Australian Journal of Clinical and Experimental Hypnosis
Vol. 23, No. 1, 1995, pp. 58–69

HYPNOSIS IN THE TREATMENT OF AN ADJUSTMENT DISORDER

Malcolm Desland

Psychologist

Kate, a 43-year-old woman suffering from an adjustment disorder and a life history of eczema, was treated using hypnosis and cognitive-behaviour therapy. Assessment of hypnotisability, therapeutic interventions and processes are presented. Therapeutic outcome for both disorders was positive. At three-month follow-up, treatment gains were maintained. The efficacy of cognitive-behaviour therapy using hypnosis is discussed

Kate was a 43-year-old woman admitted for in-patient hospital treatment by her psychiatrist, for treatment of anxiety, depression, and a psychosomatic condition. Her father had died four months earlier after a two-year battle with cancer. Since then, Kate had experienced anxiety, sleeplessness, lowered mood, and a major exacerbation of eczema, from which she had suffered since early childhood. Events following her father's death had complicated the situation, specifically legal complications over her father's will, which had evoked unresolved grief and painful childhood memories.

Kate presented in an emotional and tearful state. Following her father's death, she had experienced nightmares of his final days, disturbed sleep, excessive guilt and self-criticism over being absent at his death, anxiety, and depressive symptoms. She could not attend the funeral or visit the grave because of the way she felt. She felt she was a burden to everyone. Vague suicidal ideation was present, although no actual plans or history of suicide attempts were reported.

Her father's death was coupled with other problems. Two years previously, her daughter was raped, evoking painful memories and distress about Kate's own molestation at age 10. Coinciding with the above events was a continued deterioration of a lifelong eczema condition. At assessment, Kate presented with large areas of a red rash over her cheeks, forehead, forearms, and elbows and reported rashes were on the back of her legs, lower back, and buttocks.

Requests for reprints should be sent to M. Desland, 8/19 Campbell Street, Parramatta, N.S.W. 2150.

Kate's conventional medical treatment, that is, Egocort (cortisone ointment) (Upfal, 1991), which she had used for more than five years, had not yielded much benefit. Her condition was complicated by her diabetes condition, as cortisone interferes with diabetes management. Her diabetic condition was managed by Diabex (Metformin) (Upfal, 1991). Kate said her eczema was greatly affected by her worries. Her eczema evoked burning irritations, which itched constantly and worsened in response to such activities as public speaking (anticipatory anxiety), arguments with her children or stepmother (conflict), heat, and scratching.

HISTORY

Kate was the eldest of three children (two girls and a boy). She described herself as a nervy child and was prescribed "nerve tablets" intermittently from age 9–12. At age 10, Kate was sexually molested by a stranger. Her mother died suddenly from coronary failure at the age of 45, when Kate was 11. Her memories of her mother were vague and piecemeal. After her mother's death Kate had taken on an adult role of raising her siblings. She initially described her father as strict (this description altered during the course of therapy, as discussed later). When Kate was aged 16 her father remarried. The new step family was a place of great discontent for Kate. She felt she and her younger brother were rejected and ostracised by her stepmother and step-siblings. At 18, when she fell pregnant to her present husband, she was consequently "kicked out" of home.

Kate had been married 22 years. She described her marital relationship as positive and supportive. She has two daughters (aged 14 and 16, at home) and a 23-year-old daughter who was adopted out just after birth. This child was born illegitimately and was adopted to a friend of the family. Kate was ostracised over this for a number of years. She remains in contact with her adopted child, who now coaches both of Kate's daughters in sport. She indicated the family home had been burgled seven times in the last five years and expressed trepidation at the prospect of further attempts.

Education and Employment

Kate did not complete her secondary schooling because of her first pregnancy. She described her academic performance as average and commented she was "robbed" of better grades because of the family situation and the surrogate parent role she had undertaken. She has been involved in parenting/domestic duties since leaving the family home. Kate and her husband are involved in a distribution sales business (Amway). This elicits mixed feelings in Kate, comprising experiences of achievement and anxiety over sales and presentations.

Social Relationships

Social relationships had been restricted due to embarrassment about her eczema. She also reported being timid and quiet around people.

Substance Use

Kate drank alcohol on an intermittent social basis. She did not smoke. No other psychoactive or recreational drug use was reported.

Previous Treatment

Kate reported no previous treatment of a psychological or psychiatric nature, stating she had "struggled but always managed to get through." In the last year of her father's illness, her GP had prescribed the anti-depressant Prozac (Fluoxetine). No therapeutic effect was noted.

Psychometric Testing

The following psychometric tests were administered: (a) Beck Anxiety Inventory (BAI; Beck, Emery, & Greenburg, 1985); (b) Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961); and (c) Automatic Thoughts Questionnaire (ATQ-30; Hollon & Kendall, 1980).

These are used to assess anxiety, depressive symptoms, and associated thoughts or cognitions. Administering these also provided measures against which therapeutic outcomes could be evaluated. Kate's scores indicated high levels of anxiety (BAI = 34), moderate levels of depression (BDI = 26), and her ATQ score (ATQ = 83) indicated the main negative thoughts about herself centred around excessive responsibility.

DIAGNOSIS

Using DSM III-R (American Psychiatric Association, 1987) criteria, Kate was diagnosed along each axis as follows:

Axis I: Adjustment Disorder with features of anxiety and depression.
Axis II: No criteria for diagnosis of a Personality Disorder were met, however avoidance traits were noted.
Axis III: Diabetes (adolescent onset) and eczema (early childhood onset).
Axis IV: Cancer leading to death of her father; arising discord with step family over will; her daughter's rape two years ago; and household burglaries. Rating: severe.
Axis V: Current Global Assessment Functioning: 50. Highest level in last year: 80.

ASSESSMENT OF HYPNOTISABILITY

Hypnotisability was determined considering three factors: (a) her attitude and perception of hypnosis; (b) hypnotisability, as measured by the Stanford

Hypnotic Clinical Scale for Adults (SHCSA; Morgan & Hilgard, 1979); and (c) contraindications.

Kate reported no previous experience of hypnosis, although she had considered it at times for her eczema. Assessment of her hypnotisability indicated Kate scored in the high range on the SHCSA (4/5).

Kate reported depressed mood and scored moderate levels of depression on psychometric tests. The literature indicates mixed views on the use of hypnosis in the treatment of depression or where depressed symptomatology is present. Strickland (1971, cited in Gibson & Heap, 1991) and Burrows (1980) considered depression as a contraindication for hypnosis, as it can potentiate suicide attempts. More recent articles (Alladin, 1992a, 1992b; Alladin & Heap, 1991; Yapko, 1988, 1992) have argued against this position and demonstrated the use of hypnosis in the treatment of depression. It is necessary to consider the type of depression, the specific interventions used and the treatment context. Whether hypnosis is contraindicated or not with depression will depend on the intervention/s used within each therapeutic situation (Gibson & Heap, 1991). Simplistic interventions, for example, the use of ego-enhancement, may increase the likelihood of a suicide attempt, however specific and individualised interventions are appropriate and therapeutic (Alladin, 1992a, 1992b; Alladin & Heap, 1992; Gibson & Heap, 1991).

In Kate's case, hypnosis was used for the following reasons:

1. there was only evidence of reactive symptoms, in response to her recent bereavement, subsequent circumstances, and exacerbation of the eczema;
2. her attitude to hypnosis was positive; and
3. therapy took place in an in-patient context, enabling regular observation for unexpected suicidal behaviour.

It was hypothesised that Kate experienced ambivalence at her father's death, which evoked cognitions and emotional disturbance regarding her previous surrogate-parent role. This resulted in emotional distress and an exacerbation of eczema. The eczema's function was protective, as it enabled Kate to avoid interpersonal issues.

The in-patient context exerted a major influence, in that it provided a safe context where regular observation and containment could occur. The first hospitalisation lasted seven days, while the second hospitalisation (eight days later) lasted 21 days. Therapy occurred in stages. Each stage coincided with Kate's hospitalisation. The first stage included an explanation of hypnosis and contracting therapeutic goals.

STAGE ONE: SESSIONS 1-4

Kate was given a general overview of hypnosis as an altered state of consciousness which parallelled other spontaneous changes in normal consciousness,

for example, becoming lost in a daydream while walking on a beach, or becoming immersed in reading a good novel. Parallels were made with meditation and relaxation. She was informed a shift in attention occurs through the hypnotist's suggestions, enabling the person to suspend the usual functions of consciousness. This enables the person to focus on internal processes.

She was told that hypnosis could be used to promote relaxation, helpful imagery and suggestions for change, and that her therapy would be a "collaborative journey" (Golden, 1989) utilising her ideas as much as the therapist.

Kate's knowledge of hypnosis was limited. However, she was positive about its use and gave consent. Her initial goal was to reduce her eczema.

Session 1

Trance was induced using a modified eye fixation induction (Walker, 1979, cited in Channon-Little, 1994), emphasising the need to relax and let go with each exhalation (this induction, deepening, and dehypnotising was used throughout Kate's therapy). Deepening occurred through a 1–20 count, in which suggestions promoting relaxation, still experiences and "mental quiet" occurred. Deepening utilised relaxing, and calming suggestions similar to those of Morgan and Hilgard (1979) were used, focused on evoking a safe positive place. Kate selected pleasant memories of a parkland scene beside the sea in Sydney's south where she and her family would watch jets enter and leave Sydney airport. Dehypnotising constituted a reversal of the deepening process, that is, a 20–1 count with eyes open at 5. During the debriefing, Kate clearly experienced the suggested imagery, seeing 747 jets approach and waves breaking and feeling the offshore breeze. She reported feeling very relaxed and good. It was evident during the session that visible areas lessened in redness. I commented (with surprise) how different her arms now looked. Kate commented with less surprise how she was "kinda [*sic*] expecting this, it's through all the worry, you know." An audio-tape was made of this session. She was instructed to listen to this daily.

