

## **TWO-YEAR FOLLOW-UP FINDINGS OF HYPNOBEHAVIOURAL TREATMENT FOR BULIMIA NERVOSA**

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This paper reports a two-year follow-up of the uncontrolled preliminary investigation of the use of an eight-week hypnobeavioural treatment program for bulimia nervosa (Griffiths, 1989). Data from 14 subjects (nine subjects from the previous study and an additional five subjects) were analysed, with the results indicating significant reductions in bingeing and vomiting frequency being maintained at two-year follow-up. Improvements on self-report measures of eating pathology were maintained at two-years, but such improvements were not maintained on measures of general health, psychiatric functioning, and depression. The results, limitations of the study, and the efficacy of hypnobeavioural treatment are discussed.

Several different treatments have been applied to the dieting disorder, bulimia nervosa, including cognitive behavioural treatment (CBT), group therapy, behavioural therapy, and nutritional counselling. By far the most common approach is CBT (Fairburn, 1981, 1985). Few studies have examined the effectiveness of hypnotic techniques in treatment, although there are now several studies demonstrating that bulimic patients are more hypnotisable than their anorexic counterparts and the normal population (Griffiths & Channon-Little, 1993; Kranhold, Baumann, & Fichter, 1992; Pettinati, Horne, & Staats, 1985; Pettinati, Kogan, Margolis, Shrier, & Wade, 1989; Vanderlinden, Vanderecken, van Dyck, & Vertommen, 1993). Why there are few investigations of hypnotic techniques in the treatment of bulimia nervosa patients is surprising, considering their high hypnotisability, indicating their responsiveness to treatment which incorporates hypnosis.

From reviews of the use of hypnotic techniques in the treatment of dieting-disordered patients (Vanderlinden & Vandereycken, 1988) it is evident that most reports have been single-case examples or small sample descriptions. The only

trial of the use of hypnobeavioural treatment (HBT) for bulimia nervosa was conducted by Griffiths (1989), but this was uncontrolled. HBT is a multifaceted treatment, comprising both behavioural and hypnotic techniques, which draws on behavioural principles for its theoretical underpinnings. Behavioural techniques are used to change abnormal eating behaviours by focusing on the antecedent events leading to bulimic symptomatology and the consequences of these events such as dieting and the binge/purge cycle. Hypnosis is used to reinforce and maintain the changes in bulimic behaviours, and preliminary findings from the Griffiths' pilot study of HBT on 12 subjects suggested a positive outcome as bulimic symptoms and depression were significantly reduced with improvements maintained at nine-month follow-up.

Until recently, little was known about the medium (minimum of two years) and long-term (minimum of four years) outcomes of various types of psychological treatments for bulimia nervosa. It is important to investigate the maintenance of symptoms over time to measure the effectiveness of treatment in the medium to long term, as there is evidence of differences in the maintenance of symptom improvement two years or more after treatment. For example, a 69% abstinence rate from bingeing and vomiting at two-year follow-up was reported after a combination of psychodynamic and CBT treatment by Lacey (1983), whereas Fallon, Walsh, Sadik, Saoud, and Lukasik (1991) reported 39% of their subjects achieved "full recovery" at two-to-five-year follow-up after in-patient treatment. By contrast, Mitchell et al. (1988) found only 19% of subjects free of bulimic symptoms at two to five years after group psychotherapy. As there have been no medium-term follow-up reports of the effects of HBT, the purpose of this study was to investigate the response at two-year follow-up of the 12 patients from the pilot study and another five patients who received identical HBT.

## METHOD

### Subjects

Twelve clients who had participated in the first study and five additional clients who had completed the identical treatment and follow-up regime were included in this study. All met the DSM-III-R (American Psychiatric Association, 1987) criteria for bulimia nervosa and were referred for treatment to an eating disorders clinic at a Sydney teaching hospital. Three of the 17 clients could not be contacted or declined to participate in the study, which left 14 clients.

The demographic characteristics of the sample ( $N = 14$ ) prior to treatment were as follows: mean age 26 years ( $SD = 6.37$ ; range = 17–42 years); mean weight 64.19 kg ( $SD = 10.01$ ; range = 46.1–81.7 kg); mean height 165.54 cm ( $SD = 6.85$ ; range = 158–171 cm). The average age of onset of bingeing was 21 years ( $SD = 6.24$ ; range = 16–40 years) and stated average binge frequency per week was 5.43 ( $SD = 1.83$ ; range = 2–7 binges per week).

Of the 14 clients, three were married and 11 were single; nine were wage-

earners, three were students, and two were occupied with home duties. All clients had used vomiting as a means of weight control, and three used laxatives, one used diet pills, and two excessive exercise. Six clients had previous treatment for their eating disorder and three had made suicide attempts. Of the sample, two were highly hypnotisable, nine were moderately hypnotisable, and three were lightly hypnotisable, as assessed on the Stanford Hypnotic Clinical Scale (SHCS; Morgan & Hilgard, 1975).

### **Measures**

All subjects completed a battery of measures prior to and following treatment and at follow-up intervals for two years. The measures described in the first study included the Eating Disorder Inventory (EDI; Garner, Olmstead, & Polivy, 1983); the Zung Self-Rating Depression Scale (Zung, 1965); the General Health Questionnaire (GHQ; Goldberg, 1972); the Eysenck Personality Inventory (EPI; Eysenck & Eysenck, 1963); and five rating scales of symptom severity and expectancy of outcome (RS 1-5) devised by the author. Subjects were asked to make a rating from 0 to 100 on the five scales. On the first scale, ratings of the degree of severity of bingeing and purging were obtained. On the second, an indication of the subject's expectancy of the outcome of treatment in reducing bingeing and purging was obtained. On the third scale, subjects rated the degree of change in bulimic symptoms during treatment. On the fourth scale, subjects rated how much change they would expect from the treatment, and on the fifth scale they were asked to rate the percentage of people with bulimia nervosa they expected to be helped by the treatment.

