

## **HYPNOBEHAVIOURAL TREATMENT FOR BULIMIA NERVOSA: A TREATMENT MANUAL**

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Hypnobeavioural treatment (HBT) is one form of treatment for bulimia nervosa for which there has been some empirical support. This paper describes the manual for hypnobeavioural treatment (HBT) and future applications and developments for HBT are discussed.

The dieting disorder, bulimia nervosa, affects between 1% and 2% of adolescent and young adult women and of those effected only 1 in 10 are males. The clinical features of the disorder are now well documented and in the last 14 years since the disorder was formally recognised in DSM-III (American Psychiatric Association, 1980), several different treatment modalities have been advocated which have included a variety of psychological and pharmacological approaches. Among treatment approaches, little attention has been paid to the use of hypnosis, although the early findings from single cases and small sample descriptions have indicated that hypnosis has a role in the treatment of bulimia nervosa and more recent evidence has indicated that bulimia nervosa sufferers are highly hypnotisable and that this ability should enhance their response to hypnosis in treatment (Griffiths & Channon-Little, 1993).

This paper is concerned with an approach to the treatment of bulimia nervosa which includes behavioural and hypnotic techniques and is referred to as hypnobeavioural treatment (HBT). The approach includes behavioural techniques previously described for cognitive behavioural treatment (CBT; Fairburn, 1985) and the hypnotic techniques and suggestions have been designed to suit patients with all levels of hypnotisability.

### **RATIONALE OF THE HYPNOBEHAVIOURAL TREATMENT**

The rationale of the hypnobeavioural approach is based on the behavioural principle that antecedent events such as dieting lead to consequences of events,

such as the binge-purge cycle. HBT is a multifaceted treatment which involves a concerted effort to change maladaptive eating behaviours using behavioural techniques. The hypnotic techniques are used largely to reinforce, encourage, and maintain behavioural change. A model for the approach can be found in Table 1.

## **EMPIRICAL SUPPORT FOR HYPNOBEHAVIOURAL TREATMENT**

Findings from both uncontrolled and controlled treatment outcome studies have suggested that the symptoms of bulimia nervosa can be significantly reduced with HBT. For example, Griffiths (1989) conducted an uncontrolled trial of HBT with a small sample of 12 bulimic women and found that they responded favourably to the treatment with significantly decreased episodes of bingeing and vomiting, as well as reduced levels of depression which were maintained at nine-month follow-up with HBT.

A recent controlled investigation indicated that HBT was equally as effective as CBT. Griffiths, Hadzi-Pavlovic, and Channon-Little (1994) compared HBT and CBT with a waiting list control group, using a sample of 78 bulimia nervosa patients. The two treatments were delivered individually and matched for duration (eight weeks) and number of sessions. Immediate post-treatment outcomes indicated significant differences between the control group and the two treatments in reductions in bulimic behaviours and related eating pathology and the effects of both treatments were equal. After the control group subjects were streamed into treatment, there were no differences between the treatments in abstinence from bingeing and purging and abstinence for both treatments increased over time. Also, there were no differences between the treatments in reductions in bulimic behaviours and eating pathology or on measures of additional psychopathology such as depression, self-esteem, general health and psychiatric functioning, and social functioning.

Although HBT has been briefly described by Griffiths (1989), there are no previously published details of the treatment. The following HBT guidelines are described to enable researchers or clinicians to replicate the treatment.

## **DESCRIPTION OF THE TREATMENT**

The HBT program runs over an eight-week period. It is divided into two stages, each of four weeks duration.

### **TREATMENT STRUCTURE**

#### **STAGE 1**

The major treatment component of this four-week treatment stage is behaviour modification. An educational element and nutritional guidance are also included. This stage of treatment follows closely the treatment manual recommendations suggested by Fairburn (1985). The aim of this stage is to educate the patient

**Table 1** Hypnobeavioural Model for Bulimia Nervosa

Binge antecedents	Binge consequences	Antecedent and consequence control
Dieting	→ Physical and psychological side effects	<i>Behaviour modification</i> with self-monitoring as the prime behavioural technique
Weight and food preoccupation	→ Excessive weighing or avoidance of weighing	• Education about the disorder — causes, development and consequences
Sociocultural pressures — pursuit of thinness, fitness and exercise	↔ Pursuit of thinness, fitness or excessive exercise	• Disrupting the diet/ binge/ purge cycle
Socialising difficulties — lack of assertiveness, low self-esteem, avoidance of social situations	↔ Avoidance of social situations	• Establishing a regular eating pattern
Stress — tension, anxiety, depression, mood changes	↔ Tension, anxiety, depression and mood changes	• Devising alternative strategies to increase self-control at problem times when tempted to binge or purge
Purge antecedents	Purge consequences	<i>Positive suggestions in hypnosis</i> to enhance behavioural control
Morbid fear of weight gain	↔ Guilt and self-loathing, increased resolve to diet	<i>Practise of self-hypnosis</i> to reinforce changes in behaviour
Guilt about overeating	↔ ] → ] →	

*Note.* (↔) Some consequences of bingeing are also antecedents.

about the disorder and to help the patient disrupt the diet/binge/purge cycle by establishing normal eating habits.

The more specific *aims* of this stage of treatment are:

1. to establish a satisfactory therapeutic relationship with the patient;
2. to disrupt the diet/binge/purge cycle;
3. to provide information as to the causes of the disorder, how it develops and the side effects of the disorder;
4. to give advice and hints on establishing a pattern of regular meals and snacks;
5. to determine present dietary habits and modify towards a normal eating plan; and
6. to offer suggestions for dealing with the precipitants of the diet/binge/purge cycle.

Three interviews are necessary during this stage, two with the therapist and one with the dietitian. The interviews with the therapist are a week apart and the interview with the dietitian occurs within that week.

## **INTERVIEW 1**

This session generally takes one and a half hours. The patient is provided with the following information:

### **Treatment Structure Explanation**

Treatment lasts eight weeks, during which there are seven appointments. Stage One consists of three interviews during the four weeks: Stage Two consists of four appointments at weekly intervals. Apart from the first and third interviews, the remaining interviews extend over an hour. Patients should be followed up at six weeks, three or six months and nine months after treatment.

### **Treatment Content**

The initial aim of treatment is to educate the patient about the disorder and to assist the patient to regain control over eating. It is explained to the patient that hypnosis is used primarily to reinforce self-control, which is established gradually throughout treatment. With regular follow-ups, changes made in treatment can be enhanced and monitored. As it is a short treatment program it is emphasised that changes are likely to continue after the program has formally terminated.

### **Likely Outcome**

To facilitate treatment response and clarify expectations about treatment, I mention that most patients overcome their eating problem and maintain their improvements as a result of the program and emphasise that improvements are likely to continue after the program is completed. It is explained that the

patient may be vulnerable at times of stress and be more sensitive than the average person about eating and food and its relationship to weight and shape.

### **Need for Commitment and Consequences of Dropping out of Treatment**

The necessity of giving the program priority in the patient's life is discussed. Effort to complete homework and embracing the need to change eating habits are emphasised. I mention that the treatment program, although short, has all the essential components to help overcome the disorder and stress and that, although the therapist can advise, educate, encourage, and offer support, ultimately the patient has to try to get the most from the treatment to help herself. The importance of attending all treatment sessions is stressed and also, if she drops out of treatment she will be phoned by the therapist to discuss her reasons.