The session met its goals, in that Kate was informed about hypnosis and had shown a positive response. The content was self-selected pleasant imagery, important in the therapeutic use of hypnosis (Heap, Aravind, & Power-Smith, 1993). Audio-taping the session permitted practice and essentially "imagery training" in relaxing positive scenes. The unexpected bonus was the noticeable changes in eczema without specific interventions.

Session 2

This session was held three days after the first. Kate was pleased at her progress. She practised self-hypnosis by listening to the tape. She was more relaxed and the redness and itching had diminished.

We worked initially on diminution of her eczema, using a script for eczema (Jackson, 1989), modified for this patient (see Appendix). Suggestions of relaxation and coolness are made, as the image of Kate lying on a bed of moss-covered rocks beside a waterfall in a lush green forest is developed. The waterfall blows a gentle mist over her, especially the eczema-affected areas. Suggestions of feeling emotionally safe were added and the forest was made a special place where personally healthy decisions could be contemplated and made. The session's content ended with a post-hypnotic suggestion altering her itching to gentle patting. A greater reduction in eczema occurred in the session. During debriefing, Kate reported both visual (lush green tropical forest) and kinaesthetic (cooling sensations of the mist) imagery and felt "great." This session was audio-taped. Daily practice with this was recommended.

Between sessions 2 and 3, the following changes took place. Kate was observed to gently pat her skin. A continued lessening in her eczema occurred. Legal proceedings were commenced to resolve her father's will. Kate had also developed a prominent tremor in her arms.

Session 3

In this session Kate was positive, saying "I'm really getting somewhere." She reported contacting solicitors to finalise matters on her father's will. Her eczema was lessening in irritation, she needed less Egocort, and she felt her diabetes had improved. She was advised to consult her physician. Amid this optimism, discussion about the tremor occurred. Kate's approach changed. She expected annoyance (and presumed rejection) from myself. She believed the tremors were her fault. This exemplified the "personalisation schema" (Wright & Beck, 1983) from her childhood. Personalisation is taking excessive responsibility for others' emotions or behaviours (Wright & Beck, 1983). The tremor developed in response to anxiety provoking stimuli (e.g., contact with step family or negative thoughts).

I suggested the tremor was Kate's experience of anxiety now that the eczema had reduced and I combined this suggestion with cognitive restructuring on personalisation. Both issues formed the basis for a hypnosis session. In trance, Kate was asked to induce a manageable tremor. This was paired with her breathing rate. As breathing slowed, her tremor reduced. This became an "anchor" (Bandler & Grinder, 1979, cited in Gibson & Heap, 1991) by which Kate could control the tremors. In the session, Kate experimented with increasing and decreasing the tremors by altering breathing. Fifteen minutes were spent practising this. Kate was then asked to go to the tropic forest imagery of the previous session, where she could consider what things were hers and her responsibility. This was to counter her feelings of excessive responsibility for others. The session ended with the post-hypnotic suggestion of slowing breathing to manage anxiety generally. In the debriefing Kate said the session was very useful but was very demanding.

Session 4

This session occurred on the day of discharge. Hypnosis was not used. Kate and her husband attended and we discussed treatment and future options. During her week as an in-patient, both Kate and her husband were surprised by the changes. Her eczema was virtually gone and her husband commented that she "was more together in the way she went about things" (i.e., relaxed). Kate herself felt she had "at last begun to sort it out" with her step family. Both were eager about further treatment to "get to the bottom of" the grief and related issues.

STAGE TWO: SESSIONS 5–10

Session 5

Session 5 comprised a review of what had happened since discharge and the contracting of new therapeutic goals. Kate felt "she had gone better than expected." Her eczema had remained subdued and her use of Egocort had reduced. She had seen her physician regarding her diabetes and he was happy with her progress. She had effectively controlled her arm tremors, spoken in public with greater ease, and generally felt more relaxed in her daily life. She stated boldly her therapeutic goals were to "work on the hard stuff," namely her grief over her father's death. Kate was still experiencing some nightmares over his death and commented that, since discharge, she had been thinking a great deal about her family and childhood. The outcome to this was the insight that grieving over her father's death was thwarted by the absence of grieving over her mother's death when she was aged 11. We discussed again the use of hypnosis and the usefulness of age regression as a particular hypnotic technique to utilise in this context.

Session 6

Three days later, in session six, using the same imagery of the "magical" forest, Kate regressed to her age before Mum's death. The information elicited was very important to Kate, consisting as it did of three themes:

1. isolation and loneliness within the family;
2. the pronounced absence and emotional distance of her mother; and
3. her father's physical violence toward the family, including herself.

All these issues evoked high emotions and Kate indicated she had no conscious awareness of them previously. A sensitive exploration and ventilation of each ensued.

Kate recalled her memories as "always [feeling] wrong, in trouble, alone and frightened." Regarding her mother, she felt bewilderment, betrayal, and anger, then sadness, then understanding her mother's behaviour (self-protection against her husband). Most distressing to Kate were memories of her father's

violence and screaming. Suggestions to slow her breathing to help tolerate her emotions were made. Interestingly, Kate's arm tremor began again during recall of a memory of her father scolding her for not taking the "nerve tablets" one night, when she was aged nine. In the session debriefing, Kate was given support through expressions of understanding.

Session 7

Three days later, in this session, Kate reported feeling strong mixed emotions. Her eczema had worsened and she spoke of being "shocked about all that had happened." I discussed with her the notion of dissociation and how this process had protected her from strong emotions, which were now being expressed. Her feelings for her mother were positively reframed as part of the difficult process of letting go. Kate talked further about her father's violent, abusive behaviour and his remarriage. The session, in which hypnosis was not used, provided time for her to ventilate, understand, re-evaluate, and cognitively reframe the age regression material elicited in the previous session.

Session 8

Session 8, four days later, took place after the weekend, during which Kate's husband had taken her to the cemetery to view her father's grave. She had gone reluctantly, and the event prompted stronger mixed feelings toward her father and a worsening of her eczema, although she perceived it as being potentially beneficial. She wanted to address these feelings, specifically "to get rid of them."

In trance, Kate was asked to "capture" the experience, the physical sensations, the feelings, thoughts, and images evoked by the visit and thinking of her father. A modified clenched fist technique (Stein, 1963, cited in Gibson & Heap, 1991) was then used. Kate was asked to slowly form a fist with her non-dominant hand during a 1–5 count. As the fist slowly formed, Kate was asked to transfer the sensations, thoughts, images, and feelings to her non-dominant hand. At "five," Kate's arm tremor commenced, but she was asked to tolerate this for a short while. A reverse count (5–1) occurred, the suggestion made was that Kate could let go of the "excess stuff." Then Kate was asked to focus on her positive qualities, assets, and resources in the present. Prior to trance, Kate had listed her positive qualities as her friendly nature, capacity to survive, the love and support of her husband and family, her new hope from the current therapy, and her new ability to grieve. After becoming aware of this experience, Kate was asked to slowly form a fist with her dominant hand, during a 1–5 count. As the fist slowly formed, she was asked to transfer the sensations, thoughts, images, and feelings to this hand and to "let them grow in her hand." She was then asked to place her "positive strong" hand over her non- dominant hand.

A reverse count (5–1) was conducted during this and Kate was asked to let the positive feelings flow throughout herself. This did not produce the

usual tremor. In trance, I then asked her to report on her experiences. She commented that the first part was "really hard" and that she was very tired. The second part was a positive exercise but it "wouldn't be enough." The suggestion was then made that the exercise be repeated, to which she agreed. During the repeat of the first part of the process, Kate's arm tremor was much less noticeable. Dehypnotising and debriefing followed and Kate then reported that, although she found the initial phase (the non-dominant hand exercise) to be emotionally draining, she was pleased at the experiential effects, particularly during the repeat phase.

Session 9

In session 9, four days later, Kate entered the room in higher spirits. She felt more emotionally comfortable, relaxed, and her eczema had improved. She requested a session to work on returning home to her family. In that week, her younger brother, having left his wife, had come to live with Kate's family, bringing his four-year-old daughter. This had already resulted in arguments and Kate wanted to learn some assertive skills. She was concerned also about her fear of returning home to find it burgled again.

We negotiated to address assertion skills and managing anticipatory anxiety in the one session and to address the issue of leaving hospital to another time.

Prior to trance induction, Kate was educated about assertive behaviour (Trower, Casey, & Dryden, 1988), then, in trance, she visualised herself at home addressing her own family. When competent at this, we used further visualisations of addressing her brother, and her stepmother. At anxious or difficult moments, suggestions for slow breathing were made. The metaphor of "not letting people get under her skin" was also made. Kate was then asked to let her mind go blank and asked to recall the last time she found the house robbed and to visualise herself in that scene. She was asked to note her reactions, emotions, and body sensations. In trance, I discussed with Kate alternative feelings and thoughts. These were practised until she felt comfortable with her responses. This session was audio-taped to enable practice and further reintegration at her own pace.

Session 10

In session 10 four days later, I used age progression techniques (Gibson & Heap, 1991) to rehearse future behaviours in her home and life situation generally. Permissive suggestions were made to "contemplate future situations where she could choose to use her new behaviours, feelings, and thoughts." Kate visualised herself coping with her family, her step family, and in imagined legal situations with her father's will.