### **PROCEDURE**

All assessments and treatment were administered by the author. The treatment comprised the eight-week HBT program described by Griffiths (1989, 1993). An HBT manual was written and systematically followed, with the treatment consisting of seven sessions. Six were conducted by the therapist and one was conducted by a dietitian. The program was divided into two stages with stage one consisting of three interviews over four weeks. Self-monitoring was the prime behavioural technique used in this phase while other treatment components during this stage included education and nutritional guidance. Stage two consisted of weekly sessions of hypnosis which were conducted for four consecutive weeks. Positive suggestions given in hypnosis were structured for behavioural control and each client was instructed in the use of self-hypnosis during the second treatment session. Directions for use were given while clients were in hypnosis and it was suggested they were capable of accomplishing similar effects alone between sessions, by following at home the identical steps carried out in the session. A description of the steps involved was given together with directions to end the trance by counting backward from 20 to 1. The post-hypnotic suggestion that self-hypnosis would end spontaneously, should clients

need to be alert, was given. Clients were asked to record the frequency of bingeing and vomiting throughout treatment and follow-up.

### **Follow-Up**

Clients contacted for the two-year follow-up were asked to complete and return the psychological questionnaires and to indicate the weekly frequency of weight control techniques; that is, bingeing, vomiting, use of laxatives, diet pills and diuretics, and over-exercising, for the previous three months.

### **Statistical Analyses**

*Bingeing and vomiting frequency* The means of weekly bingeing and vomiting were calculated throughout treatment to nine-month follow-up as for the pilot study. For the two-year follow-up, the mean weekly frequency of bingeing and vomiting over the three-month period prior to follow-up was calculated.

Two overall MANOVAs were performed on the means of bingeing and vomiting across the time intervals pre-treatment, post-treatment, six-week, and two-year follow-ups. Because the main interest of this study was in the longer term follow-up interval after treatment, data for the three-, six-, and nine-month follow-up intervals were not included in the analysis. A series of pair-wise comparisons was conducted, where pre-treatment was compared with post-treatment, six-weeks, and two-year follow-up for both bingeing and vomiting. The alpha level of significance was set at  $p < .05$  for the comparisons.

*Psychological measures* Using the MANOVA model, 18 outcome variables (EDI-DT, EDI-B, EDI-BD, EDI-I, EDI-P, EDI-ID, EDI-IA, EDI-MF, GHQ, Zung SDS, EPI-E, EPI-N, EPI-LS, RS-1, RS-2, RS-3, RS-4, and RS-5) were subjected to a repeated-measures analysis of variance for multivariate data. The data were analysed from pre-treatment to two-year follow-up. For the reason outlined in the previous section, data for the three-, six-, and nine-month follow-up intervals were not included in the analysis.

## **RESULTS**

### **Bingeing and Vomiting Frequency**

Table 1 shows the means of weekly bingeing and vomiting episodes for pre-treatment, post-treatment, six-week, and two-year follow-up intervals.

The overall MANOVA across time (i.e., within subjects) for binge frequency indicated a significant difference between occasions,  $F(3, 39) = 8.31, p < .0001$ . Similarly, the overall MANOVA across time (i.e., within subjects) for vomiting frequency indicated a significant difference between occasions,  $F(3, 39) = 9.67, p < .0001$ .

The comparisons of pre-treatment bingeing with bingeing at post-treatment, six-week, and two-year follow-up time intervals revealed a significant difference for each comparison. There was a significant reduction from pre-

**Table 1** Means and Standard Deviations of Weekly Bingeing and Vomiting From Pre-Treatment to Two-Year Follow-Up for 14 Bulimia Nervosa Patients

	Bingeing		Vomiting	
	Mean	SD	Mean	SD
Pre-treatment	8.29	9.36	7.79	8.62
Post-treatment	1.00	1.57	0.57	1.34
Six weeks	0.64	1.51	0.21	0.58
Two years	0.89	1.44	0.75	1.48

treatment to post-treatment bingeing,  $t(13) = 2.79, p < .02$ ; from pre- to six-week follow-up bingeing  $t(13) = 3.01, p < .01$ ; and from pre- to two-year follow-up bingeing  $t(13) = 3.02, p < .01$ .

Comparing pre-treatment vomiting with vomiting at post-treatment, six-week, and two-year follow-up time intervals revealed a significant difference for each comparison. There was a significant reduction from pre- to post-treatment vomiting,  $t(13) = 3.05, p < .01$ ; from pre- to six-week follow-up vomiting  $t(13) = 3.25, p < .01$ ; and from pre- to two-year follow-up vomiting,  $t(13) = 3.22, p < .01$ .

Of the 14 subjects, 57% ( $n = 8$ ) were abstinent from bingeing and 71% ( $n = 10$ ) were abstinent from vomiting for the three months prior to two-year follow-up. Only one subject had maintained a reduction of less than 50% for both bingeing and vomiting.

### Psychological Measures

Table 2 shows the mean scores and standard deviations for the 18 dependent variables for the sample for pre-treatment, post-treatment, six-week, and two-year follow-up intervals.

Table 3 shows the MANOVA  $F$  values for the contrasts comparing pre-treatment with post-treatment, six-week, and two-year follow-up. Also indicated in the table are those contrasts which were significant for each variable using the Bonferroni adjustment.

There were several significant differences in various comparisons and comment will be made on those of interest only. There was significant reduction in symptomatology between pre-treatment and two-year follow-up on the following EDI subscales: Drive for thinness,  $F(1, 13) = 55.65, p < .0001$ ; Bulimia,  $F(1, 13) = 40.49, p < .0001$ ; Body dissatisfaction,  $F(1, 13) = 13.38, p < .003$ ; Ineffectiveness,  $F(1, 13) = 8.04, p < .01$ ; Interoceptive awareness,  $F(1, 13) = 23.63, p < .0001$ .