### **Information on Bulimia Nervosa, Programs for Recovery and Food and Nutrition**

As well as being given a relevant reading list, the recommended books are discussed with patients. Many have already read extensively about their disorder and decline further reading material on the matter, whereas others may not have read anything about their disorder and may find further reading useful. Patients reading inappropriate books, for example, on dieting, are discouraged from doing so. As part of education about her problem and what to do about it, patients are given information in the form of a four-page handout called *Information on Bulimia Nervosa*. Each patient is issued with a booklet on food and nutrition published by the New South Wales Department of Health. As a section in the booklet on weight control diets is inappropriate for dieting-disordered patients to read, this section is crossed out prior to giving the booklet to patients. Any similar booklet on food and nutrition should be thoroughly examined as to its appropriateness for dieting-disordered individuals prior to its distribution.

The following information is given to each patient verbally:

*Causes of bulimia nervosa* Societal pressure, such as the effect of the media, the pressures on women to pursue thinness, emphasis on fitness and exercise and the prejudice against obesity in the community is discussed with the patient. To illustrate the cultural ideal of thinness, special reference is made to the study of the shapes of *Playboy* centrefolds and Miss America Pageant queens over a 20-year period (Garner, Garfinkel, Schwartz, & Thompson, 1980).

*Dieting and the physiological effects of starvation which are consequences of this* The fact that bulimia often starts when a woman diets to avoid sweet things or carbohydrates, which in turn make her hungry and leads to food cravings and possible over-eating, is discussed with patients.

*The development of the diet/binge/purge cycle* The following description of the development of the cycle is given:

1. that severe restrictive dieting causes bingeing;
2. after bingeing, patients may feel overweight and fear becoming fat, which leads to vomiting/purging; and
3. This then leads to feelings of guilt and depression, which can lead people to diet and therefore start the process again.

*The physical and psychological side effects of the diet/binge/purge cycle* Patients should then be informed that these consequences of their disorder will resolve as their eating habits improve. The following information can be given on consequences. Bingeing can produce acute dilation of the stomach, menstrual disturbance, salivary gland enlargement (especially the parotid). Self-induced vomiting and purgative abuse result in metabolic disturbance (especially hypokalaemia), cardiac arrhythmias, renal damage, tetany, peripheral parasthesia, epileptic seizures, and dehydration. Self-induced vomiting on its own can cause steatorrhoea (fat in faeces), finger clubbing, and rebound water retention when laxatives are ceased.

The most frequently reported psychological consequences of the disorder are depression, guilt, and anxiety about binge/purge behaviours. Feelings of anger and distrust with oneself at the loss of control undermines feelings of self-worth. Social anxiety can contribute to avoidance of social situations in which the patient's eating habits may be exposed to others. Attitudes toward food, eating, and weight are directly affected by the patient's dysfunctional thoughts, beliefs, and values.

### **Advice on Establishing Normal Eating Habits**

Patients are first advised to cease dieting and try to establish normal eating habits again. They are given a handout called *Normalising Eating Habits* which is considered crucial to this treatment stage and therefore thoroughly discussed with each patient. This handout can be found in Appendix A. Through discussion, the handout is tailored to the patient's eating patterns and lifestyle and suggested changes to the patient's eating patterns are discussed. The handout was compiled from Fairburn's (1985) advice on prescribing a pattern of regular eating.

### **Additional Advice Given**

*Body weight* Patients are shown correct weight ratios, from the Australian Nutrition Foundation Inc. Chart. They are shown the appropriate weight to achieve which lies within the healthy range for their height. They are told to expect weight fluctuations which may occur on a day-to-day basis and also as a result of the program and advised that it is best to postpone deciding on a specific weight until eating habits are normal, since only then will they know how much can be eaten to maintain a stable weight. Only after this

has occurred should they consider moderate dietary restriction (under supervision) if still dissatisfied with their weight.

*Vomiting, laxatives, and diuretics* Patients are advised against the continued use of self-induced vomiting, laxatives, and diuretics or any other means of maladaptive weight control they might be using. They are advised to choose meals and snacks which they are not prepared to vomit and, if tempted to vomit, to engage in a distracting activity for a short time to prevent vomiting. Patients are asked to cease taking laxatives and diuretics and to discard supplies from this point; the side effects of continued use of these agents are reiterated.

*Exercise* A moderate amount of exercise is encouraged because of its psychological benefits. The use of exercise to control weight is strongly discouraged.

*Socialising* To enhance self-control over eating, patients are encouraged to eat with other people in a variety of social situations. "Forbidden" foods are included or gradually introduced in the overall meal plan. It is suggested, when socialising, to focus on the conversation rather than concentrate on the food.

*Changes in mood* If patients are prone to depression, it is explained that this loss of self-esteem is due to years of bingeing and purging. They are advised that the depression resolves itself as they gain control over bingeing and purging and that depression, anxiety, and tension can result from trying to deal with day-to-day stresses and situations. They are encouraged to develop alternative ways of coping with stress, such as relaxation training or learning a meditative form of relaxation.

*Weight measurement* Patients are asked to weigh themselves weekly. For patients who either avoid weighing or weigh themselves daily, it is difficult for them to adjust. It is essential that they do it, however, as their eating habits change during treatment and their fear of becoming fat can be highlighted.

### **Instructions in Self-Monitoring**

Patients are given a written handout of self-monitoring instructions of their eating habits and the frequency of their bingeing and purging episodes. The self-monitoring sheets are clearly set out for each patient to complete and the type of monitoring sheet used can be found in Appendix B — *Food and Behaviour Diary*. The instructions and sheets are also thoroughly discussed with each patient. Patients are asked to record their weight on the self-monitoring sheets each time they weigh themselves.

The rationale for monitoring is explained, in that it helps the patient and therapist analyse the patient's eating habits and the circumstances under which problems arise. As this is a major treatment component it is emphasised that

it is important for them to confront their eating problem by recording in this way in order to improve their eating habits.

Patients are given self-monitoring sheets for the four weeks of the self-monitoring phase of the treatment. For their appointment with the dietitian, they are asked to show her the self-monitored sheets they have completed up until that time. This is to give the dietitian some indication of the patient's eating habits. For their next appointment with the therapist, it is requested that the first week's self-monitored sheets are returned.

### **Dietitian**

An appointment is made for the patient to see the dietitian at the end of the first interview. The dietitian's appointment is arranged to take place prior to the next treatment session with the therapist.

### **INTERVIEW 2**

This interview, which generally lasts for one hour, is conducted by the dietitian and has specific goals. After she peruses and reviews the self-monitoring sheets for the previous week she interviews the patient and obtains a food history. She also explains the concept of regular meals and snacks and the normalisation of eating. She then outlines a meal plan based on the patient's food history, food preferences, dietary guidelines and lifestyle. The meal plan is written in a structured format and tailored to the patient's individual needs and given to the patient. There is no further contact with the dietitian after this interview.

### **INTERVIEW 3**

This interview is conducted by the therapist who reviews the patient's self-monitoring sheets completed since the previous appointment. The monitoring sheets for each day are discussed in depth and the therapist checks to see that the self-monitoring is being carried out correctly. This interview takes one to one and a half hours.

Episodes of excessive eating or bingeing are discussed and suggestions such as stress management and relaxation training are made for handling the problem times which lead to bingeing. For example, the patient is encouraged to keep a list of activities to distract herself when she feels tempted to binge. She is praised for all efforts and improvements made throughout treatment.