Session 11

The final session was conducted in hospital and hypnosis was not used. We discussed Kate's hospitalisations with her husband present. Both were positive

about her treatment and the use of hypnosis. Kate had kept each of the taped sessions within hospital for future use as she needed them. Our discussion centered on continuing improvement and caution rather than "cure." The BDI, BAI, and ATQ were re-administered and Kate's scores were now within the normal range on each.

Follow-Up and Outcomes

A review session occurred two weeks later. Changes had been maintained and we decided to meet at monthly intervals. No further hypnosis was conducted.

For three weeks after discharge, Kate listened to the tapes "now and then," and then discontinued, no longer feeling the need for them. In review sessions, Kate reported "feeling better" and more confident. Issues concerning her father's death no longer distressed her and her relationships with others became more positive. Anxiety was apparent at times, but manageable in regard to the legal proceedings over the will. Her eczema remained significantly subdued. She continued to use ointments but less regularly.

Seven weeks later, Kate telphoned to advise that her eczema had returned. No coinciding events were identified and the hypnosis tapes had been used to no avail. This information was perplexing and an appointment was made for four days hence. Kate called back that same day to tell me she had seen her GP, who diagnosed secondary infection through contact with suffering from influenza. He had prescribed antibiotics. Kate called again the day of the appointment to say the eczema had cleared and cancelled the appointment.

It is now three months since her discharge and both eczema and psychosocial situations remain effectively controlled.

DISCUSSION

A number of factors warrant discussion: the role of hypnosis throughout therapy; symptom removal and altering the underlying and associated factors; the treatment context; and other influences affecting therapy outcomes.

Hypnotic phenomena and interventions clearly facilitated a reduction in eczema. This is consistent with reports in the literature (Bowers, 1976, Brown & Fromm, 1987; Gibson & Heap, 1991). Specifically, the direct-access hypnotic strategies have on autonomic activity and sensory processes has been important. One could expect appropriate yet non-individualised interventions to reduce eczema. This effect was further potentiated by individualised interventions which involved and empowered the client in the therapeutic process. The "ease of change," that is, experiencing positive changes in a lifelong disorder after only several sessions further engaged the client's active participation in therapy. Perhaps this promoted a "double-edged" effect. The client developed strong positive expectations about treatment and perhaps believed in or hoped for a faster cure. She was very willing for another hospitalisation and for further

use of hypnosis to alleviate her other problems. Reciprocally, this enthusiasm may have been involved in her difficulties in the second hospitalisation, magnifying her disappointment and distress at the worsening of her eczema, in relation to associated issues.

Changing underlying and associated factors, using hypnosis with cognitive-behaviour therapy, was very effective. Hypnotic techniques, such as pleasant imagery, permissive suggestions, age regression, post-hypnotic suggestions, the clenched fist technique, and behavioural rehearsal via age progression contributed an "efficiency" to restructuring cognitions and experiences.

The audio-taping of sessions enabled Kate to practise away from the therapy context. The effect of in-patient treatment was also an important factor. Arguably, the in-patient setting permitted a "time out," constant observation and more regular sessions enabling support to occur. This close supportive environment promoted sufficient containment of emotions, so that effective changes could occur. The closeness of sessions in time enabled a strong flow across sessions to occur. Although the basis of Kate's treatment for eczema was psychological therapy, with hypnosis as an important adjunct, appropriate medical supervision was also necessary. This was evidenced by the temporary reinstatement of medication for eczema, following her secondary infections.

In retrospect, perhaps a modification to the approach used may have been to inform and educate the client about ner expectations of change and the relationship between her eczema and her emotions.

REFERENCES

Alladin, A. (1992a). Hypnosis with depression. *American Journal of Preventive Psychiatry and Neurology, 3*, 13–18.

Alladin, A. (1992b). Depression as a dissociative state. *Hypnos, 29*, 243–253.

Alladin, A., & Heap, M. (1991). Hypnosis and depression. In M. Heap & W. Dryden (Eds.), *Hypnotherapy: A handbook* (pp. 61–76). London: Open University Press.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

Beck, A. T., Emery, G., & Greenburg, R. L. (1985). *Anxiety disorders and phobias.* New York: Basic Books.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J. E., & Erbaugh, J. K. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561–567.

Bowers, K. S. (1976). *Hypnosis for the seriously curious.* London: Norton & Co.

Brown, D. P., & Fromm, E. (1987). *Hypnosis and behavioral medicine.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Burrows, G. D. (1980). Affective disorders and hypnosis. In G. D. Burrows & L. Dennerstein (Eds.), *Handbook of hypnosis and psychosomatic medicine* (pp. 149–170). Amsterdam: Elsevier/North.

Channon-Little, L. (1994). The use of hypnosis in a systematic desensitisation paradigm for the treatment of specific phobias: An outline and case study. In B. J. Evans (Ed.), *Hypnosis in management of anxiety disorders* (pp. 111–116). Heidelberg: The Australian Journal of Clinical and Experimental Hypnosis.

Gibson, H. B., & Heap, M. (1991). *Hypnosis in therapy.* London: Lawrence Erlbaum Associates.

Golden, W. L. (1989). Resistance and change in cognitive behaviour therapy. In W. Dryden & P. Trower (Eds.), *Cognitive psychotherapy: Stasis and change* (pp. 3–13). London: Cassell.

Heap, M., Aravind, K. K., & Power-Smith, P. (1993). *A psychosomatic medicine research clinic.* Paper presented at the 6th European Congress of Hypnosis and Psychosomatic Medicine, Vienna, Austria.

Hollon, S. D. & Kendall, P. C. (1980). Cognitive self-statements in depression: Development of an automatic thought questionnaire. *Cognitive Therapy and Research, 4*, 383–395.

Jackson, A. (1989). *Stress control through self-hypnosis.* Sydney: Doubleday.

Morgan, A. H., & Hilgard, J. R. (1979). The Stanford Hypnotic Clinical Scale for Adults. *American Journal of Clinical Hypnosis, 2*, 134–147.

Trower, P., Casey, A., & Dryden, W. (1988). *Cognitive behavioural counselling in action.* London: Sage Publications.

Upfal, J. (1991). *The Australian drug guide.* Melbourne: Schwartz & Wilkinson.

Williams, J. M. (1992). *The psychological treatment of depression* (2nd ed.). London: Routledge.

Wright, J. H. & Beck, A. T. (1983). Cognitive therapy of depression: Theory and practice. *Hospital and Community Psychiatry, 12*, 1119–1126.

Yapko, M. D. (1988). *When living hurts.* New York: Brunner/Mazel.

Yapko, M. D. (1992). *Hypnosis and the treatments for depressions: Strategies for change.* New York: Brunner/Mazel.

APPENDIX

Modified script from Jackson (1989, p. 175):

You feel so relaxed . . . your mind is at ease . . . your skin feels calm . . . and cool . . . so cool . . . Picture yourself in a magical forest . . . The trees are tall, the light is soft as in the early morning . . . the air is cool and fresh . . . You are lying on a bed . . . of soft . . . cool moss . . . The moss is a cool and a deep emerald green like the leaves throughout the forest . . . near a flowing waterfall . . . where the water flows white and fast . . . A fine spray . . . is drifting over your body . . . over your arms, neck, face, and shoulders [affected areas] . . . It is soothing . . . so, so soothing . . . Nothing matters but the feelings of coolness and being being refreshed . . . Meanwhile the bed of moss soothes and cools your back and legs . . . soothing you all the time . . . it's soothing . . . so soothing . . . In this wonderful soothing place you can take it easy . . . give yourself time to reflect in a soothing manner . . . what's been happening . . . In this soothing cool place . . . you will find yourself being able to make soothing healthy decisions for yourself . . . healthy decisions that help free you . . . let your skin feel soothed . . . and yourself make healthy decisions.

Australian Journal of Clinical and Experimental Hypnosis
Vol. 23, No. 1, 1995, pp. 70–77

HYPNOSIS IN THE TREATMENT OF SEXUAL DESIRE DISORDERS

Ivan Bakich

Psychologist

This paper examines the aetiology and treatment of sexual desire disorders and examines how hypnosis may be integrated into treatment. The possible role of past sexual trauma in the causation and treatment of sexual desire disorders is emphasised and discussed with reference to clinical case material. Two clinical cases in which hypnotic age regression was used as an uncovering technique to elicit repressed sexual trauma are included.

Individuals and couples frequently present with problems of a sexual nature. During therapy it is not uncommon to hear the male partner comment: "Really, everything is OK in our relationship but sex is non-existent — I may as well join the priesthood." The female partner may, sometimes apologetically or with a trace of guilt, comment: "I do love you, nothing has changed between us, but I just don't have any interest in sex any more" or "I don't know what's wrong with me any more."

In her pioneering work with sexual desire disorders, Kaplan (1979) reported a high incidence of these clinical problems. She found the frequency of inhibited sexual desire among couples to be very high, with 40% reporting the problem. In his work at the University of Manitoba Sexual Disorders Clinic, Jehu (1988) found over 56% of sexually abused women reported impaired sexual motivation. More recently, in a review of treatment approaches for sexual dysfunctions, Hammond (1990) suggested that sexual desire disorders were the issue at cause in more than 50% of treatments. While there have been reports of sexual desire disorders among males, its occurrence seems considerably more frequent among females. Weeks and Hof (1987) argued that approximately 40% of women and 18% of men reported low sexual desire and research has confirmed that the incidence of the disorder is considerably higher among women who were sexually abused (Jehu, 1988).

Requests for reprints should be sent to Ivan Bakich, PO Box 220, Concord West, N.S.W. 2138.