There were no significant differences between pre-treatment and two-year follow-up in GHQ scores, levels of depression on the Zung SDS, or on any of the scales of the EPI. There was a significant reduction between pre-treatment

**Table 2** Means (and Standard Deviations) on the 18 Dependent Variables, Pre-Treatment to Two-Year Follow-Up

Variable	Pre	Post	Six weeks	Two years
EDI				
EDI-DT	14.71 (3.14)	7.29 (6.75)	7.43 (6.75)	4.86 (5.55)
EDI-B	10.50 (4.60)	1.50 (2.38)	1.14(11.41)	0.71 (1.89)
EDI-BD	17.86 (8.30)	11.00 (9.16)	11.00 (10.32)	8.43 (8.06)
EDI-I	8.14 (6.89)	2.43 (2.92)	2.43 (2.88)	2.43 (3.52)
EDI-P	9.21 (6.03)	8.43 (5.16)	8.14 (5.66)	7.21 (4.32)
EDI-ID	5.00 (5.36)	2.14 (2.35)	2.36 (2.76)	2.93 (3.83)
EDI-IA	9.93 (5.76)	2.14 (2.35)	1.64 (1.91)	1.64 (2.82)
EDI-MF	3.14 (2.14)	1.00 (1.62)	1.64 (2.02)	1.71 (3.43)
GHQ	9.29 (8.61)	1.00 (1.52)	1.86 (3.04)	5.86 (6.71)
Zung SDS	45.23(10.24)	33.62 (8.28)	33.46 (7.21)	36.31(12.64)
EPI				
E	11.25 (5.61)	11.67 (2.74)	11.75 (3.69)	11.91 (3.29)
N	16.75 (5.22)	13.33 (5.48)	11.75 (5.58)	12.50 (5.40)
LS	2.83 (1.19)	2.75 (1.66)	2.83 (0.84)	2.33 (1.44)
Expectancy scales				
RS-1	83.33(21.89)	25.00(24.31)	17.50(22.61)	15.80(18.81)
RS-2	84.17(22.34)	85.33(16.21)	95.00 (9.05)	91.67(10.29)
RS-3	70.00(21.60)	91.43 (6.90)	92.86 (4.88)	87.14(16.03)
RS-4	83.33(15.06)	88.33(11.69)	95.00 (5.48)	85.10(16.43)
RS-5	70.00(16.73)	65.00(26.65)	81.67(11.69)	93.33 (8.17)

and two-year follow-up for RS-1  $F(1, 13) = 68.15, p < .0001$ , but not for the other three scales.

## DISCUSSION

Results of the current study indicate that significant reductions in bingeing and vomiting frequently were sustained when subjects were followed up at the medium term of two years. The bingeing and vomiting abstinence rates are comparable to the two-year follow-up findings for combined CBT and psychodynamic treatment, presented in groups and individually, described by Lacey (1983). The preliminary findings from this study and the previous pilot study suggest that bulimia nervosa may respond to a multifaceted treatment program and that the use of self-hypnosis after treatment may have assisted patients to maintain their progress at two-year follow-up. However, strong claims cannot be made for the effectiveness of the treatment due to the limitations of the investigation, such as patients having additional treatment during follow-up, the small sample size, and lack of comparison group. A larger controlled study would need to address some of the methodological deficiencies of the two pilot studies. Further, it is not possible from either pilot study to

**Table 3** Summary of MANOVA *F* Values for Contrasts From Pre-Treatment to Two-Year Follow-Up

Variate	Contrast pre vs. post	Contrast pre vs. 6-week f-u	Contrast pre vs. 2-week f-u
EDI-DT	36.46*	32.33*	55.66*
EDI-B	37.61*	48.69*	40.49*
EDI-BD	20.98*	14.26*	13.38*
EDI-I	16.29*	9.67*	8.04*
EDI-P	0.31	0.98	2.41
EDI-ID	4.92	5.31	1.57
EDI-IA	24.07*	33.87*	23.63*
EDI-MF	11.34*	4.38	2.36
GHQ	14.18	10.49*	1.57
Zung SDS	43.93*	33.96*	6.61
EPI-E	0.11	0.08	0.14
EPI-N	3.96	12.69*	6.89
EPI-LS	0.07	0.00	0.80
RS-1	38.83*	63.82*	68.15*
RS-2	0.09	2.32	1.03
RS-3	6.25	7.46	2.23
RS-4	0.79	2.75	0.04
RS-5	0.79	3.18	10.65

\* $p < .05$  Bonferroni.

determine which of the components of HBT produced the most change.

Results of other outcome measures produced some interesting findings, with not all improvements maintained. Improvements on four EDI subscales—that is, EDI-DT, EDI-B, EDI-BD, and EDI-I—were maintained at two-year follow-up. Further improvements at two-year follow-up were noted on the EDI-IA subscale. The pattern of changes on the EDI subscales at two years is similar to the post-treatment changes for a CBT group, reported by Freeman, Barry, Dunkeld-Turnbull, and Henderson (1988).

Improvements in general health and non-psychotic functioning, as measured by the GHQ, were not sustained at two-year follow-up. Results from the GHQ in both pilot studies suggest that HBT does not change persistent psychopathology. Fairburn, Kirk, O'Conner, and Cooper (1986) found that CBT was effective in sustaining improvements in general psychopathology (measured by the Present State Examination at one-year follow-up). Their more recent controlled investigation (Fairburn, Jones, Peveler, Hope, & O'Conner, 1993) demonstrated similar effects. Two-year follow-up findings are not available to provide comparisons with findings from this present study.

Reductions in the level of depression, as measured by the Zung SDS, were not maintained at two years. This contrasts with the finding of sustained

improvements in depression at 30-month follow-up, reported by Luka, Agras, and Schneider (1986). This discrepancy suggests HBT treatment may be less effective in maintaining longer term improvements in depression than CBT used by Luka et al. (1986).

