I find this "child-like" approach to be a comfortable way of working. Furthermore, patients report that it works well for them and that they find it to be a comfortable therapeutic technique.

BOOK REVIEWS

Discussing Sexuality: A Guide for Health Practitioners. Michael W. Ross and Lorna D. Channon-Little. Sydney: MacLennan & Petty. 1991. xii + 148. \$25.00.

Masters and Johnson (1970) in their classic book *Human Sexual Inadequacy* comment extensively on the difficulties involved in taking accurate sexual histories and on the widespread failure of health professionals to handle the taking of sexual histories in a productive way. Things have changed since 1970. On the one hand, society in general is widely believed to have become more relaxed about sexual issues. On the other hand, the ability to take a good sexual history in appropriate circumstances has been moved, by the appearance of HIV, from professional nicety to professional necessity.

The authors of *Discussing Sexuality* state that the aim of the book is "to provide a simple, straightforward guide for the health practitioner." The book certainly achieves this aim. The early chapters, which deal with the nuts and bolts of sexual history-taking, provide clear and logical instructions. The way the book is set out helps a lot in the clarity of the guidelines it gives: there are plenty of subheadings, and detailed instructions, such as specific questions to ask in particular circumstances, are set inside clearly-labelled boxes. Boxes are extensively used in the book for two other purposes: to highlight summarised information that needs to be readily available, such as "Some possible organic causes of dysfunction" or "Non-verbal indicators of listening"; and to provide brief case histories. I found the very frequent use of boxes in some chapters to give a slightly staccato quality to the experience of reading whole chapters. However, I believe the book is most appropriate for use as a resource and reference book and in this role the boxes would be extremely useful.

Later sections of the book broaden out from the narrow focus of history-taking to cover issues such as diagnosis of sexual dysfunction, basic sexual counselling, legal and ethical considerations, and issues specifically connected with STD infections or with the needs of homosexual patients. There are also chapters concerned with the links between sexuality and preventive health care, drug use, and chronic illness. Thus the book gives consideration to a quite comprehensive range of situations in which sexuality is important.

There is little in *Discussing Sexuality* that would be new to practitioners who work in the area of sexuality. However, the strength of the book lies not in the originality of the material but in the way the information is organised and presented. The authors have gathered together information that I have not seen brought together elsewhere and organised it in a way that makes

it easily absorbed. I would strongly recommend the book to those members of a wide variety of health professions — medicine, psychology, physiotherapy, social work, rehabilitation therapy, etc. — who do not work in settings such as STD clinics where sexuality is a central issue, but who necessarily encounter the need to gain accurate sexual information from some clients. Indeed, I believe this book would be a good investment for any such practitioner who has not had the benefit of specific training in how to discuss sexuality in professional settings. More proactively, I think the principles incorporated in this book could well be included in the undergraduate training of health professionals. Not all of those who are trained to be physiotherapists or doctors or psychologists or suchlike will end up in jobs that require them to be able to take a good sexual history, but none would be harmed, either professionally or personally, by being able to do so.

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Images of Trauma. David Healey. London: Faber and Faber. 1993. xvii + 270. \$45.

David Healey is a psychiatrist and head of the Department of Psychological Medicine at the University of Wales. He was born and educated in Dublin and his writing style has the easy flow of the Irish. The style and procedure of referencing gives the impression of reading a history book rather than a scientific discussion. In fact, it is a most interesting account of the history of psychological medicine.

The book traces the influence of discoveries in other disciplines on the concepts and theories in psychology and psychiatry with particular reference to the evolution of post-traumatic stress disorder. Dr Healey maps the changes in acceptance of psychoanalysis and behaviourism with the concomitant implications of these schools of thought for treatment.

The first half of the book sets out in some detail the evolution of the idea that psychological disorder may be a result of an environmental stressor on a previously healthy, well-adjusted individual. This was formalised in 1980 when the category of PTSD was created in the DSM-III and was the first time that it was accepted that a psychological problem could be precipitated entirely by external events. This acknowledgment had enormous legal and financial consequences in terms of compensation payments and litigation. It has also returned us to the point in 1895 when Freud claimed that hysteria was caused by childhood seduction — a connection obscured for most of this century after Freud retracted his statements in favour of his theories of infantile sexual fantasy.

The second half of the book examines the implications of the diagnosis of PTSD for the traditional views of mental illness and for treatment. In particular, it looks at the concepts of repression, dissociation, consciousness, rhythmicity, origins of psychotherapy, hypnosis, transference, imagery, resistance, competence, and family therapy.

The final chapter summarises much of the book and examines in some detail the genesis and significance of the neuroses. It looks at the legacy of Descartes' distinction of spiritual mind and material brain and particularly the idea of neurosis being caused by genetically determined degeneracy — an idea which led to an emphasis on biological treatment of neuroses and to pharmaceutical companies having a major influence on treatment regimes and research. Dr Healey ends with a sceptical glance into the future.

This is a most interesting book for those who wish to have a clearer idea of the history of anxiety disorders and treatment. It is not a practical “how to do therapy” book.

ROBBIE CORBETT