AETIOLOGY

Kaplan (1979) argued sexual desire is an appetite governed by biological and experiential factors. Like any other basic drive, the sex drive has a survival value. Sexual centres located in specific areas in the brain are closely linked and responsive to such hormones as testosterone. Without sufficient hormonal supply these centres cannot operate and libido declines. For "normal" sexual desire to occur, anatomical and physiological integrity of the sex centres is required. Sexual desire sometimes diminishes in response to changes in the individual's psychophysiological state, resulting from depression, stress, drug abuse, illnesses, and hormonal imbalances (Leiblum & Rosen, 1987; Weeks & Hof, 1987)

It is also not uncommon for sexual desire disorders to be partly determined by previously learned behaviour and sexual experiences. In order to deal with anxiety that may stem from the fear of success and intimacy in sexual situations, clients learn to avoid such situations. At the cognitive level, these clients also engage in negative thought patterns, to help them process events which happen to them, often contributing to irrational belief systems regarding sexual activity (Jehu, 1984; Lo Piccolo & Friedman, 1988).

A number of sociopsychological factors may also contribute to the occurrence of sexual desire disorders. These include marital discord; interpersonal or relationship problems, and inadequate sexual information (Weeks & Hof, 1987).

While there is paucity of information on the sexual responses of sexually abused clients, there is increasing evidence of two specific forms of sexual desire disorder, hypoactive sexual desire disorders and sexual aversion disorder, being present in these cases (Jehu, 1984, 1988; Hammond, 1990; Milne, 1993). Thus, previous traumatic sexual experiences, that may have been repressed, can have an important role in the causation of sexual desire disorders.

The focus of this paper is the role of past sexual trauma in the aetiology and treatment of sexual desire disorders.

SYMPTOMS AND DIAGNOSTIC CRITERIA

In my clinical work, I have found a significant increase in requests for hypnotic age regression from women who believe they were the victims of sexual abuse earlier in their life. Symptoms frequently reported by these women include frightening recurrent dreams, nightmares, or flashbacks to some unexplained past event.

These symptoms are usually accompanied by the lack of interest in sexual activity with their partner. In many cases there are marital conflicts, with one or the other partner feeling rejected, unloved, or abandoned by the other. The female partner is often perplexed by her lack of sexual motivation.

Sexual desire disorder was first classified in the Diagnostic and Statistical Manual — DSM-III (American Psychiatric Association [APA], 1980) as Inhibited Sexual Desire (ISD). However, DSM-IIIR (1987) revised the disorder

and included diagnostic criteria for Hypoactive Sexual Desire Disorder (HSDD) and Sexual Aversion Disorder (SAD), as follows. Diagnostic criteria for Hypoactive Sexual Desire Disorder 302.71:

> A. Persistently or recurrently deficient or absent sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age, sex and the context of the person's life.
> B. Occurrence not exclusively during the course of another Axis I disorder (other than a Sexual Dysfunction), such as Major Depression. (APA, 1987, p. 293)

Diagnostic criteria for Sexual Aversion Disorder 302.79:

> A. Persistent or recurrent extreme aversion to, and avoidance of, all or almost all, genital sexual contact with a sexual partner.
> B. Occurrence not exclusively during the course of another Axis I disorder (other than a Sexual Dysfunction), such as Obsessive Compulsive Disorder or Major Depression. (APA, 1987, p. 293)

When assessing the extent and severity of any case of sexual desire disorder, it is necessary to take a comprehensive sexual and marital/life history. There are comprehensive assessment protocols for this purpose (Jehu, 1988). Clinicians also use a variety of questionnaires to assess clients' motivation, attitudes, and feelings. These include the Sexual Arousal Inventory (Hoon, Hoon, & Wincze, 1976), the Index of Sexual Satisfaction Scale (ISS; Hudson, Harrison, & Crosscup, 1981), and one's longing for union as measured by the Passionate Love Scale (Hatfield & Sprecher, 1986). In assessing the disorder it is necessary to investigate the absence of sexual responsiveness to given sexual cues by the partner (Leiblum & Rosen, 1988). These disorders are multifaceted problems and therefore not simple to diagnose and treat.

Some writers have argued that by diagnosing and classifying sexual desire disorders within the psychiatric mental disorders system, individuals are unnecessarily stigmatised (Leiblum & Rosen, 1988; O'Carroll, 1991).

Treatment approaches for these disorders can be multifaceted, but little attention has been given by therapists to the use of hypnosis in treating these pervasive sexual problems (Hammond, 1990; Milne, 1993).

TREATMENT APPROACHES

While a number of approaches to the treatment of sexual desire disorders are used by clinicians, most emphasise the importance of the client's intrapsychic conflicts and the need to focus on these conflicts in therapy (Kaplan, 1979). Kaplan argues that psychodynamic therapy, coupled with behavioural techniques, should be the treatment of first choice. However, it is my experience that the choice of treatment will depend on the nature and duration of the presenting problem. For example, the choice of psychoanalytic therapy as the preferred mode of treatment may depend on the availability of a psychotherapist, his/her training, and time efficiency/management issues. The

therapist should consider whether the disorder is primary (global) or secondary (situational) (Kaplan, 1979). A primary disorder is reflected in a lifelong history of disinterest in sex, while a secondary (situational) disorder is characterised by the loss of sexual desire following a period of relatively normal sexual desire. Global disorders usually encapsulate a total lack of arousal in all situations, as opposed to situational disorders which may occur with only one partner or form of sexual activity. By its very nature, a global disorder is more difficult to treat than a secondary disorder and may be coupled with resistance, requiring long-term therapeutic endeavour (Kaplan, 1979; Leiblum & Rosen, 1987; Lo Piccolo, 1980).

More recently, cognitive-behavioural interventions have been used very successfully in the treatment of sexual desire disorders. The proponents of cognitive-behavioural approaches contend that clients need to change their cognitive style, eliminate negative thoughts, and focus on positive thought patterns and a rational belief system (Jehu, 1988; Leiblum & Rosen, 1988; Lo Piccolo & Friedman, 1988).

Whatever the theoretical stance taken by the therapist in relation to treatment, it is also necessary to address the importance of relationship factors and interpersonal interaction patterns of the client with his or her partner. It is also vital that the therapist consider the indication of any organic cause for the disorder, such as hormonal imbalance or malfunction, and to ensure appropriate treatment at this level.

Recently, some authors have highlighted the value of hypnosis as an adjunct to the treatment of sexual desire disorders (e.g., Hammond, 1990; Milne, 1993). While Hammond (1990) directed his attention to the necessity for more hypnotic work in the treatment of sexual disorders, Milne (1993) reported the use of hypnosis in helping clients access past sexual trauma and heal past wounds.

The two cases described below demonstrate the use of hypnotic age regression in uncovering past sexual trauma during the treatment of sexual desire disorder.

CASE 1

Mrs G, a 31-year-old woman, came to see me complaining of her feelings of disgust when approached by her husband for sexual activity. Both Mrs and Mr G were professional people working in the same profession. They had been married three years at the time of Mrs G's therapy. She was seen alone, as her husband was unable to attend due to unexpected business commitments. Mr G was four years her senior, and according to Mrs G, their marriage was reasonable except for the sexual problems that brought considerable distress to their relationship. She reported that her husband was a caring and understanding man. There were no children at this stage of their marriage.

The history taken in the first session revealed that Mrs G came from a happy home and had caring parents. She reported a series of brief sexual

encounters with a number of partners prior to her marriage, but she felt little or no emotional attachment to any of these partners. Having completed the sexual act with these partners, she felt disgust and sickening feelings. She could not look at the man's genitals or touch his body and reported disgust just seeing or touching the man's penis.

In the two years prior to therapy, Mrs G reported similar feelings of disgust and aversion to any sexual activity with her husband. She could not bring herself even to view, let alone touch his penis, or have sexual intercourse. She was in state of despair and stated that she would do anything to "get rid of these feelings." She did not know why she felt "yucky" when she thought of sex, or why she could not touch her husband's genitals. She reported a violent, sickening reaction if he asked her to touch him. She said, "I can't stand the wetness and stickiness of his penis, I just can't."

From Mrs G's comments and history, I decided she met the criteria for Sexual Aversion Disorder (APA, 1987).

Mrs G wanted to know what the problem was and she was prepared to do "anything" to discover what, if anything, happened to her earlier in her life. Following discussion, she agreed to try hypnosis. Mrs G was a responsive client and achieved medium level trance.

The client was asked to imagine an ordinary diary, each page being numbered and each number representing a year in her life. She was asked to go back as far as she could and stop if she felt she needed to look at any of the numbers. She was to let me know using idiomotor signalling. She stopped after several minutes and then I asked her why she decided to stop at that point. She began to turn nervously in the chair and then told the story of her first sexual experience at the age of 16 or 17. She vividly described her first lover, a much older man who used to ejaculate over her body, then smear the ejaculate over her. Mrs G then described her lover urinating over her body. At this point, visible signs of nausea were obvious; she was pressing her hands over her stomach in disgust. She began to sob, she could not touch any part of her body, for she felt "yucky" and "sticky."

Over the next three sessions visual imagery was used to help Mrs G desensitise to her husband's body and genitalia. She was instructed to "see" herself and her husband first being naked, then to gradually touch her lover little by little, as she felt comfortable enough to do so. If she experienced discomfort she was then to visualise the most pleasant surroundings until she felt okay. She was told her unconscious mind would help her forget her first lover and the unpleasant memories. By the end of our fourth session, Mrs G reported that she felt a little better and was able to touch her husband and talk about her "yucky" experience.

Our telephone conversation a few months later and the follow-up indicated that Mrs G was now freer communing with her husband and sexual intercourse was taking place.