There were no significant changes in levels of N or E on the EPI at two-year follow-up. As these are purported to be personality trait measures, one would not expect them to change significantly over time.

Self-reports of patients on one of the severity and expectancy of outcome rating scales supported the objective findings from the study. Subjects reported a significant reduction in the degree of distress from their bingeing and vomiting which was maintained at two-year follow-up. It is noteworthy that subjects considered a significant percentage (93%) of people would be helped by the treatment. This high percentage could suggest that subjects were optimistic about the type of treatment in which they had participated. Whether this expectancy of improvement in others receiving the treatment would apply to themselves was not explored.

Sixty-four per cent of the subjects were moderately hypnotisable, supporting the notion that subjects do not have to be highly hypnotisable to benefit from this treatment. The two highly hypnotisable subjects in the sample were abstinent from bingeing and vomiting at two-year follow-up, suggesting an association between hypnotisability and outcome which needs to be investigated in a larger sample of highly hypnotisable bulimic subjects.

The limitations of this study are recognised and summarised as follows. First, the outcome variables depend solely on subjects' self-reports and may merely reflect an underestimation of current problems, to reassure the therapist that treatment had been helpful. Attempts to use biological indicators of binge/purge episodes, such as serum amylase in treatment studies, have been unsuccessful (Agras, Schneider, Arnow, Raeburn, & Telch, 1989) and bulimic subjects are reluctant to inform or discuss their problem with others, so that obtaining corroborative evidence from relatives and friends is difficult. Given these difficulties, self-report measures remain the most frequently used means of assessing bulimic behaviours (Laessle et al., 1991).

Second, a number of subjects had received additional treatment during the two-year period following first contact with the therapist and dietitian. One subject had additional treatment elsewhere since her initial treatment. Another subject received treatment for depression between follow-ups and three subjects had requested treatment for relapses and were seen prior to their two-year follow-up. One subject had lost a significant amount of weight and developed anorexia nervosa at two-year follow-up and was referred for treatment. The remaining subjects were seen only for the structured-treatment sessions and designated follow-ups by the therapist. Three subjects had seen the dietitian for an additional dietary session and one subject saw the dietitian for two sessions between treatment completion and two-year outcome. Additional treatment during follow-up limits interpretation of the data. A further study would need to



investigate the response of only those subjects who did not have additional treatment during follow-up or to compare the responses of those who had or did not have further treatment.

The third limitation was that the sample size was small and there was no control group, which limits the generalisability of these results. These deficiencies have been addressed in a recent controlled investigation by the author conducted on a large sample of clients (Griffiths, 1993). The results of this latest study suggest HBT is equally as effective as CBT and that both treatments are better than no treatment at all (Griffiths, Hadzi-Pavlovic, & Channon-Little, 1994). However, a long-term follow-up of these results has yet to be conducted.

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## **COPING WITH THE STRESS OF TOURETTE SYNDROME IN CHILDREN AND ADOLESCENTS: USE OF SELF- HYPNOSIS TECHNIQUES**

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Tourette syndrome (TS) is a serious and complex neurobehavioural disorder with onset in childhood, affecting vocalisations and causing multiple motor tics. Children with TS often experience a sense of loss of control over their body, and may be ostracised. No prospective studies of hypnosis for TS exist. Clinical reports have described successful application of different self-regulatory techniques for the modulation of symptoms. This paper describes a clinically effective approach applied in helping over 35 different young people help themselves with this complex disorder. A variety of useful self-hypnosis strategies are described and illustrated with case examples.

Tourette syndrome (TS) is a serious and complex hereditary neurobehavioural disorder characterised by lifelong duration of a constellation of troubling symptoms, defined by childhood onset of vocalisations and multiple motor tics present almost daily for at least one year, and by distress or impairment in functioning (American Psychiatric Association [APA], 1994). Associated problems may include attentional difficulties, learning and conduct disorders, obsessive–compulsive phenomena, and echo or copying behaviours. A common observation and belief is that children with TS are “unable to control themselves” and behaviours are thought of as involuntary.

The prevalence of TS varies from 1 in 100 school-aged boys (Comings, 1990) to 4–5 per 10,000 (APA, 1994). Three times as many boys as girls are affected and as many as a million Americans are said to have TS (Comings, 1990).

The impact of TS on a child’s social and emotional development can be

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**Table 1** Stresses of Tourette Syndrome

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- Feeling out of control (tic-paradigm of loss/absence of control)
  - Embarrassed about a particular or unusual tic, twitch, or movement
  - Anxiety:
    - About what people say
    - About how to respond
  - Fear:
    - Of ridicule, lack of acceptance/understanding, and social ostracism
    - Of more and more loss of control
    - That it will never go away
  - Anticipatory anxiety:
    - That it will get worse, e.g., giving a speech in class, while playing football, during a recital
  - Pain and fatigue in muscle groups that have had major tics (e.g., commonly neck and shoulders >> headaches, neckaches).
  - School problems for (some) children with TS:
    - Primary TS symptoms—motor and vocal tics
    - ADHD—impulsivity, inattention, distractibility
    - Learning disorders
    - Obsessive-compulsive behaviours
    - Phobias and panic attacks (including test anxiety)
    - Other secondary symptoms:
      - echolalia, palilalia
      - short temper.
      - coprolalia, copropraxia
      - excessive touching and sexual touching
    - Poor socialisation skills
    - Poor self-esteem
    - >>> SCHOOL PHOBIA
  - Having to take medication + medication effects
- 

devastating (Table 1). Symptoms typically expose children to significant social ridicule and rejection at home and school. TS is typically manifest between ages 2 and 15 years with mean onset 7 years (Golden, 1986.) It may go undiagnosed for three to five years, while children experience ostracism, a sense of loss of control, and low self-esteem.