The patient's cooperation with adherence to the meal plan as well as recommendations and suggestions made by the dietitian are discussed fully. Patients are referred to the handout on *Normalising Eating Habits* each time they feel they need a reminder as to what to do. If the patient needs to go through the handout again to reinforce new behaviour patterns the therapist makes herself available to do this and to answer any questions. The patient is encouraged to understand the importance of reducing the frequency of binge/purge episodes and to increase the number of binge- and purge-free days.



Achieving success in reducing binge frequency gradually rather than opting for perfection straight away is discussed with the patient, together with the need to change old eating behaviour patterns which the patient may fear changing. It is pointed out that progress generally follows a step-like pattern and that it is important that they not expect too much of themselves too soon. The bingeing symptom which may have filled a need in their life and had certain benefits for them in the past, is explored and strategies for binge avoidance are discussed.

Patients are reminded to post back weekly to the therapist the next two weeks of self-monitoring sheets. Stamped addressed envelopes are provided for this purpose. They are informed that for the next three weeks there will be no appointment with the therapist. The reasons for this are explained:

1. to enable them to work on the suggestions and advice given in the previous two sessions;
2. to allow them time to begin adhering to the meal plan prescribed by the dietitian; and
3. to allow them time to gradually change their eating habits and to follow a more normal or regular pattern.

They are informed that the therapist will be observing the improvements made in their eating habits by studying the self-monitoring sheets posted back, even though no actual appointment is made for the patient to be seen. Patients are also informed that self-monitoring sheets for the third weeks are to be brought with them to their next interview which commences the second stage of the treatment. It is mentioned that the second stage of treatment will comprise four sessions of hypnosis which will assist them in reinforcing their progress during the previous weeks.

Stage Two of the treatment program starts at their next appointment.

## **STAGE 2**

Hypnosis is introduced in this stage. Weekly sessions of hypnosis are conducted using positive suggestions for behavioural control over four weeks. The specific aims of this stage are:

1. to maintain a regular pattern of eating and changes in eating behaviours;
2. to provide positive suggestions in hypnosis which have specific aims;
3. to provide strategies for future difficulties which may precipitate bingeing episodes; and
4. to explain differences between "lapses" and "relapses" and how to deal with them.

## **INTERVIEWS 4 TO 7**

Prior to commencing hypnosis in Interview 4, all self-monitoring sheets for the previous treatment phase are reviewed. The frequency of bingeing

and purging episodes over that time is discussed with the patient and she is encouraged strongly to reduce the frequency of these behaviours. Attention is given to the factors which might be maintaining the bingeing and purging. Strategies for dealing with problem times, and the importance of maintaining or continuing as their goal the establishment of a regular pattern of eating habits, are discussed again.

The meal plan prescribed by the dietitian is discussed to ensure that the patient is complying with the dietitian's recommendations. For the next four weeks they are asked to keep a record of the frequency of binge/purge episodes on a daily basis. The frequency of binge/purge episodes is reviewed at the start of each interview. Patients are told that they do not have to continue self-monitoring during this treatment stage but if they feel that it would be helpful to continue monitoring for a little longer they should do so. They are informed that suggestions in hypnosis will be given to them by the therapist in each of the next four interviews.

*Hypnosis* Treatment in hypnosis is commenced and continues for approximately 20 to 30 minutes, although each treatment interview takes approximately one hour. The procedure for the hypnosis used in each interview is as follows: (a) induction using eye closure and progressive relaxation: The induction procedure of the SHCS: Adult (Morgan & Hilgard, 1979) is followed; (b) deepening using counting from 1 to 20: The deepening procedure of the SHCS: Adult is used; (c) positive suggestions for behavioural control. The initial suggestions follow the ego-strengthening suggestions used by Stanton (1975). The script for the hypnotic suggestions for behavioural control is provided in Appendix C; and (d) hypnosis is terminated by counting backwards from 20 to 1.

The aims of the positive suggestions in hypnosis are:

1. to enhance self-control over bingeing and purging;
2. to reinforce changes in eating habits;
3. to reinforce advice on establishing normal eating habits given in Stage 1;
4. to increase control over problem situations which precipitate bingeing and purging;
5. to enhance self-esteem and relaxation; and
6. to encourage increasing participation in social situations which may have previously been avoided.

Hypnotic suggestions are modified to the patient's needs, to take into account the reduction in symptomatology from session to session. If patients wish to use the hypnosis for relaxation purposes they are encouraged to do so. They are also instructed in self-hypnosis so that they can practise the procedure and positive suggestions at home. Directions for its use are given in the second hypnosis session while the patient is still in hypnosis and it is suggested that

she is capable of achieving similar effects at home alone between sessions, by following the identical steps carried out in the session. The post-hypnotic suggestion that self-hypnosis will terminate spontaneously, should the need arise such as alerting herself to some danger (e.g., the smell of something burning on the stove), is also given. In some cases it is necessary to make a tape of the hypnosis procedure for the patient to use at home.

*Termination, follow-up arrangements, maintenance of progress and preparation for future difficulties* In interview 6, the therapist reminds the patient that the end of treatment is near and follow-up appointments will be made, but that their progress is likely to continue following treatment. They are encouraged to discuss their feelings about ending treatment.

If patients request moderate weight reduction once eating habits are normal, or if they request changes in eating habits other than those recommended in the program, it is stressed that this will be carried out only with the strictest supervision by the dietitian or therapist after the program is completed.

Patients are encouraged to practise self-hypnosis after treatment ends and to continue to adhere to a normal meal plan and a regular pattern of eating. The therapist reminds the patient about experiencing difficulties in the future, particularly at times of stress. In order to prepare for this, a plan for use at times the patient senses her eating is becoming a problem, is constructed.

The patient is warned about occasional setbacks, but is told that she will cope successfully with these as she did with treatment. She is told not to be disheartened by the occasional slip-up and to regard these as "lapses" and not "relapses" into her old behaviours. She is told to consider why the lapse may have occurred so as to prevent it from occurring in the future. She is reminded about the importance of attending follow-up interviews which are then arranged.

## **FUTURE APPLICATIONS AND DEVELOPMENTS OF HYPOBEHAVIOURAL TREATMENT**

To this point, HBT has not been used with patients with anorexia nervosa, where the literature is still limited to descriptions of hypnotic techniques, single cases, and small sample sizes. Certainly behavioural techniques on their own have been shown to be effective in the treatment of anorexia nervosa. However, the need for weight restoration in anorexia nervosa alters the course and goals of hypnosis for this disorder compared to bulimia nervosa, since the poor cognitive capabilities or lack of concentration characteristic of the side effects of starvation or low weight in anorexia must be corrected before hypnosis can be effectively used. This does not mean that hypnotic techniques are not valuable for this disorder. Indeed hypnotic techniques have been used with anorexic patients since Pierre Janet first saw the potential of hypnosis in anorexic treatment in 1907. Yet despite this there has been no attempt to

evaluate the effectiveness of hypnotic techniques for the condition. The time has come for renewed interest in evaluation, particularly when there are recent descriptions of innovative techniques for anorexia nervosa (Lynn, Rhue, Kvaal, & Maré, 1993). Further, the combination of behavioural techniques and hypnotic imagery tailored to the individual's level of hypnotisability would provide a useful treatment approach for either anorexia or bulimia nervosa in view of recent findings from Griffiths, Channon-Little, and Hadzi-Pavlovic (in press) that there was no association between hypnotisability and outcome in HBT when hypnotic suggestions were not tailored to the individual's hypnotic capabilities.