CASE 2

Mrs and Mr K referred themselves to me after a long period of unsuccessful therapy elsewhere. Mrs K. complained about her disinterest in sex and her husband's dissatisfaction with their sex life. Consequently, their marriage was suffering considerable stress. Mrs K reported she had visited various health professionals, and had gone through hormonal treatments in order to motivate her sexual desire. She had excessive facial and arm hair growth, which had resulted from hormonal treatment. The couple reported that their marriage was okay, they had three adolescent children aged 11, 13, and 16, at school. Mr K complained, and appeared distressed by, the lack of sexual response from his sexual partner. As soon as he put his hand on her leg or between her legs, she would "freeze."

I saw the couple jointly and individually over six sessions. Mrs K's past history revealed limited sex education, a rigid family, and emotionally distant parents. She held strong religious values and sex was never discussed in her home. Her husband was her "first" man and "love." They had been married 17 years at the time of therapy. Mrs K reported total lack of sexual motivation in the last five years. She talked at length about her previous sex therapy which she felt was a waste of time and money. No change had ensued and she discontinued the therapy. She decided to try again because there were marital issues in question.

Mrs K reported experiencing flashbacks when her husband tried to touch her between her legs. She did not know why, however, she reported seeing a "hairy" hand and arm during these flashbacks. Her husband had very little or no hair on his arms.

Mrs K reported a negative self-perception and body image and saw herself as undesirable and unattractive. To the contrary, she appeared as a gentle, likeable, and attractive woman. She reported having experienced sexual desire on previous occasions and satisfying sex with her husband. The client met the criteria for the Hypoactive Sexual Desire Disorder (APA, 1987).

Hypnotic age regression with Mrs K provided the following information. At the age of approximately 12, she was living with her parents and younger sister in rented accommodation, shortly after their arrival in Australia. Mrs K was in her first year of high school and her younger sister was in primary school. Both her parents were at work. The landlord who was from the same country of origin as the family drank heavily and was at home every day when Mrs K came home from school. She reported the landlord's sexual advances, he kissed her forcefully, touched her breasts, and grabbed her genitalia. Mrs K reported vivid pictures of his (hairy) hand going down between her legs. Sexual intercourse did not take place.

Mrs K was helped to "let go" of her fear and the "hairy" hand. In trance she was told that her mind would let go of her intrusive images, the hand that was to touch her in the future would be her husband's and that hand

was gentle and caring. Ego-enhancing suggestions for positive change (Stanton, 1993) were given during treatment, to help Mrs K improve her self-image.

The last session was with both partners, and both reported some improvements. Mrs K felt more at ease with her husband. He has learned to listen to his wife and to share her experience. At a three-month follow-up interview, the couple reported improvements in their sexual activities.

CONCLUDING REMARKS

These two cases present successful outcomes, but this is not always the case. The difficulty with the sexual desire disorders revolve around the complex nature of the problem, their aetiology, and the treatment strategies. These disorders are difficult to treat (Kaplan, 1979; O'Carroll, 1991) because of the multidimensional factors in their aetiology. Whatever the treatment, it appears that hypnosis is a potent adjunct in the diagnosis and treatment of sexual desire disorders (Hammond, 1990; Milne, 1993). While there is a definite lack of controlled treatment studies (O'Carroll, 1991), clinicians' therapeutic experience and judgment suggest that hypnosis should always be considered as an approach in therapy. It certainly appears useful in uncovering past sexual trauma which is an important factor in the aetiology of the disorder, and can be usefully integrated with psychodynamic and cognitive-behavioural treatments in systemic marital/couples/individual counselling.

REFERENCES

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

Hammond, D. C. (1990). *Handbook of hypnotic suggestions and metaphors.* New York: W.W. Norton.

Hatfield, E., & Sprecher, S. (1986). Measuring passionate love in intimate relations. *Journal of Adolescence, 9*, 383–410.

Hoon, E. F., Hoon, P., & Wincze, J. P. (1976). An inventory for the measurement of female sexual arousability. *Archives of Sexual Behavior, 5*, 291–300.

Hudson, W. W., Harrison, D. F., & Crosscup, P. C. (1981). A short-form scale to measure sexual discord in dyadic relationships. *The Journal of Sex Research, 17*, 157–174.

Jehu, D. (1984). Sexual inadequacy. In K. Howells (Ed.), *The psychology of sexual diversity* (pp. 135–160). Oxford: Basil Blackwell.

Jehu, D. (988). *Beyond sexual abuse: Therapy with women who were childhood victims.* Chichester: John Wiley.

Kaplan, H. S. (1979). *Disorders of sexual desire.* New York: Brunner/Mazel.

Leiblum, S. R., & Rosen, R. C. (1987). Current approaches to the evaluation of sexual desire disorders. *The Journal of Sex Research, 23*, 141–162.

Leiblum, S. R., & Rosen, R. C. (Eds.). (1988). *Sexual desire disorders.* New York: Guilford Press.

Lo Piccolo, L. (1980). Low sexual desire. In S. R. Leiblum & L. A. Pervin (Eds.), *Principles and practice of sex therapy* (pp. 29–64). London: Tavistock Publications.

Lo Piccolo, J., & Friedman, J. M. (1988). Broad-spectrum treatment of low sexual desire: Integration of cognitive, behavioral, and systemic therapy. In S. R. Leiblum

and R. C. Rosen (Eds.), *Sexual desire disorders* (pp. 107–144) New York: Guilford Press.

Milne, G. (1993). Remembering childhood sexual abuse. *Australian Journal of Clinical and Experimental Hypnosis, 21*, 49–58.

O'Carroll, R. (1991). Sexual desire disorders: A review of controlled treatment studies. *The Journal of Sex Research, 28*, 607–624.

Stanton, H. E. (1993). Ego-enhancement for positive change. *Australian Journal of Clinical and Experimental Hypnosis, 21*, 59–64.

Weeks, G. R., & Hof, L. (Eds.). (1987). *Integrating sex and marital therapy: A clinical guide*. New York: Brunner/Mazel.

Australian Journal of Clinical and Experimental Hypnosis
Vol. 23, No. 1, 1995, pp. 78–92

CASE NOTES

The aim of Case Notes is to enable readers to contribute brief items and case material drawn from their own experience. These may be case situations in which hypnosis has been used in treatment or a description of specific hypnotherapeutic techniques used within treatment contexts. The contributor is asked to supply as much information as is needed to ensure the reader has an understanding of the situation, the therapeutic aims of the hypnosis, and outcomes. It may also be appropriate for the contributor to research the relevant research and clinical literature to justify and explain their use of hypnosis. While the standard criteria for publication in the journal will not necessarily apply to Case Notes, a clear exposition of the ethical professional practice of hypnosis will be required if the material is to be published.

PRACTITIONER-TAUGHT SELF-HYPNOSIS: DESCRIPTION AND PATIENT REPORTS

J. Arthur Jackson

Royal North Shore Hospital

Lorna D. Channon-Little

Psychologist

Self-hypnosis is often an integral component in treatment with hypnosis, yet relatively few scientific papers have been published evaluating its efficacy. This case report describes our approach to the integration of self-hypnosis in hypnotherapy and reports clients' assessment of the usefulness of the techniques described.

Self-hypnosis, guided by the practitioner, is often suggested as an adjunct to hetero-hypnosis in the therapeutic context (Clarke & Jackson, 1983; Fromm et al., 1981; Jackson, 1989; Johnson, 1979; Soskis, 1986).

Self-hypnosis as an adjunct to practitioner-administered hypnosis has two main advantages over hetero-hypnosis alone. It reduces dependency responses in patients as the focus of treatment includes active participation by the patient

Dr J. A. Jackson, PO, Box 594, Chatswood, N.S.W. 2067.

(Clarke & Jackson, 1983; Spiegel & Spiegel, 1978). It also moves the attention from an exclusive concentration on the transactions of the doctor–patient interaction to "the patient's active coping efforts in his day-to-day life outside the clinic [as] the therapist has come to be viewed as a consultant, a collaborator with the patient in devising, testing, and applying a variety of self-control strategies" (Clarke & Jackson, 1983, p. 145).

Self-hypnosis has received scant attention in the literature. For example, neither of the benchmark summaries of hypnosis theory index even a single mention of self-hypnosis (Sheehan & Perry, 1976; Lynn & Rhue, 1991). *The International Journal of Clinical and Experimental Hypnosis* published a special edition on the topic in 1981, in the preface to which Erika Fromm wrote: "Self-hypnosis is a still uncharted area in hypnosis research. Hypnotherapists generally teach their patients self-hypnosis for the purposes of pain control, relaxation, reduction of anxiety, and the building of ego strength to enable them to cope with their problems" (1981, Foreword).

In their review of the available literature, Fromm et al. (1981) argued the defining difference between self-hypnosis and hetero-hypnosis lies in the areas of attention and ego receptivity. Free-floating attention and ego receptivity to stimuli from within define successful self-hypnosis, while concentrative attention and receptivity to stimuli from the therapist are state-specific to hetero-hypnosis. They also argued that imagery is much richer in self-hypnosis than in hetero-hypnosis, whereas the techniques of age regression and positive and negative hallucinations are markedly more successful in hetero-hypnosis. As Sacerdote (1981) also argued, Fromm et al. (1981) suggested that self-hypnosis is generally taught to the client, following hetero-hypnosis, and that many clients' initial use of self-hypnosis is tentative, accompanied by self-doubt and anxiety until the process feels more comfortable. When this stage is reached, many clients quickly and easily go into self-trance, at which point trance depth and absorption is increased.