Specific uses of relaxation, hypnosis, biofeedback, or analogous techniques for complex tic disorders are mentioned little in the literature (Clements, 1972; Friedman, 1980; Tophoff, 1973). No prospective studies of the value of these techniques for TS are published. In reports of single-case studies, results with hypnotherapy range from complete remission (Lindner & Stevens, 1967; Spithall, 1974) to temporary symptom relief (Eisenberg, Ascher, & Kanner, 1959; Fernando, 1967; McKinnon, 1967; Polites, Kruger, & Stevenson, 1965; Schneck, 1960). Anxiety-reduction through desensitisation or relaxation has been described (Savicki & Carlin, 1972; St James-Roberts & Powell, 1979;

Thomas, Abrams, & Johnson, 1971) with limited generalisation of their benefits (Canavan & Powell, 1981; Turpin & Powell, 1984). A recent review of behavioral treatment outcome studies of TS described 32 studies with behavioral therapy as the primary treatment. One study included 10 subjects, one included six, and several had two or three while the majority were single-subject designs and reports (Peterson & Azrin, 1993).

I first applied hypnotic strategies for TS in 1981. That youngster's success was recorded in a later report in which we (Kohen & Botts, 1987) described the clinical effectiveness of RMI in four children (5 to 9½ years) and reported on four others. Zahm (1983) described a carefully done clinical outcome study of hypnosis therapy, and Young and associates (Young, 1989, 1991; Young & Montano, 1988) have described a hypnobehavioral approach to helping youngsters with TS.

Since the first opportunity in 1981, I have taught self-hypnosis strategies of RMI to over 40 children and adolescents with varying degrees of severity of TS. This experience suggests that direct effects of self-hypnosis on the tics of TS (Table 2) include:

1. reduction of intensity, frequency, and duration of a given motor or vocal tic(s) after they have appeared; and
2. apparently associated response prevention. Thus, self-hypnosis rehearsal and suppression of tics appear to contribute to a reduction in the actual frequency and/or intensity of tics. This has not yet been studied and these observations are derived from clinical observations and individual patient reports.

**Table 2** Self-Hypnosis for Tics of Tourette Syndrome

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*Direct effects:*

- 1 Decreased intensity and frequency of tic(s)
    - STOP sign imagery
    - Favourite-place imagery = > being somewhere where you never tic
    - Relaxation = > dissociation from and control of tic, e.g., relax toes upwards to head
    - Transfer the tic = > send tic from face/neck to toe or finger where it can "wiggle all it wants to"
    - \* Image the tic = > "mirror" in mind, measure tic intensity on a meter, scale: then reduce it
  - 2 Response prevention
    - Rehearsal of tic and suppression in private (e.g., home)
    - Rehearse imagining situations where "used to" have tics >> alter the outcome in imagery
  - 3 Future projection
    - \* Imagine how it will feel when no tics to bother or disturb—how life will be different and better
-

Indirect effects (Table 3) of self-hypnosis in the tics and stresses of Tourette syndrome include:

1. General anxiety reduction. Self-hypnosis for relaxation seems to be an extremely significant factor in the reduction of the stresses of TS. As a known major trigger to the appearance of new tics and the exacerbation of existing tic behaviours, stress plays a potentially pivotal role in this disorder. Accordingly, with reduction of stress through self-hypnosis often comes reduction of tics.
2. A second important indirect effect of self-hypnosis for TS is understood in its application toward problems co-morbid with TS. This undefined process may be modulation of co-morbid problems and resultant decrease in anxiety and, therefore, tics. Examples include using the relaxation and mental imagery of self-hypnosis as an adjunct in reducing the impulsivity or inattention of associated attention deficit hyperactivity disorder (ADHD), or to aid in reducing OCD behaviours, or facilitating management of learning difficulties.

The clinical approach and strategies described in the two representative cases reflect the clinical efficacy of RMI (or self-hypnosis) techniques for the various stressful aspects of TS in young people.

**Table 3** Self-Hypnosis for Tics of Tourette Syndrome

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*Indirect effects:*

- 1 Anxiety reduction (anticipatory anxiety, new places, things, places/times of excitement)
  - 2 For co-morbid features:
    - Relaxation/imagery for help with concentration and learning for co-morbid learning difficulties
    - Relaxation/imagery self-hypnosis for impulsivity of ADHD
    - Relaxation/imagery for OCD features (e.g., STOP sign, future projection, etc.)
- 

**Case Report — Keith**

Keith was a 14-year-old when he was initially referred to “help him relax and learn to control or eliminate tics.” The referring paediatric neurologist had diagnosed TS at age 11, based on a history of multiple motor tics since age eight, including facial grimacing, stretching of the mouth, wide-eyed eye openings, and upward and left lateral gaze. Throat-clearing was noted at age nine, and at age 12 exaggerated head-nodding began.

At his first visit Keith said: “I get nervous and then I worry about it. It just happens when I think about it, and I know I do it.” His awareness of a need for

some self-control contrasted with his evident sense of frustration of helplessness. He said: "I make myself not do those other tics, they come back sometime for a day or two, but then I make myself not do them. I can make myself not do it, and in school I can't put as much concentration in it, and so it gets worse. I get nervous, and the nervous [sic] makes it worse."

To at once assess his motivation and offer reframing, he was asked: "Would it be OK to find a way where you can concentrate on it without spending as much time, or can you *build up the concentrating?*" He agreed with this hypnotic suggestion and I told him directly I was quite sure I could help him to help himself.

At the second visit five days later he noted: "My head isn't doing it nearly as much as before [his own use of dissociative language] because I switched habits [a reflection both of more personal responsibility...and sadness]. I started to do something else so my head's going away" and he demonstrated a facial grimace with a forward thrust of lips and chin. He said: "When I *think* of it I do it, when I forget about it, I don't do it. Up to 80-100 times per day." Sad and worried, he said, "I can control this, but its really hard, it's like a cough building up," describing the sensory tic quality of being able to "suppress" the tic for a while until it "overflows" or "breaks through."