HBT lends itself to application in the group setting, particularly where professional resources are limited and where it is necessary to deal with large numbers of referrals. Adapting the individual HBT program for the group situation would not be difficult and there are obvious advantages to the patient in participating in a group, such as sharing with others who have similar problems and counteracting feelings of "aloneness" as well as learning the principles and techniques necessary to overcome bulimia nervosa. The behavioural techniques could readily be applied and as the hypnotic suggestions are suitable for all levels of hypnotisability, very few modifications would be necessary for group sessions. Indeed, even though other treatments such as CBT were designed to be used individually, recent controlled studies (e.g., Wolf & Crowther, 1992) have shown that CBT can be effectively adapted to use in groups. Similarly, a controlled evaluation of individual versus group HBT with bulimia nervosa needs to be conducted.

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## **APPENDIX A**

### **NORMALISING EATING HABITS \***

The main thing in overcoming bulimia nervosa is to change the diet/binge/purge cycle. By eating normal well-balanced meals each day, fewer calories will be consumed.

Eating needs to be restricted to three planned meals each day, plus two to three planned snacks. There should rarely be more than a three-hour interval between eating times and you should always know when you are due to eat next. This eating pattern should take precedence over other activities, irrespective of the circumstances or appetite — you should not skip any meals or snacks. Conversely, however, between these times, you should do your utmost to refrain from eating.

### **HINTS ON WHAT TO DO**

1. Stop dieting. Give yourself permission to eat. Legalise all food, allow yourself the food YOU want, not what you think you SHOULD or SHOULD NOT eat.
2. Normal meals should be tailored to your individual needs and modified to accommodate weekends, when your routine varies.
3. If your daily routine is varied, then devise an eating plan to suit each day. Plan your meals as much as possible, even if your day is unpredictable.
4. Change your eating habits in gradual stages. Try eating breakfast and lunches first, then include dinner and planned snacks to include the whole day.
5. Adopt a varied diet and do not count calories.
6. You should eat “average size” proportions. Do not continue eating when you feel bloated or too full in the stomach. Sensations of appetite, hunger, and fullness are likely to be disturbed and, in the meantime, they should not be used to determine when you stop or start eating.
7. Eat slowly and enjoy your food. Enjoy tasting food as would a gourmet.
8. Try to gradually include “forbidden” food, for example, cakes and sweets, so that you do not feel deprived of the things you may like to eat.
9. If you are troubled by feelings of fullness after the small amounts of food you eat, it is best to wear loose clothes, particularly at mealtimes.

\*Handout given to patient in the first treatment session.



## APPENDIX C

### SCRIPT FOR SUGGESTIONS GIVEN IN HYPNOSIS

Your mind has now become extremely sensitive and receptive to the suggestions I am to give you and, because they relate to changing your eating habits and are ones you want me to give you, they will be absorbed very deeply into your subconscious mind. Tell yourself that everything I suggest will be indelibly fixed in your mind so that the effect of these suggestions will be irresistible, completely irresistible. They will help you continuously, day and night, wherever you are, always powerfully working for your benefit so that you will be completely confident that everything I say will happen as I say it will happen.

As the days pass, you are going to have self-control over your bingeing and purging. You are aware of the physical and the psychological side effects and you will find that the mere knowledge of these will help to 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 plus two to three planned snacks each day. You will be able to allow no more than three-hour intervals between eating times and you will always know when you are due to eat next. This eating pattern should take precedence over other activities, irrespective of the circumstances or your appetite. You should not skip any meals or snacks. Conversely, between meals, you should do your utmost to refrain from eating.

Planning of meals should occur as much as possible and try to adopt a varied meal plan. Do not count calories. Always eat average sized portions and do not continue eating when you feel full. As has already been pointed out to you, sensations of appetite, hunger and fullness are likely to be disturbed but these will get better and better as your eating habits improve. As your eating habits are improving gradually, you remember your goal is to plan your meals as well as plan your day to accommodate these meals. Remember to wear loose clothes at mealtimes if you are troubled after eating small amounts of foods.

You will try more and more to choose meals and snacks which you are prepared not to purge. If you feel tempted to purge after a particular meal or snack, you will engage in a distracting activity for an hour or so to prevent you from the purging activity. If you are still taking laxatives or diuretics, you will cease to do so and discard your supplies from now on.

You will find an increasing tendency not to avoid social situations but rather you will be able to eat foods which perhaps you would have normally avoided, but you will eat these foods in normal quantities and thus, in doing so, will be able to stabilise your weight. You will find that you will enjoy social situations as well as enjoy your self-control over bingeing and purging.

As a result of your progress, you will also find that problems or situations which triggered your bingeing and purging will lose their ability to do so. Should you at any time feel tense or anxious, you can always calm your mind and relax your body by taking five deep breaths and as you breathe out, feel yourself letting go of the tension, unwinding and just letting the calmness and relaxation flow through all your mind and body.



## **THE USE OF HYPNOSIS IN THE TREATMENT OF CHRONIC OSTEOARTHRITIC PAIN: A CASE STUDY**

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This case study describes the use of hypnotherapy with a 54-year-old mother of three adult children, for alleviation of persistent pain from generalised osteoarthritis. An earlier stomach ulcer condition, a hysterectomy, and a fractured pelvis as the result of an accident were previous illnesses which had been resolved with medical treatment, and handled well by the client. However, a history of occupationally induced repetitive strain injury (RSI) and, later, the osteoarthritis had resulted in the client suffering long periods of confusing and demoralising pain.

During the seven consultations conducted up to the time of writing this case history, hypnosis was successfully used to assist the client in managing the osteoarthritic pain.

Jill was a 54-year-old mother of three, who self-referred two weeks prior to the commencement of consultations in June 1993. The necessary referral was obtained from her general practitioner, who was pleased with the intention to use psychotherapy, and hypnosis in particular, and very interested in the outcome. She also confirmed that Jill's previous ulcer condition obviated the use of anti-inflammatory medication and that, as a consequence, the strategies for pain management were now very limited.

### **HISTORY OF PRESENTING ILLNESS**

Jill's chronic osteoarthritic pain began to emerge following a motorbike accident two years prior to my work with her (see Medical History below). Shortly after the accident she began suffering from increasingly persistent pain in ankle, knee, finger and wrist joints, elbows, and neck. The pain was a particular problem on awakening, and physically "getting moving" to start the day had been difficult. In addition to being unable to take anti-inflammatory medication, Jill disliked taking pain-killers, or "being dependent" on drugs of any sort. She had therefore been without any drug treatment for the arthritis.

The diagnosis of osteoarthritis by a specialist rheumatologist in December 1992 prompted a response from that practitioner that Jill "would just have to live with the pain." This statement was not acceptable to her, and she was keen to explore avenues which might offer relief. She had understood hypnosis to be one of the options available.

The pain had hampered the many physical activities Jill enjoyed. Bushwalking and gardening were great interests, and the degree of relative inflexibility, immobility, and pain caused by the arthritis had frustrated her a great deal. She claimed to have made no concessions to the illness in carrying out her domestic responsibilities, and she had continued with her interests as much as possible. When she was "feeling low" for any other reason, Jill found the pain from the arthritis seemed worse, to "hurt more," to be "a bigger burden." Her family were sympathetic about her condition, and aware of the determination with which she had "refused to let it beat her."