A review of the literature suggests that the greatest benefit from self-hypnosis comes to those clients who have been able to reach deep therapist-induced trance; for the majority of clients, the value of self-hypnosis lies in relaxation and anxiety control. Sacerdote (1981) developed detailed induction and deepening procedures for hetero-hypnosis which he argued maximise the potential gains from subsequent self-hypnosis. He describes to the client that learning to enter trance is similar to learning to ride a bicycle with assistance from an instructor and thereafter retaining the newly acquired skill. Deepening techniques then used by the therapist reflect not only the client's creative imagination, but build upon the fact that self-hypnotic experiences tend to be more free and creative than hetero-hypnotic ones (Fromm et al., 1981).

AN APPROACH TO TEACHING SELF-HYPNOSIS

We have found that patients are, in general, poorly disciplined when it comes to practising self-hypnotic techniques. By and large, they still see therapy as

something that "happens" in the consulting room but in which they play little role. The concept of hypnotic treatment being a cooperative enterprise is surprisingly difficult to establish with many people.

It is our experience that unless patients are given a detailed explanation and rationale as to why they should practise self-hypnosis, it is unlikely they will become involved to any degree. It should not be assumed that, because a patient is comfortable in hypnosis, they will have the same feelings about using these techniques on their own.

There is little doubt that discussing a patient's beliefs, correcting misconceptions, and explaining where, when, and how to use self-hypnosis is time-consuming. Without such a thorough initial approach, though, it becomes difficult to get a patient to gradually take over responsibility for their own management. This, in our opinion, should always be the aim in any form of behavioural therapy, including hypnosis.

The practitioner (JAJ) adopts the approach of introducing the concept of self-hypnosis in the second therapeutic session. This gives a patient the chance to experience hetero-hypnosis and discuss any changes arising from it. For the sake of ease of understanding he discusses self-hypnosis over two separate weeks, dividing the explanation into the induction and the therapeutic phases.

Although this may seem to be an artificial subdivision, it makes it much easier for patients to assimilate techniques without being overwhelmed by them. It has the added advantage of clarifying the idea that hypnosis is not, in and of itself, a therapy. We like to emphasise that hypnosis and self-hypnosis are simply ways of "tapping into" unconscious mind processes. How that access is utilised depends on the manner in which suggestions and imagery processes are used.

SELF-HYPNOSIS TECHNIQUE

Last week, I took you through an hypnotic session in which you experienced a series of relaxation and other responses. You may like to comment about any changes you noticed after that session and anything you may have noticed since then.

Today, I want to discuss how you can use these techniques on your own. This is an important part of treatment, for it allows you to take over your own control in a gradual way. You may think this is going to be too hard for you, but we will take it in stages so that you can learn a little at a time until you become proficient at it.

I mentioned in our first meeting together that my role in treatment is simply that of a guide or teacher. Helping you deal with your anxiety has to be a cooperative enterprise and your role in helping yourself get better is all-important.

Doing these self-hypnosis exercises on a regular basis will do several things for you. First, you will notice positive changes after each session

and this will help you realise that you CAN take control over many of the things that used to bother you. You'll notice how much better this makes you feel about yourself. It really does have a great effect on improving your self-esteem, for things no longer seem out of control all the time.

The second reason why it's important to learn your own skills and techniques of self-hypnosis is to ensure your problems don't recur in the future. You see, many of the problems you are experiencing are not necessarily of your making. We all inherit certain characteristics from our parents and sometimes these can predispose us to becoming anxious or depressed. But just because you may have this genetic predisposition to a problem doesn't mean that you have to resign yourself to being affected by it for evermore. If you set aside a little time each day using these techniques, the chances are that you will remain free from all those unpleasant difficulties.

I guess you could draw an analogy with physical fitness. If you spent many months getting fit, would it make sense to, then, decide that you no longer needed to exercise? Obviously not, for you'd soon find that your degree of fitness deteriorates at a fairly rapid rate. Mental fitness, in a sense, is no different. So unless you are prepared to put a little time and effort into this exercise on a daily basis, you will probably find all those stress and anxiety problems returning.

What I am talking about is the need to set aside one or two 20-minute periods each day as your quiet, meditative time. In effect, this only amounts to about 2 per cent of your day and yet patients often state that they can't find the time. I suppose the reason is that we all lead fairly busy lives.

So now I'm asking you to fit one more activity into your day. The only way you will do this successfully is to create this special space as your own quiet time. It should become a time when you can detach yourself from all the cares and concerns of the day.

Choose a time of the day when you are not under pressure to rush off and do other things. Select a place where you are unlikely to be disturbed. It's probably wise not to do it on the bed as you are more inclined to go to sleep there. I suggest you use a chair or lie on the floor on a blanket or camping mat.

If it is cold, make sure you are warmly clothed or that the room is warm. You see, when you become very relaxed, your metabolism tends to slow down and there is a strong likelihood you will feel chilled and this will interfere with your relaxation.

Correcting Myths and Misconceptions

At our first meeting together, we discussed the various myths and misconceptions that surround hypnosis. Self-hypnosis, too, often has its own set of misconceptions. Do you have any particular concerns that bother you?

I have found that the most common concern patients voice is that they fear they may be "stuck" in self-hypnosis and be unable to get themselves

out. Is this something you fear? Let me reassure you that you can bring yourself out of self- hypnosis whenever you wish by using the cue I will show you.

Many people wonder, too, whether the suggestions they give to themselves will be of much help. Well, the simple fact is that all suggestions, whether given in hypnosis or self-hypnosis, have a powerful effect on helping to change how you feel and react to life.

Finally, some people get bothered by the fact that they cannot seem to achieve the same depth of relaxation as they do in hypnosis. Let me reassure you this isn't important. When you are experiencing hypnosis with me, your conscious mind can, as it were, sit to one side and simply be an observer.

When you are using self-hypnosis, on the other hand, your conscious mind is to a large extent having to act as the director of proceedings. For this reason, it's unlikely you will reach the same depth of disengagement or detachment from things around you. The best advice I can give you is to enjoy it for what it is, rather than become overly concerned about how deeply relaxed you feel.

The Explanation

I am going to discuss self-hypnosis in two parts. The first, which I will talk about today, is all about how to induce the self-hypnotic state. At your next consultation, I will describe the ways in which you can utilise self-hypnosis in order to produce changes in the way you think, feel, and react in everyday life.

I discussed, previously, *where* and *when* you should carry out these self-hypnotic exercises, and recommended that you try to find one or two periods each day. I realise this may seem a lot but the rewards you gain will far outweigh the time you set aside. Later, you will probably be able to reduce self-hypnosis to once a day.

Now let's look at *how* you can take yourself into self-hypnosis. There are four steps or stages that I will describe to you, each of which plays a role into taking you into a deeper state of relaxation.

1. You can roll up your eyes and let the lids slide down over them. Let me show you how to do it. If you find that too difficult, you can simply close your eyes.

2. Now for the relaxation of the body. Feel as though you are going to breathe away the tension from different muscle groups in the body. Start with the muscles around the eyes and the face. As you focus on that part of your body, let go of more and more tension and strain each time you gently breathe out. Feel the eyelids becoming *so* heavy; the face becoming soft; the jaw muscles relaxing so that your lips part quite naturally. [This approach is used to describe all parts of the body].

3. Once you have relaxed your body, you are now ready to relax your mind. This is probably the most important of all these procedures.

Unfortunately, it can also prove to be the most difficult. I am going to ask you to think of the word *CALM* each time you breathe out slowly. The purpose of this technique is to get your mind as still and focused as possible.

The problem that everyone has at first is that their mind is constantly besieged by all sorts of other thoughts and intrusions. Unfortunately, as long as your mind keeps wandering off in this way, it will seriously interfere with how relaxed or disengaged your mind becomes.

Now, if you *try* to shut out those distractions, this will only serve to make them even more intrusive. Let me show how that works: for the next few minutes, *try* not to think of the colour "blue." I see you're having some difficulty doing this. I'm sure you were not thinking of the colour before I mentioned it but now your mind seems to be completely preoccupied with it. That's because you *tried* to shut out the thought.

The same principle applies to self-hypnosis. Other thoughts are sure to come into your mind, but if they do, let them pass through as if they are unimportant. Keep refocussing on the word *CALM* until you are no longer aware of these intrusive thoughts. This may take a time at first but you will find it becomes easier with practice.

4. Once your mind is relatively quiet, you can move on to this fourth procedure, which is simply a way of deepening your relaxation. There are many ways of doing this and you might like to experiment with ones of your own once you become familiar with self-hypnosis.

Imagine you are standing at the top of 10 steps, just as you did when you went into hypnosis last time you were here. You are looking down at a beautiful scene. This may be one that you recall from the past, or one your mind spontaneously creates.

Picture yourself going down each of the steps in time with each breath out. This brings rhythm and timing into that deepening process, so that you don't rush it. Count silently from one with each step, and let each step take you further and further into relaxation. Once you are in your peaceful scene, take time to enjoy all the peace and beauty of that special place.

Normally, you would use your peaceful state of mind and body to gently "reprogram" your mind, and I will talk more about this next time. But, for now, simply learn *how* to take yourself into a self-hypnotic state so that you can enjoy the feelings of complete relaxation.

When you are ready to bring self-hypnosis to a close, you can do this whenever you wish by silently counting from five to one. The count of "one" will always be the signal for your eyes to open and for you to come out of the self-hypnotic state feeling completely at ease, quite refreshed and feeling so much better in every way.

This therapeutic session is devoted to explaining and then guiding the patient

step by step through the self-hypnosis process. Furthermore, it is valuable to the patient if they are given a printed description of the whole procedure. Anxious people are notoriously forgetful!