In response, I taught him about neurotransmitters and introduced the idea that he could signal the body at the *right* time in the *right* way. Playing tennis (one of his favourite activities) was used as a metaphor, to offer the dissociative suggestion that "Muscles can learn to do the right things in the right way." By way of reinforcing positive expectations, an explanation was given along with embedded suggestions to the effect that "How we talk is how we think is what we do, so I'll be asking you to switch your talking sometimes to help switch your thinking and therefore switch the behaviour."

The first formal induction of hypnosis was conducted with a peripheral temperature biofeedback "experiment" as a metaphor to see what might happen to the temperature while he was altering his thinking via imagination, eye closure, and favourite-place imagery. Intensification, or deepening, proceeded with multisensory imagery. Progressive relaxation was conducted from toes upward to purposely begin and focus as far away as possible from the (facial) site of the tic behaviours. Metaphoric reference was made to the brain as the "main computer" and "boss of the body." In trance Keith was given feedback that he had "probably noticed" that his muscles had become relaxed, his breathing had slowed, and stillness had occurred "without even talking about it," embedding the explanatory suggestion "*because* the mind is focused and when the mind relaxes doing imagination the body listens and relaxes too." This was provided as education, as a metaphor for success and control, and as a post-hypnotic suggestion. Ideomotor signalling was taught for trance ratification and he was stunned, reporting later that "I didn't think it would happen."

In the context of storytelling, the idea of a STOP sign (Kohen, 1995) was introduced: "I knew a kid once who had the same problem, much more than you,

and he told me he developed the idea that whenever he was about to have a tic, he'd notice it in his mind *right before* it happened, he'd imagine a STOP sign filling his imagination and STOPPING the tic ... Funny how it worked, but it did. The more he practised, the better he got." At the end of the first experience, he was taught self-hypnosis and agreed to practise 10–15 minutes per day. With biofeedback, he achieved a peripheral temperature change of 2.6 degrees, and reported after the "experiment" that he had switched his imagery to imagining snowboarding and playing basketball, dribbling the ball on the snow:

At the third visit a week later, he reported effective practice of self-hypnosis, noting "I make myself picture something, basketball or baseball or football or skiing and I don't plan it, it just comes in my mind." He added: "My habits are much better ... hardly there at all," and "oh yeah, I used the STOP sign a few times." In contrast to the first two visits, no tics were observed during this visit. Hypnotherapy included ego-strengthening and pride in his success, and new ideas, including depositing a dose of relaxation in a bank account of comfort, to be able to draw upon at any time. An audiotape of the session was made for home use.

At the fourth visit two weeks later he proudly reported a continued and dramatic decrease of tics. "I'm not doing my habits very much." In hypnosis, I suggested amnesia for tics and how to do them. He was told that he had much more experience with *not* ticquing, and he agreed. Also added was the suggestion to transfer the tic to one or both big toes or to some other place where it wouldn't bother or disturb him.

Over the next several weeks Keith improved and, like many youngsters, began practising self-hypnosis less often, only when he seemed to need it most. When, by mutual agreement, the time between visits was increased to four weeks, some increase in tics was noted.

At the sixth visit he reported: "My habits have really gotten bad." In the interim, one stressor was the beginning of a new physical exercise program. New tics included wide eye-stretching, and mouth-stretching new grimaces, which he said was a "4" on a scale of 0–12 with 12 = the worst. He observed: "I still do my face, it's a 12, I do that one constantly unless I forget about it." He reported that the tape was not helping him at all, and that he "couldn't" hold the tics back.

During a lengthy and intense hypnotherapy session, a new tape was prepared and I emphasised several new ideas including: (a) future projection imagery, seeing himself in a mirror, one day, week, month, or year older, tic-free; (b) remembering to forget how to tic; and (c) applying the STOP sign in a new and abrupt fashion.

Two weeks later Keith reported that "My habits are much better than when I first came to see you, the only one I do now is my eyes." Despite suggestions to practise daily, he was content to use hypnosis "about once in three days, whenever I've been having a lot of tics in one day." He was anxious about his forthcoming summer camp and was given the suggestion to pack for camp but



not to pack the tics. He later reported a wonderful time at camp with minimal problems with tics while there.

After a year of follow-up he remains improved, with continuing adolescent adjustment struggles, variable reappearance of tics in association with stress, and confidence that recommitment to his self-hypnosis practice is useful in providing relief and comfort.

### **Case 2 — Betty**

Betty was just over seven years old when referred by her paediatrician for relaxation and imagery training (self-hypnosis) for tics, which had begun less than a year before at age six. She was first noted to be “flipping her head as though she had hair in her face” and eye-blinking appeared a month later, followed soon thereafter by jaw-thrusting, throat-clearing, and sniffing. So-called “humping and squirming” behaviour in her bottom were also of concern to her parents. When she was first seen by a paediatric neurologist, her symptoms had been present for only three months and were mild. He informed the family that Betty had “mild TS,” emphasised the role of stress, and told them there was no evidence of associated ADHD. When they asked about “biofeedback” he said (incorrectly) that she was too young. In response, the parents experienced a lot of guilt about their hectic and “stressful” lifestyle, and the mother quit her job in order to be more accessible to Betty.

At the same time as the referral from the paediatrician in February 1993, Betty had also begun making humming and squeaking noises, and was being teased at school. When the mother recontacted the neurologist, he confirmed the diagnosis and suggested a trial of medication, but the parents declined. The paediatrician then referred the family to Behavioural Paediatrics for help with self-regulation. At the initial visit (July 1993) the parents reported waxing and waning of multiple motor and vocal tics and on the rating Scale of Tic Disorders (Barkley, 1988), noted moderate tics including eye-blinking, mild tics of the jaw and mouth, neck, chest, abdomen, and shoulders, and severe/frequent tics of the arms, fingers, and hands. Reported vocalisations included sniffing and throat clearing as well as humming. Complex movements including skipping and hopping behaviours were also noted. Betty’s tics were especially evident while with family, watching TV, and during meals, and much less prevalent while at school. Betty had recently told her parents: “I made it go away just from my thoughts.”