Jill commented that, compared with the RSI, from which she had suffered some years before, her arthritis "at least showed up on an X-ray!"

She demonstrated a strong sense of responsibility for management of her arthritis and much of the frustration she described was couched in wry terms. The relationship expressed between "feeling low" and the accompanying exacerbation of dis-ease from the arthritis, was framed by Jill as simply further evidence of her need to control the pain, rather than having it control her.

## **PAST MEDICAL HISTORY**

Jill reported no serious illnesses in childhood and early adulthood. Her three pregnancies had been normal and resulted in normal deliveries.

In 1981 she began experiencing pain, particularly in the wrists, shoulders, and neck. Initial treatment was with physiotherapy and acupuncture. Four years after the onset of symptoms, RSI was diagnosed, leading to a Worker's Compensation payment of \$17,000 and the cessation of Jill's employment at her employer's request. He had felt she could no longer keep up with the demands of the job. Jill was very unhappy about leaving work. Though realising her condition made her less efficient, she wished for more flexibility in her employer's attitudes and arrangement of work responsibilities. A cause of particular distress was the common community attitude of the time, endorsed by those contesting her case, that RSI was an imaginary illness. After Jill left work, the RSI ceased to be a problem unless she engaged in repetitive fine motor activities such as folding letters. As these activities were part of Jill's Girl Guide activities, they were now avoidable.

As a prolapse of the uterus had resulted from Jill's three pregnancies, a hysterectomy was performed in 1986. Shortly after that time she was diagnosed with duodenal ulcers. These were effectively treated with large doses of antibiotics. Because of this history, she had been unable to take anti-inflammatory drugs for her arthritis and she remained very careful with her diet. She had smoked about ten cigarettes a day for most of her adult life.

In early 1991, Jill commenced hormone replacement therapy (HRT) for hot flushes and emotional lability associated with menopause. She elected to discontinue this after a nearly a year and the symptoms did not return.

In October 1991, Jill suffered one major and three minor fractures of the pelvis when she collided with a car while riding her motorbike. With several days hospitalisation, followed by appropriate rest and gradually increased exercise, recovery from these injuries was apparently complete. Shortly after this episode, the symptoms of osteoarthritis began to emerge.

There was no personal or family history of psychiatric illness.

## **FAMILY HISTORY**

As the second of three children, with a brother nearly two years her senior, and a sister nine years younger than her, Jill recalled a very happy home life as she was growing up. The relationship between the parents was described as affectionate and stable and affection for the children from both was strong and consistent. The one sore point for Jill was the favouritism shown to the youngest sister, the "baby of the family," who Jill felt grew up with little sense of responsibility. The family was working-class, and Jill was always aware of the need for hard work in order to get ahead in life.

Her father's death in the late 1960s from coronary disease was more of an emotional shock to her than the death of her mother in the mid-1970s, after she was struck by a car. Her mother's death, while sudden, followed a history of strokes. Jill's brother, to whom she was particularly attached, died suddenly at age 43 of a heart attack, leaving a wife and two children, now teenagers. Jill was fond of, and stayed in contact with his family.

Jill progressed normally through the milestones of childhood and adolescence. She described her childhood as "happy and normal" and her years of schooling were remembered with pleasure. At 15, she started work and maintained night-school studies in engineering drafting. Her first job was with an engineering firm and, after three years, she moved to a job with a prestigious firm of architects. She left work, aged 24, when pregnant with her first child. Between these jobs, in her late teens, she worked for several months as a jillaroo in northern Queensland. This experience was a "great adventure." Jill returned to work in plan printing and the preparation of contracts in 1973, when her youngest child started school. She left her last job in the mid-'80s, after being diagnosed with RSI. She had not worked since that time.

Jill's teenage social life was active, with a number of male friends. She enjoyed the fun, without developing any real involvement. At 18 she met her husband when she joined the archery club of which he was a member. Their early relationship was happy, with shared interests.

The couple married when Jill was 21, and her husband 27. He turned 60 in 1993, and had been retired for five years from the statutory authority which had been his main employer in clerical and paymaster positions, receiving

a reasonable superannuation sum. There were three children in the family. The eldest daughter, aged 29, was divorced, with two boys from that marriage. She was currently living in a happy de facto relationship, as was the second daughter, who, at 27, had recently given birth to her first child. This birth had delighted the whole family. The third child, a son, was 25, single, and living at home with his parents. Jill felt great affection for her three children and grandchildren, and had frequent contact with them all.

Jill's time was occupied with domestic duties, gardening, friends, the Guide movement, her children and grandchildren, and riding her motorbike, often on weekend group outings in the company of her husband. Her training in martial arts had made her a woman who did not easily feel physical fear or intimidation.

## **MENTAL STATE EXAMINATION**

### **Appearance and Behaviour**

Jill presented as a down-to-earth looking woman, quick to smile, relaxed, and often vivacious in facial expression. Her dress was casual, and she gave the impression of being self-confident and composed. Her active movements and seated posture gave no indication of her arthritic condition, and her manner was warmly courteous and self-assured. She appeared interested in the process of therapy, and keen to give it a real chance of success. Her speech was succinct, often humorous, and pleasantly assertive.

### **Perception, Thinking, Mood, and Insight**

There was no evidence of any abnormalities in these areas. Jill was aware of the stress and frustration which had accompanied her ongoing experiences of pain, and she was hopeful that hypnosis would also help her to control these feelings.

## **DIAGNOSIS, SUMMARY, AND OPINION**

The chronic pain accompanying osteoarthritis was the primary target of therapy, the medical condition having already been diagnosed by a specialist practitioner. There was no pattern of symptoms which would point to depression as a causal factor of Jill's pain and ample medical evidence for its organic origin. The presence of secondary gain was not at this stage an obvious feature of the pain.

It was mentioned earlier that Jill had found when she was "feeling low" the arthritis seemed to "hurt more, to be a bigger burden." Jill's condition therefore fitted into the DSMIII R category 316.00, Psychological Factors Affecting Physical Condition.

I judged hypnotherapy to be an appropriate strategy to help Jill manage her pain. There were no contraindications to its use and Jill matched well the characteristics of a "good candidate" as described by Rose (1993): (a) her pain appeared to be mainly of organic origin, (b) she expressed the belief that hypnosis could be helpful, (c) she indicated willingness to practise self-hypnosis, (d) there appeared real motivation to improve, and (e) she developed good rapport with the therapist.

As with all cases of chronic pain, it was clear that helping Jill with her current pain was a task which was very much dealing with the whole person.

The strong relationship between chronic pain and low self-esteem has been the subject of study by Elton, Burrows, and Stanley (1988) and, in Jill's case, ego-strengthening, competency and control issues also needed to be addressed. Hammond (1990) has said that: "Ego-strengthening is a technique that is indicated for all patients who come to us looking for alleviation of their suffering, regardless of what their symptoms are" (p. 110).

## **TREATMENT PLAN**

I assessed Jill's hypnotisability using the Creative Imagination Scale (Wilson & Barber, 1978) and used gradual muscle relaxation and imagery as the induction method. The relaxation technique of induction was judged to be appropriate for a client who had enjoyed yoga classes some years previously and for whom relaxation would assist with pain reduction. With the long-term goal being a significant reduction in Jill's pain, further sessions were designed with two particular strategies in mind. First, it was intended to make an audio tape of successive sessions for her home use. The tape was to be used between sessions, particularly in the morning, since she had expressed the wish to "get out of bed and leave the pain in the bed behind [her]." Second, Jill would be taught self-hypnosis to further assist self-management of the pain.