The next therapeutic session is devoted to discussing with the patient how they can utilise self-hypnosis to deal with their particular problems. The value of suggestions or affirmations can be dealt with, together with the role of imagery.

Few patients, in our experience, have any notion of how to formulate positive suggestions and we encourage the use of a work diary in which they can construct their self-suggestions. We find it helpful to give patients examples of general coping suggestions so that they have some models with which to work. We believe that the patient's progress with the work diary should be monitored each consultation. This allows the therapist the opportunity to suggest changes, especially if the patient's suggestions are negatively orientated, and also encourages a greater degree of involvement from the patient.

Perhaps the major thrust of this part of therapy is that it provides a platform for discussing cognitive factors. This is the time when we introduce the concept of negative self-talk and its effects on behaviours. Recognising and challenging negative self-talk also becomes part of the homework assignment.

We have chosen to set out our approach in some detail since, in our experience, therapists tend to spend insufficient time teaching the fundamentals of self-hypnosis. It is little wonder, therefore, that patients are poorly motivated to develop techniques of self-management.

We believe that *constant* explanation, monitoring, reassurance, and encouragement are essential if patients are to become responsible, in the long term, for their own control. This, after all, is the aim of cognitive-behaviour therapy, and self-hypnosis not only forms an essential part of that therapy, but also provides a valuable means of reinforcing a sense of independence.

PATIENT REPORTS

Approximately 60 patients who attended the specialist medical hypnosis practice of one of the authors (JAJ) were asked to complete a set of questionnaire items about their use of self-hypnosis based on the program outlined above. Twenty-three men and 35 women completed useable questionnaires. The mean age of the respondents was 35.2 years (*sd* 14.66). Patients were asked how often they were told to practise self-hypnosis and how often they had actually used it. They were asked if they had received any aids, such as audio tapes, for their self-hypnosis practice. Further questions asked if they thought they were able to go into trance using self-hypnosis and, if so, was this in any way different from hypnosis with the doctor. They were asked to describe any differences. A final item asked the patients to describe any difficulties they had experienced with self-hypnosis.

Both the patients (prior to the consultation) and the practitioner (after the

consultation) estimated the degree of improvement as "no change," "a little better," "a lot better," or "completely cured."

All patients said that they have complied with the instruction to use self-hypnosis as part of their treatment. The practitioner had told the majority (57, 98.3%) to use self-hypnosis daily. Two patients had been told to use it twice daily. The patients reported use was high: eight patients (13.8%) said they had used it two to three times daily, 24 (41.4%) said they had used it daily, 21 (36.2%) said they had used it four to six times a week, four (6.9%) said they had used it two or three times a week, and one patient reported use about once a week. There was no significant difference in reported usage between patients who rated themselves a little improved and those who noted greater improvement ($\chi^2 = 0.89$, $df = 1$ $p = .5$) when compliers (i.e., those who used self-hypnosis at the rate recommended by the practitioner) and non-compliers were contrasted.

Forty-seven patients (81%) felt they had achieved a trance state using self-hypnosis, while the remaining 11 (19%) were unable to do so. For a majority (31, 56.4%) the state achieved was different from that resulting from hypnosis with the practitioner. For most, hypnosis was better with the practitioner. The difference most commonly reported was a less deep trance, noted by 13 (25%) of respondents. For some patients, self-hypnosis had advantages over hetero-hypnosis: self-hypnosis was more relaxed (3, 5.8%) and deeper (1, 1.9%). For most, however, self-hypnosis seems less compelling than hetero-hypnosis. Patients felt less relaxed (4, 7.7%) and more self-critical (2, 3.8%), found it difficult to carry out the procedure (2, 3.8%), and hard to be self-directing (2, 3.8%). Other negative comments, each given by one respondent (1.9%), included the greater skill of the doctor, the lightness of the trance, the problem of falling asleep, the reduced impact of suggestions, the lack of reinforcement from the doctor, and so on.

The next item asked specifically about difficulties in carrying out self-hypnosis. There were two major classes of response — those which concerned problems in the process of self-hypnosis and those relating to logistical difficulties. The major problem involved maintaining focused attention in the self-hypnosis setting. Sixteen responses (34.8%) concerned difficulty in concentration and 11 (23.9%) described interruption of the train of thought by other worries or ideas. Six responses (10.9%) concerned difficulty in relaxing and six (13%) were problems related to falling asleep. Practical barriers to self-hypnosis included lack of time (9, 19.6%) and lack of privacy (4, 8.7%).

This is a very compliant group of patients, as evidenced by the high retention rate. Phillips (1988) noted that over a broad range of psychotherapeutic interventions, retention at the fifth session approximated 30 per cent. The current sample showed almost double this rate.

It is not possible to compare outcomes for compliers and non-compliers in that all patients reported that they had made some effort to carry out self-hypnosis. The lack of difference in improvement levels of high and low

compliers suggests that the impact of hetero-hypnosis in therapy is much greater than that of self-hypnosis, a conclusion consistent with the view reported in clinical and research reviews (Fromm et al. 1981; Sacerdote, 1981). This is underlined by the fact that most patients felt that hypnosis with the practitioner was better than self-hypnosis.

REFERENCES

Clarke, J. C. & Jackson, J. A. (1983). *Hypnosis and behaviour therapy: The treatment of anxiety and phobias.* New York: Springer.

Fromm, E., Brown, D. P., Hurt, S. W., Oberlander, J. Z., Boxer, A. M., & Pfeifer, G. (1981). The phenomena and characteristics of self-hypnosis. *International Journal of Clinical and Experimental Hypnosis, 19,* 189–247.

Jackson, J. (1989). *Stress control through self-hypnosis.* Sydney: Doubleday.

Johnson, L. S. (1979). Self-hypnosis: Behavioural and phenomenological comparisons with heterohypnosis. *International Journal of Clinical and Experimental Hypnosis, 27,* 240–264.

Lynn, S. J. & Rhue, J. W. (1991). *Theories of hypnosis: Current models and perspectives.* New York: Guilford Press.

Phillips, E. L. (1988). *Patient compliance: New light on health delivery systems in medicine and psychotherapy.*New York: Hans Huber.

Sacerdote, P. (1981). Teaching self-hypnosis to adults. *International Journal of Clinical and Experimental Hypnosis, 19,* 282–297.

Sheehan, P. W. & Perry, C. W. (1976). *Methodologies of hypnosis: A critical appraisal of contemporary paradigms of hypnosis.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Soskis, D. A. (1986). *Teaching self-hypnosis: An introductory guide for clinicians.* New York: W.W. Norton.

Spiegel, H., & Spiegel, D. (1978). *Trance and treatment: Clinical uses of hypnosis.* New York: Basic Books.

SINGLE-SESSION THERAPY AND THE NEURO-ASSOCIATIVE CONDITIONING MODEL

Harry E. Stanton

University of Tasmania

As the first therapeutic encounter with a patient may be the only one which takes place, it is important to maximise its effectiveness. One way of doing this is through the use of Robbins' neuro-associative conditioning (NAC) model, as a means of structuring a single-session approach. In this paper, the model is explained. Particular attention is given to the key elements of interrupting patients' maladaptive emotional

Harry E. Stanton, Professional Development Unit, Centre for Education, University of Tasmania, GPO Box 252C, Hobart, Tasmania 7001.

or behavioural patterns with Bandler's theatre technique, and creating a more adaptive pattern using success imagery. A case study illustrates how the approach is used to deal with extreme anxiety.

Brief therapy is usually defined in terms of specific time limits over which the therapy is conducted, these ranging from single sessions to 50 sessions (Dilts, Grinder, Bandler, Bandler, & DeLozier, 1980; Malan, 1976). The former specification, that of a single session, appears particularly appropriate, given Talmon's finding that "the most frequent length of therapy for every one of the therapists [in the Department of Psychiatry at the Kaiser Permanente Medical Centre] was a single session" (Talmon, 1990). His study of 100,000 outpatient appointments during a five-year period indicated that this frequency of single-session treatments remained extremely constant.

Client dissatisfaction with treatment was not the causal factor for this brevity of interaction for, as Talmon demonstrated, almost 80% of the patients felt they had received everything they needed from their single session. This finding supports earlier studies which indicated that length of treatment does not proportionally enhance therapeutic benefits (Jones & Vischi, 1979; Mumford, Schleisinger, & Glass, 1984).

It is essential that we use well our first session with a client, making it complete in itself, for it may well be the only one we will have. One way of doing so makes use of Robbins' (1991) neuro-associative conditioning model, designed to achieve rapid change.

THE NEURO-ASSOCIATIVE CONDITIONING MODEL

Robbins' initial step involves deciding, quite specifically, what it is that the client really wants and identifying that which is preventing them from achieving this. Once this goal is specified, step two involves mobilising the leverage necessary to move the client toward the achievement of the specified goal. To Robbins, this means associating pain to NOT changing now and pleasure to the experience of changing now. Such associations create a sense of urgency which overrides the client's propensity to perceive change as a *should* rather than a *must*. Believing that knowing why change is necessary is much more important than knowing how it is to be accomplished, Robbins places great emphasis on assembling very strong reasons for why change should take place. As a means to this end, he uses both pain-inducing questions: "What will it cost me if I do not change?" and pleasure-inducing questions: "What kind of momentum could I create if I make this change in my life?"

Step three in therapy involves interruption of the client's limiting patterns. As Robbins points out, to get new results in our lives, knowing what we want and getting leverage on ourselves is not enough. By continuing to do the same things and running the same inappropriate patterns, we are not going to change no matter how highly motivated we may be. However, if

we interrupt our limiting patterns of behaviour or emotions by scrambling the sensations we link to our memories, we are more likely to be successful. The major reason why this should be so is that we tend to upset ourselves by the way in which we represent things in our mind. We run the same record over and over again. Instead of continuing to do this, Robbins suggests we take this mental record and scratch it so many times that we cannot experience the feelings anymore. That is what interruption is designed to achieve.