At the first visit, I used storytelling to introduce the idea of the brain as computer and a bicycle metaphor, wherein she agreed that, like after learning to ride a bicycle, *the muscles can learn to do things by themselves automatically* after they’ve been trained.

Towards the end of the first visit and in the interest of creating curiosity and giving Betty something to “do” and “use” when she went home, an “experiment” of relaxation/mental imagery (self-hypnosis) was done with parents present. Betty was invited, both directly and through suggestion, to

"Close your eyes. Now picture in your mind's imagination a STOP sign. I don't know what it will look like because in everyone's imagination there is a different STOP sign and it can look however it looks." She reported "It's a blue triangle!" "Now, each night before you go to sleep, *put* the STOP sign up in your mind. Every night, before bed remind yourself to 'DO THE STOP SIGN' WHENEVER your muscles are doing something that you do not want them to do."

Betty and her parents liked this and she agreed to do self-monitoring of this self-hypnosis strategy by putting a smiley-faced sticker on a calendar every time she thought about her blue triangle STOP sign. Tics observed and ignored during this first visit included shoulder-rolling, facial grimacing, throat-clearing, and hand movements.

At the second visit two weeks later Betty reported the stop sign was now a pink triangle and "It stops the movements!" Asked about practising, she said "I do the stop sign for five minutes after lunch, before supper, and at bedtime" even though she had only been given the hypnotic suggestion to practise at bedtime.

After watching a video of other children doing hypnosis, Betty practised self-hypnosis, rehearsed "being a snowgirl" with melting for progressive relaxation, and growing into a strong tree. Self-hypnosis was taught and she agreed to practise this at home. Over the next three visits at two-week intervals, demonstrable improvement was reported (parent, child) and observed, with obvious decrease in frequency, intensity, and duration of tics. The mother reported that, while Betty had generally improved, the weekends were worse and she judged this to be due to increased stress during that time.

During these visits new strategies for tic control were added, including: (a) being as relaxed as a Raggedy Ann doll (for general and specific muscle relaxation training); (b) imagining being a puppy with metaphors for control; (c) imagining being very tiny, taking a trip through her body, visiting all of the parts, getting to the main computer we call the brain, and there finding the *twitch switch* and turning it down or all the way off; and (d) transferring the tics down the body to the big toes, or to the hands to imagine throwing the tics away. These and other suggestions were incorporated in an audiotape of the office visit and given to Betty, for her use in practice at home.

While stress continued to trigger more tics, Betty and her mother reported she could now achieve better and faster control of new or recurrent tics, even when they recurred at stressful times. With a month between visits she reported some increase in large muscle movements, including arms going out, hands, and some truncal "jerking" all of which mother characterised as a "setback." No specific discernible cause or stress was identified. Betty was taught the "friendly fingers" (fingers-together induction technique) both as a dissociation technique and with the suggestion that, with concentration, the muscles can learn to do what they should do the right way. Such new strategies also seemed important to keep Betty from becoming either bored with, or mistrustful of, her self-

hypnosis, particularly since tic behaviour would occasionally "break through" and she would temporarily think "this doesn't work any more." Similarly, the "magic mirror" was used as a future projection imagery technique in which she was encouraged to imagine herself and how well she was doing in one, two, or three weeks; three or four months; and one, two, or three years older.

With dramatic improvement, the frequency of visits was reduced to every three months. At Betty's seventh visit four months later she was tic-free, doing great in school in a "gifted" program, and practising self-hypnosis daily. At her request, a new tape was made of the hypnotherapy practice session. Two and a half months later she remained tic-free, though arm-scratching and picking her cuticles had appeared.

At Betty's ninth visit in the summer of 1994, her mother expressed frustration that, although a mild humming noise had begun and occasional facial tics were present, Betty was refusing to practise self-hypnosis regularly, but would do so if mother insisted. Mother realised any change seemed to function as a stress trigger for the appearance of tics and she bemoaned Betty's reluctance to practise unless tics occurred. Supportive counselling for the mother was provided with good success and her willingness and ability to "back away" allowed Betty the autonomy to apply self-hypnosis in the way that worked best for her.

Betty reported the only tic bothering her was the "bottom itching" habit. After she described her current passion for horses and books about horses, the hypnotherapy session which followed was accordingly tailored to this imagery. Suggestions were offered that she could imagine being so tiny that she enter her own body and find a beautiful and perfect sized tiny horse to ride for an adventure around her body, eventually arriving at the wonderful mountains and valleys of the brain and in the computer finding the *switch* for the bottom *twitch*. In trance, she described a switch which was a brown triangle which she then "turned down."

Betty's subsequent return to school for the 1994-95 year was the smoothest transition she had ever had, with no increase in tic behaviours noted. She continues to do well and the frequency of her visits is currently at every six months, with as-needed phone reinforcement.

## DISCUSSION

As the cases illustrate, induction with children *is usually quick and easy*. The manner in which we develop rapport, the language utilised, and the content and expectations embodied in the hypnotic suggestions must all be understood in a developmental context. Thus, a preschool-age child understands and experiences hypnosis as analogous to "pretending"; a latency-aged child most easily understand hypnosis when it is described, discussed, and experienced as "the same as daydreaming"; and for an adolescent, one must appeal not only to their developing ego and conscience, but also to their understanding of

alternative states of mind with which they may have already had experience, and what they might call "zoning out" or "spacing out" (Olness & Kohen, in press).