Consultations were planned to be at approximately weekly intervals.

## **PROGRESS OF TREATMENT**

### **Session 1**

In the first session the case history was taken.

### **Session 2**

This session commenced with the administering of the Creative Imagination Scale, followed by a brief outline of the therapeutic plan. Jill's overall score on the Scale was 20, at the bottom of the range of medium-high hypnotisability.

### **Session 3**

Trance was induced using a progressive muscle relaxation technique and counting down deepened the trance. Jill's preferred imagery of a garden was

then used, with further deepening as she watched the leaves falling, one by one, from an autumn tree above her. Rose's (1990) red balloon technique helped Jill to "offload" the pain and, on termination of trance, she found that the pain was still present to some extent, but "not as sharp."

#### **Session 4**

Jill began by describing the degree of relief from pain she had experienced for the rest of the evening following the previous session. She had enjoyed having me actually present to help her and doubted if she would be able to achieve such effective relief working only with the tape which we were to make during this session. It was apparent that strong positive transference had occurred and, while Jill needed the necessary time to become confident with and comfortable about working alone, a steady process of taking increasing independence in the practice of the skills needed to be encouraged.

Discussion led to Jill's comment that, while she realised pain was an important warning signal, she would like to "turn down" the degree of pain so it would not be at the forefront of her mind. I described imagery in which she could get a mental picture of lines or wires of communication between her mind (the "controller"), and the particular sites around her body which were causing distress. She would then imagine "turning down the dial" existing along each of these pathways, moving around them one at a time, so that the pain would not continue to have her foremost attention. A similar technique has been described by Hilgard (1988).

A tape was made of this session. At the conclusion, Jill remarked that she was finding the progressive muscle relaxation very effective and easy and that the imagery had been clear and "made sense" to her. She was to use the tape each morning to overcome her most difficult period.

#### **Session 5**

Jill reported she was having a much more restful sleep and was often waking freer of pain and stiffness. The improved sleep she described as "an unexpected bonus" from the therapy. However, she was having some difficulty using the tape at home in the morning, as a busy household got under way for the day. The ensuing frustration was now becoming associated with the time which she had anticipated to be both therapeutic and her own. An emerging issue was the need for Jill to be able to find and guarantee uninterrupted time for herself.

As it was clear that Jill needed to employ strategies which left her calm, a new tape was made in this session. It included the imagery used in the previous session, but was designed to capitalise on two factors — Jill was obviously finding an evening session beneficial, and others in the household would have retired, allowing Jill some predictable quiet time.

The new tape, to be used prior to retiring, included suggestions of restful sleep, with relaxed, comfortable limbs and joints, this sleep to follow easily from whatever few tasks still remained for the evening. Further, that Jill would wake with a degree of freedom from pain and stiffness that would help her to move confidently into her day's activities. Jill was by this time an excellent trance subject.

We agreed that at the next session she would learn self-hypnosis.

### Session 6

In the preceding week, Jill had achieved relaxed and uninterrupted use of the tape, which was leading to more refreshing and comfortable sleep. She reported not only a more comfortable, less disabled awakening but, very importantly, the *anticipation* of improved sleep and pain relief. She described herself as not feeling nearly so much "controlled and upset" by the arthritis and able to increasingly divorce herself from the distress it had been causing. Under hypnosis, Jill was given a cue for self-hypnosis, with the suggestion that, in trance, she would be able to "scan" her joints, "adjust the dials to turn down the pain" and bring herself out of trance, able to continue with her activities. Two short practices of self-hypnosis concluded the consultation.

### Session 7

By the seventh session, Jill had been experiencing more pain. Her cassette recorder had broken down and finding predictable time alone was still proving difficult. However, it was rewarding that Jill was now using self-hypnosis with increasing success to control pain and stiffness, for instance, after a long car ride.

As Jill was finding hypnosis an effective technique for alleviating her pain, it was agreed that the next sessions would also emphasise: (a) exploration of ways of increasing her family's understanding of her therapeutic needs, (b) encouragement of a wider range of assertive techniques for dealing with the firm expression of her own needs, and (c) using hypnosis for ego-strengthening.

The session concluded with ego-strengthening suggestions under hypnosis, a reiteration of Jill's competencies in many areas, and suggestions of her ability to transfer her increasing feelings of confidence and self-esteem to the control of her own time and requirements. In a follow-up phone call to confirm her next appointment, Jill said she was now finding that she was reacting less to other issues in her life which previously had angered or frustrated her. She was feeling rewarded by this and by her increasing objectivity.

## DISCUSSION

It is evident from the above history that Jill had not been free of illness for some 12 years. She described herself as being a positive, active individual

prior to this 12-year history, but that this was proving more difficult to sustain since the onset of osteoarthritis. The continuing physical condition had tended to “wear down” a woman who had given evidence of considerable courage.

The case has raised several interesting issues for discussion.

### **The Patient's Experience of Pain**

The pain literature makes several pertinent points regarding the experience and management of pain. It is the fundamental paradox of pain that it is at once both beneficial and harmful. In chronic pain, the pain symptoms persist beyond the point where they are giving necessary warning signals. The suffering (general annoyance, disturbance, and distress), continues without function. Anxiety, helplessness, depression, increased dependency, and restricted social contact are also common concomitants of pain (Hilgard & Hilgard, 1975; Yapko, 1990).

The attitude of health carers also may have an impact upon the patient's experience of pain. Particularly “unforgivable,” in Rose's (1990) view, is a statement to the patients that “[they'll] just have to learn to live with the pain” (p. 4).

Professional attitudes to the condition of repetitive strain injury (RSI) may have rendered this condition even more psychologically problematic for its sufferers than other conditions involving chronic pain.

Byrne (1992) made the following editorial comment in the *Medical Journal of Australia*: “Seldom can such controversy have raged, and such divergent views been expressed . . . as on this issue . . . many doctors would regard the ‘RSI epidemic’ as a fictitious phenomenon which is best forgotten. The danger with this view is that the baby may be thrown out with the bathwater” (p. 372).

In proposing a neuropathic pathogenesis for RSI, Cohen, Arroya, Champion, and Browne (1992), have cautioned against mere psychogenic hypotheses on the absence of signs of physical disease alone. The demoralising attitude of some professionals toward pain has been described by Melzack and Wall (1988): “Any deviation from the one-to-one psychophysical relationship [between injury and pain], led to suspicions of a psychological abnormality. Generations of patients failed to impress their doctors with their pain” (p. 183).

It is impossible to discuss the nature of pain as experienced by the subject of this case history without observing that, through the years of pain with RSI, then osteoarthritis, Jill had been exposed to many of these experiences. When she was eventually diagnosed as having RSI, she was one of those in the difficult position of feeling that many people (including those opposing her compensation case) did not believe her case was genuine. This is exemplified in her comment about the osteoarthritis: “At least it shows up on an X ray!”

In addition to being in pain, she was asked to leave a job she enjoyed, on the grounds that she could no longer keep up sufficient pace. As a consequence of leaving work, she was without the social contact with colleagues



and the rewards, both financial and personal, of the job. As her compensation payment was dissipated, she became dependent upon her husband. While Jill recovered quite normally, in terms of functioning and pain resolution, from both her hysterectomy and fractured pelvis, her chronic pain had particularly demoralising and frustrating connotations.