Once the original maladaptive behaviour or emotional pattern has been disturbed in this way, it is necessary to install a new, empowering alternative. This is step four in the model and it is based on the assumptions that the major reason most people's attempts to change are only temporary lies in their failure to find an alternative way of getting out of pain and into feelings of pleasure.

Step five involves conditioning the new pattern by continual rehearsal, preferably with emotional intensity. This can be done with imaginative rehearsal.

The final step is that of testing through future pacing. The client imagines the situation or situations which were, in the past, sources of frustration and to notice whether their new pattern has replaced the old.

Though all six steps are important and should find their place in the single session, here I want to focus primarily on the key elements of disrupting the existing maladaptive patterns and replacing them with a more adaptive alternative.

INTERRUPTION PATTERN — THE THEATRE TECHNIQUE

Bandler (1985) has described a pattern ideally designed for the interruption of unwanted behaviour. It makes use of dissociation, mental imagery, and humour, a combination likely to provide the "scratching of the record" needed to disrupt old patterns.

1. Clients imagine they are sitting in a movie theatre. On the screen before them they are to see a black-and-white snapshot of themselves in a situation just before they had the particular unwanted response.
2. Clients then float out of their bodies up to the projection box of the theatre, where they can "watch themselves watching themselves." From that position they are able to see themselves sitting in the middle of the theatre and also see themselves in the still picture which is on the screen.
3. That snapshot up on the screen is then transformed into a black-and-white movie, which is to be watched from the beginning until just beyond the end of the unwanted experience.
4. When clients get to this end point, they stop the movie, make it into a slide, turn it into colour, then jump inside the picture and run the movie backwards, taking only one to two seconds to do so. Everything is to take place in reverse, with people walking and talking backwards. As the intent is to make this as amusing as possible, it can be turned into a cartoon and

a ridiculous soundtrack added.

Once an existing behaviour/feeling pattern is disrupted in this way, opportunity exists for the installation of the desired new behaviour/feeling.

INSTALLING NEW BEHAVIOUR — SUCCESS IMAGERY

To help clients install a new behaviour pattern, the 5/1 — success — 1/5 technique can be very helpful. Its brevity ensures that it fits comfortably into the single-session format along with the use of the theatre technique. Three steps are used in this technique: (a) inducing a receptive mind set; (b) placing a single suggestion, or a single theme involving a network of suggestions, in the mind; and (c) returning to alertness.

The procedure begins with the use of six deep breaths, with a focus on the client's out-breaths. As clients exhale, they count "Five," letting their breath go. They count "Four" with the next breath, letting go a little more and continuing to do so with the next three breaths, counting "Three," "Two," and "One." On the final breath, as they let go as much as possible, they use a key word or words, such as "Relax," "Calm," "Peace," or "Let go." Clients then move to the second step, that of the success scenario. Should the presenting problem, for example, be that of examination anxiety, they would imagine themselves entering the room, sitting down, turning over the paper, noting down key points for all questions, starting on the easiest question, writing fluently and effortlessly, stopping to add more points to their notes for later questions, moving on to the next question, and finding each one becoming easier than the previous one. They might also imagine themselves talking with friends after the examination, realising they had provided correct answers and feeling satisfied that they had done themselves justice.

A very attractive success scenario is thus created in their minds so that, every time they think about it, they prepare their minds to repeat the performance at the actual examination. Each time thoughts of the impending test cross their minds, they switch immediately into imagining the success experience, replacing fear and anxiety. During the actual examination, as far as their minds are concerned, they have already handled it, mentally, many times.

The final step repeats the six-breaths pattern, this time the emphasis falling on the in-breath. As clients breathe in, they count "One," imagining they are drawing in alertness and energy. This process continues as they count "Two," "Three," "Four," and "Five" with the next four in-breaths. On the final breath, as they breathe in, they use a key word, such as "Wide awake," "Energy," "Zest," or "Go" to restore full alertness.

This method not only embodies Robbins' step of new behaviour installation, it provides the means for achieving his two final steps. Clients often fail to practise hypnotherapeutic or self-hypnotherapeutic techniques they are taught, due to "lack of time." The approach described here is quick and simple and clients may be more likely to persevere, effecting the practice that is so important.

Because they are also seeing themselves as successful in the future, they are testing the new pattern in the manner Robbins would suggest.

The following case study shows how this single-session treatment can be used with a client suffering from anxiety.

JAN — FEAR OF TRAVELLING OVER THE BRIDGE

Jan, a 34-year-old divorced mother of three small children, lived on Hobart's western shore and, each day, drove herself to work on the eastern shore. This was proving increasingly difficult for her to accomplish because of her anxiety about travelling over the Tasman Bridge linking the two shores. This anxiety appeared to stem from an uncomfortable experience which had taken place eight months previously.

On the occasion in question, Jan was travelling to work when a car in the adjacent lane moved too close; forcing her car against a retaining wall. Although her life was not in any real danger, the noise of the impact, the temporary loss of control, and the squealing of brakes terrified Jan. For some hours after the incident she was badly shaken, trembling and tearful. Although she had recovered sufficiently to drive home that evening, each succeeding day it became more difficult for her to cross the bridge. She began to feel that she would have to resign from her job.

As Jan was able to identify an experience which seemed to have precipitated her anxiety, it was appropriate to make use of the theatre technique. Although she would normally become quite upset when thinking about the accident, using the double dissociation of visualising herself in the audience and in the projection box enabled Jan to view the experience in a detached way, without the extremely unpleasant feelings it had previously evoked. This sense of remoteness helped her modify the fear which she had associated with the situation.

Jan imagined herself entering the theatre, sitting down, and seeing herself on the screen just prior to being involved in the accident. At this point, she was looking at herself driving over the bridge, feeling quite at ease and comfortable, listening to music on her cassette player. After mentally floating up to the projection box, she was able to look down and simultaneously see herself and the black-and-white slide on the screen. She then ran the black-and-white movie of the traumatic episode, stopping it as a slide at the point when she felt reasonably comfortable again. This was several hours after the incident had occurred. Mentally she entered the picture of herself on the screen, turned it into colour, and ran it backwards as a movie, stopping at the starting point. When I asked her to think again of the traumatic episode, she was able to do so without the strong emotion which had characterised her earlier recall. However, the memory did still bother her.

Although Bandler claims the theatre technique needs to be done only once, my experience has been that, in some cases, it is necessary to repeat it several times until all the emotion has been drained from the experience. In Jan's

case, during the second repetition, she began to smile, being, as she later related, somewhat amused at the ludicrous picture presented by the cars moving backwards. She had also mentally painted red noses on the cars involved and turned their drivers into cartoon characters who stuttered and gurgled.

Having completed the theatre procedure, Jan used the six out-breaths and her key word "Calm." She then imagined herself travelling over the bridge, listening to her favourite music, singing along with it, and arriving at the other side comfortable and at ease. Several successful trips were made in this way. She then went back into her past experience, remembering a number of very pleasant drives over the bridge. These she combined into a mental success videotape which she transferred forward so she "saw" herself doing the same thing the next morning when she would travel to work. After doing so, she returned to alertness with her key word "Zest."

Jan practised this success imagery a number of times before actually travelling over the bridge and, although admitting to initial nervousness, she handled the situation without difficulty. This has been continued for the past 18 months.

CONCLUSION

This single-session approach has been successfully used with a number of my clients. In many cases, anxiety was the presenting problem but the technique is applicable to a wide range of problems. It lends itself admirably to sports psychology, particularly when athletes have been injured and have, as a result, lost confidence in their ability. It is also most effective in the alleviation of stress and the enhancement of educational performance.

The use of this particular interruption is dependent upon the precipitating or traumatic incident being identifiable. If such an incident cannot be linked to the client's problem, alternative interruption patterns may be more successful, such as the use of metaphors (Stanton, 1992).

The approach I have described is both simple and direct. However, do not allow its simplicity and brevity to disguise its real value. I have found it to be extremely effective in helping people achieve rapid changes in their lives, supporting Robbins' view that change can be instantaneous. His model is a very sensible one and a variety of hypnotherapeutic approaches, quite distinct from that I have described, may be explained using its concepts. It would be productive, I feel, for readers to explore how their own favourite techniques might be explained, and perhaps better understood, when analysed in Robbins' terms.

REFERENCES

Bandler, R. (1985). *Using your brain — for a change.* Moab, UT: Real People Press.

Dilts, R., Grinder, J., Bandler, R., Bandler, L, & DeLozier, J. (1980). *Neuro-linguistic programming: Vol 1.* Cupertino, CA: Meta Publications.

Jones, K. & Vischi, T. (1979). Impact of alcohol, drug abuse, and mental health treatment on medical care utilisation: A review of the literature. *Medical Care Supplement, 17,* 1–82.

Malan, D. H. (1976). *The frontier of brief psychotherapy: An example of the convergence of research and clinical practice.* New York: Plenum Press.

Mumford, E., Schleisinger, G. H., & Glass, G. V. (1984). A new look at evidence about reduced cost of medical utilisation following mental health treatment. *American Journal of Psychiatry, 141,* 1145–1158.

Robbins, A. (1991). *Awakening the giant within.* New York: Simon & Schuster.

Stanton, H. E. (1992). Using metaphors to overcome performance anxiety. *Australian Journal of Adult and Community Education, 32,* 163–167.

Talmon, M. (1990). *Single session therapy.* San Francisco: Jossey-Bass