### **The use of Hypnosis**

Hypnosis acts on both the sensory and suffering aspects of pain. It is more effective than behavioural psychotherapy alone and is recommended by Elton et al. (1988) as the method of choice in the treatment of chronic pain. For its relaxing qualities alone, hypnosis is an effective technique, as the tension associated with pain may exaggerate pain (Hilgard, 1988). There is evidence, too, that relaxation, consistently practised, increases self-efficacy (Everly, 1990). Self-hypnosis, in particular, is likely to enhance a feeling of control and personal power. The client's own resources are more quickly relied upon, and treatment effects are more generalisable, with the client able to apply the skills to other situations.

### **The Therapeutic Relationship**

Good positive transference was established in the first couple of sessions. Jill was keen to work, and expressed trust in the process. In the early sessions she had indicated that it was important to her to actually have me present with her, rather than using a tape. This seemed reasonable while she gained confidence in using hypnosis.

It was possible that, as a seemingly very independent person, Jill may well be "letting go," and allowing herself to be cared for for the first time in some years. I felt that her independence would be maintained as she became more skilled and confident with handling her pain. Certainly Jill's effective use of self-hypnosis demonstrated a willingness to become increasingly responsible for her pain management.

In retrospect, it may have been beneficial to have introduced self-hypnosis earlier in the process of the therapy.

In conclusion, the prime objective of therapy was to alleviate chronic pain from osteoarthritis. Increasing management of the pain was achieved, with the client confident that, given the necessary conditions for practice of hypnosis, she could continue to control her discomfort. However, at the time of writing up this case history, hypnotherapy was still ongoing. The client's case has continued to prove interesting and challenging.

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## **A SIMPLE HYPNOTICALLY BASED NLP TECHNIQUE USED WITH TWO CLIENTS IN CRIMINAL JUSTICE SETTINGS**

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Much of the language of neuro-linguistic programming (NLP) derives from Ericksonian hypnosis and the techniques utilised in both can be successfully integrated to facilitate effective therapeutic change, particularly in cases where clients have poorer verbal and social skills, or are resistant to behaviour change in therapy. This paper describes the use of NLP and Ericksonian techniques in hypnosis with clients in the criminal justice system.

Clients within the criminal justice system often present a particular challenge for the therapist. They are people who frequently have poor verbal and social skills and reactions to frustration or provocation may be extreme. Many are reluctant to talk openly for a variety of reasons and may have scant patience or motivation to follow detailed behaviour change programs. These people are usually not the "worried well," many have been severely abused, physically and emotionally. In times of conflict, emotions commonly run high with the attendant risks of violence directed against self or others being a realistic possibility.

In times of crisis, rather than battle against hostility and resistance, it is sometimes advantageous to adopt a more subtle approach, which draws on the individual's internal resources. The techniques of neuro-linguistic programming (NLP) can produce good results, with their ability to unobtrusively enhance and strengthen internal representations. Much of the language of NLP is drawn from the hypnotic techniques of Milton Erickson (Bandler & Grinder, 1975; Grinder, DeLozier, & Bandler, 1977), so that careful attention to language patterns by the therapist can result in a powerful intervention. Erickson was the master of the art of using his own meticulous observations of his clients' physiological processes to gain rapport and to lead and pace the individual into a trance state. By providing continuous feedback that was

"artfully vague" (O'Connor & Seymour, 1990), he enabled the person's subconscious mind to attach the most appropriate meanings to his statements and to generate the most resourceful choices and responses.

NLP, by also utilising the principles of meticulous observation, together with explicit modelling and linguistic analysis, developed very specific techniques, based on the knowledge thus derived of how people create and structure their internal experiences.

Where these two conceptual frameworks are very closely related is in the notion that no-one experiences reality directly and totally; rather we experience our interpretations of reality. In other words the "map" of experience is not the territory (Bandler & Grinder, 1975). We deal with the vast amount of sensory information that we receive by the processes of generalisation (simplifying and connecting similarities), deletion (selective awareness of some information and not of other), and distortion (using the mind's creative capacity to generate new alternative forms of information; O'Connor & Seymour, 1990). These are entirely normal processes; however, if they operate in an ineffective or pathological manner, the individual is likely to experience problems which are very difficult to resolve externally or consciously in that the mechanisms that generated them occurred at an unconscious level.

Bearing the foregoing in mind, it can follow that a specific NLP technique, which draws upon the structure of an individual's subjective experience, may be considerably enhanced by the use of Ericksonian language patterns. These can allow that person to attach the most appropriate meanings to the words used, thus leading them to a more effective utilisation of their unconscious resources by reinterpreting or restructuring the deletions, distortions, and generalisations that gave rise to the difficulties occurring in conscious awareness.

One of the simplest and earliest of the NLP techniques is known as "collapsing anchors" (Bandler & Grinder, 1982). Basically, the technique consists of three steps:

1. "Anchoring" (Cameron-Bandler, 1985), an unpleasant feeling or state, usually by means of a touch to the back of the hand, so that repetition of the particular touch reaccesses the experience.
2. Building up and similarly anchoring on the opposite hand a strong resource state.
3. Accessing or "firing" both anchors simultaneously, triggering an integration reaction in the client, which usually lasts for several minutes and is marked by physiological signs such as changes in breathing rate, skin colour, lip size, fine muscle movement and, sometimes, by tears. Simply stated, the basic premise of the technique is that the resource state empowers or ameliorates the state of deficit at an unconscious level, leading to a wider range of conscious behaviour choice. It follows then, that the stronger the resource state, the more effective the intervention is likely to be.

I have consistently found that, using this technique, the language patterns of hypnotic suggestion are effective in enhancing resource states, facilitating

an integrated outcome and installing the expectation that change is taking place and will continue to take place. By keeping language patterns as content-free as possible, the client is able to draw upon his/her own resources, experiences and internal representations, thus minimising the likelihood of resistance to solutions that may be perceived as being imposed from without. Use can be made here of embedded commands, presuppositions, linking, analogue marking, and metaphor (Bandler & Grinder, 1975; Grinder & Bandler, 1981; Grinder et al., 1977), as well as indirect suggestion, distraction and concepts such as the gaining and losing of powers (Erickson, Rossi, & Rossi, 1976; Stanton, 1982).

## CASE STUDIES

### Case 1

The first of the cases reported here is that of a 28-year-old Maori man, charged with assault on a female. A university student with no previous history of psychological disorder or criminal behaviour, he had some months prior to being seen, become involved in an affair with a married woman whom he had met in one of his classes. On realising that she was not taking the relationship seriously, he became depressed and violent, assaulting her on several occasions and harassing her very persistently at home by telephone and by personal visit. Rather than diminishing, his threats of violence became more extreme as police, court, and community agency involvement increased. A remand to a psychiatric facility, release on probation, and attendance at an anger management group brought about no reduction in the intensity of his feelings or his threats towards the complainant.

When seen at the probation office, he presented in an agitated state, describing himself as "obsessed" with the woman complainant, thinking of her incessantly, and "burning" with rage at the way he perceived her to have treated him. Questioning revealed that he was completely familiar with the standard approaches to anger management, dealing with obsessive thinking, and stopping violence. None of these methods, according to him, had any discernible impact, even though he was able to recognise that his feelings were extreme and irrational.

It was suggested to him that he take part in a short exercise to work with his feelings at an emotional and unconscious level, to which he agreed. The basics of the collapse anchors technique were explained to him.

His state of anger and hostility was accessed and anchored on the back of one hand. It was necessary to touch on these feelings only briefly as they were obviously very strong. While doing so, his skin colour rapidly darkened, his facial muscles and lips tightened, his breathing became shallow and rapid, and his eyes became defocused and protruding. In short, he quickly displayed all the signs normally associated with a state of extreme anger.

He was then invited to leave this state for a while and some 20 minutes were spent building up and anchoring a resource state on the opposite hand. Suggestions of inner strength, maturity, and problem solving ability were drawn from his intelligence, academic achievement, sporting prowess and employment, all areas in which he had excelled. Additional links were made to his cultural heritage of tradition, dignity, timelessness, spirituality, and the honour afforded to both self and others, particularly women. He was led towards experiencing all of these qualities in as many internal representation systems as possible — how he saw himself and others, how he felt on the inside, what he heard himself saying about himself and others and so on. Minute nods of his head during this procedure indicated that appropriate rapport and leading were taking place.

After checking that the client agreed that this was indeed a very strong resource state, both the resource and the deficit anchors were accessed together. He was told as this happened that he may experience some strange inner feelings and sensation, but that this was OK and they would pass. Suggestions, again as content-free as possible, were made for five minutes to the effect that he could become aware of new possibilities unfolding, new strengths and abilities developing, and that he may be able to see these continuing far into his future, gently but decisively overcoming any relevant problems.

There followed a period of 10 to 15 minutes, during which he sat virtually immobile, breathing shallowly, with eyes downcast and defocused. This state of trance at this point in the technique is common in the writer's experience and should be allowed to pass uninterrupted. Eventually, with shifts of breathing and eye-blink rate he reoriented to present time and stated that the exercise had given him new perspectives to think about. It was suggested to him that the intervention would not simply stop there, but that a process had begun which would continue over a period of some time.

On his visit the following week, he indicated that the feelings were still present, but were much less intense and were controllable. He reported a continuing reduction of anger and hostility over the next month and completed the remainder of his probation without incident. At 12-month follow-up, he had resumed his university studies, attending some classes at which the victim of his offending was also present, again without incident.

## Case 2

The second case is that of a 30-year-old part Maori man, sentenced to 10 years imprisonment for aggravated robbery. Soon after sentence he began to experience panic attacks during which he would hyperventilate, tremble, sweat profusely, become violently agitated, and fear that he was going to die. These attacks did not respond to treatment efforts, but continued with such frequency that it was feared he would harm himself or others and he was transferred to the special unit for psychologically disturbed inmates at Auckland Prison.

He was seen there at the request of staff within a matter of minutes following a panic attack. It could be seen that his skin colour had a greyish pallor, he was tremulous and tearful. As this man was known to the writer from a previous sentence, rapport was quickly established and he readily agreed to take part in an exercise aimed at resolving his bad feelings.

His feelings of panic were accessed and anchored on the back of a hand. Again, as with Case 1, it was necessary to spend only a brief time doing this as the associated feelings were only too evident.

A state of resourcefulness was built up for him over the next 20 minutes to half an hour, drawing on his past achievements, respect and popularity within the institution, and particularly on his prowess as a league player, at which he had a reputation for absolute fearlessness. It was important for this particular intervention, considering the recency of the panic attack, that all of this man's representational systems actually reflected an increase in feelings of resourcefulness. Thus, as the resource building procedure progressed, his posture improved, his breathing steadied and slowed, his voice lost its tremor and reflected assertion and confidence, and he began to volunteer information indicative of a more robust self-image.

As with the previous case, on the "firing" of both anchors together, there followed a period of some 15 minutes during which he sat immobile in a trance state. During the early part of this state, suggestions were made that he could become aware of the strengths of his past abilities growing steadily through his present difficulties, resolving them and creating new possibilities for the future.

The panic attacks ceased from that day and did not recur during the follow-up period of 12 months. He was moved from the special purposes unit within a week and eventually transferred to another less secure institution.

## DISCUSSION

In these two cases, a basic NLP technique, enhanced by hypnotic language patterns, worked effectively and elegantly to bring about successful outcomes. During recent years there has been an explosion of NLP techniques as reflected in the available training courses and literature. Through all this, we need to keep in mind that the techniques are predicated on a profoundly simple principle: taking a resource to a state of deficit so that healing or change may take place. It must be realised, however, that while the basic idea is indeed simple, the work that must be done to make it effective is by no means as straightforward.

In both the cases reported here, hypnotic language patterns have provided a vital complement to the NLP techniques. For example, in the rapport/resource building phases, the following may be considered as a representative example:



As you sit there listening to me . . . you can start to go back to some of the ways you've coped with problems in the past . . . and as you become aware . . . you can be calmer . . . more relaxed . . . yes . . . that's right . . . and as you feel calmer and stronger . . . you find yourself becoming more aware of how you look when you are like that . . . yourself . . . to others . . . and how you feel inside . . . and as you feel stronger inside you know that means you can handle just about any hassle . . . and that can feel really good . . . doesn't it . . .

Note here that (among other things) pacing of current experience leads to a dissociation and a presupposition that ability is here. This is linked to commands to be calmer and relaxed and feedback given on noting physiological responses. Linkage is then made of calmness to internal feelings and representations and to a complex equivalence that these feelings mean there is an ability to handle a wide range of problems. Further links are then made to feeling good in the present.

As each phase of the resource state continues to be built up in this way in each representational system, it is anchored until a complete resource state is achieved. The advantage here is that the client is guided by language that is largely content-free to draw upon his own internal resources to generate this state, rather than having another person's conceptions imposed from an external source. If this exercise were to be attempted from a "consciousness" or rational perspective, there would likely be disbelief, resistance and "Yes, but . . ." forms of objection. Carried out in the above manner, however, resistance was minimised or eliminated entirely and the remainder of the NLP technique proceeding from this base was consequently more powerful and broad-ranging in its effects.

Similarly, in the integration phase of the interventions the language patterns can be vital in pacing the experience to determine outcome, as for example:

You can feel some quite strange feeling at this time, but that's okay . . . they will pass and they mean that changes are taking place out of your conscious awareness . . . and you can know that these feelings here . . . [increasing positive anchor pressure] . . . are gently but surely spreading . . . bringing new abilities . . . different and better ways of doing all those things . . . and as these abilities grow and develop . . . these things here . . . [drawing attention to the "negative" anchor] . . . are becoming less necessary and fading away . . . and you can see those new strong abilities stretching right out into your future . . .

Here, the integration experience is continuously paced and a sequence of presupposition, complex equivalence, suggestion, and command lead into a future-pacing direction that the abilities will carry on into this person's future. In this manner, the client can be led into the fairly deep trance state previously mentioned, in which no further speech from the therapist is necessary, but



during which it is quite evident that a great deal of unconscious activity is taking place. It is particularly in these latter processes that occur during the integration stage that reinterpretation and restructuring of unconscious processes take place and more effective structures relating to deletions, distortions, and generalisations begin to emerge and consolidate.

There are a number of NLP interventions which can be enhanced in this manner by careful attention to language patterns. Given this attention to detail, the outcome is often an effective and rapid resolution of problems, some of which may have been in a "stuck" state for lengthy periods of time.

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