### **SPECIFIC THERAPEUTIC SUGGESTIONS**

During a first trance experience, there are several specific goals for a child with TS:

1. they have a positive trance experience, which is natural and easy;
2. they experience purposefully developed relaxation and positive imagery;
3. they experience a diminution of tics and/or vocalisations during trance;
4. they learn self-hypnosis to practise at home; and
5. they hear stories about how other children use self-hypnosis to decrease and stop their tics.

As illustrated, stories are told in order to provide the young client/patient not only with the intrinsic ego strength of choosing for themselves, but also to provide a kind of menu of options of ways to modulate tics. The child's patients serve as the best source for such stories, but new stories are also created and tailored to fit the child's own unique needs, interests, background, and personal imagery.

The teaching of self-hypnosis as part of each first hypnotic experience not only promotes self-control, but is designed to immunise against dependency, and prevent development of a belief that success comes from the clinician or his or her office. In view of the unpredictable, stress-sensitive, and recurrent nature of Tourette syndrome, the clinician must be mindful not only of the need for ongoing sensitivity and supportive counselling, but also of the need to be flexible, and to have new alternatives and ideas available to help those who get "stuck" and/or "bored."

Audiotapes are prepared for occasional use as a "booster" at home by recording a regular visit in order to "have the coach at home." Such audiotapes, made specifically and intimately for each child, seem to be much more valuable than "generic" relaxation tapes prepared for broad audiences.

For TS I have always taught progressive relaxation from the toes upward (Kohen & Botts, 1987), purposely ignoring the common sites of tics (i.e., the face, mouth, head, and neck) until the trance has deepened, the patient's comfort and pride have grown, and a growing sense of control is emerging. By paying little or no attention to the site of "the problem," patients are accordingly invited hypnotically to dissociate from the problem.

### **SUMMARY**

As described, this treatment approach begins with a personalised focus on development of therapeutic rapport with the patient. With each child, I seek to develop a paced utilisation of the child's reality, likes and dislikes, and their inner world of imagination, as the context and reference for hypnotic focus, as well as cognitive mastery. The wide variety of effective hypnotic techniques

described share characteristics of clarifying and expanding a positive expectancy mindset, the development of metaphors for control through storytelling and dissociation, and the overall creation of an atmosphere in which change becomes believable and possible. Thoughtful application of this approach has added significantly to the treatment options and positive outcomes for young people suffering from Tourette syndrome whom we have had the opportunity to know.

In helping young people to manage the stress of TS, I have developed an approach which emphasises the self-monitoring and self-management strategies of relaxation/mental imagery (RMI, self-hypnosis). All patients with TS with whom I have worked report that they have benefited. A few indicated that they learned "only relaxation." Most, however, say that learning RMI has made a significant positive impact on their lives, reducing the nature and frequency of their tics, and helping them develop a more positive sense of self-control. None has experienced adverse effects.

Much more research must be conducted to better understand the aetiology, expression, and most appropriate therapeutic approaches for management of Tourette syndrome. Until prospective, controlled studies of hypnotic approaches to TS can be carried out, however, clinical experience suggests that children and adolescents with TS would benefit from learning self-hypnosis as an adjunct in coping with the stresses of this disorder.

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## REPRESSED MEMORIES SOMETIMES A MINEFIELD

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During Freud's early work with hypnosis he developed a "seduction theory" to explain the origin of hysterical neuroses in his women patients. He later expressed the belief these childhood sexual traumas were incestuous fantasies. Thus, according to some, began the "age of denial." Almost 100 years later, the pendulum began to swing the other way. Now it has been suggested that clinicians who work with repressed memory patients "sometimes walk a minefield." Such is the situation in the U.S.A., where the "false memory syndrome" is endemic. The symptoms are already apparent in Australia.

### HISTORICAL BACKGROUND

In his early discussion of causes of female hysteria, Freud often mentioned seduction by adults, notable in *The Aetiology of Hysteria* (1896), published in the year he repudiated hypnosis. "But nowhere in these early publications did he specifically inculcate the girl's father ... Indeed he admitted to having, on two occasions, suppressed the fact of the father's responsibility." He wrote of "many distressing hours ... when almost all my women patients told me they had been seduced by their father ... It was only later that I was able to recognise in the fantasy of being seduced by the father, the expression of the typical Oedipus complex in women" (1966, p. 584).

Freud's relief from his dilemma is understandable, as is the familiar charge that he renounced the evidence of father-daughter seduction in favour of a theory designed to defend against it (Courtois, 1988).

This was the period in which Freud's "main interest was directed to discovering infantile sexual traumas" (1966, p. 584). Hence it was as a "trauma-focused" practitioner, he recovered repressed memories of incest from most of his women patients and it can never be known how many of these memories were false positives. Of greater historical importance was the influence on successive generations of his theory of oedipal fantasies.

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Less than two generations ago the incidence of incest was estimated at one or two cases per year, per million of population (Weinberg, 1955). According to Summit (1982), these figures were drawn from court records "in the naive belief that incest was subject to report and prosecution" (p. 130).

Then came statistical surveys, mostly in the late 1970s and 1980s, in which it was reported that 50% of stepdaughters had experienced some degree of sexual victimisation, while 60–70% of runaways, drug addicts, and prostitutes reported an incestuous background (Finkelhor, 1979, 1986). Russell (1986), in an often quoted study, estimated 20% of women had at least one incestuous experience before the age of 18.

The problem, according to health workers like Roland Summit (1982) and Suzanne Sgroi (1975), was the reluctance of community leaders to accept the evidence. Summit, a Los Angeles community psychiatrist, complained that "Nobody could care. Teachers, doctors, mental health specialists, police investigators, prosecutors, judges, juries, *everyone* in the adult world finds some logical reason to defend the adult against the distress of the child. The monster in the closet doesn't really exist" (pp. 127–128). He quotes Suzanne Sgroi, a physician, who he claims spent years of frustration trying to encourage protective intervention. In 1975 she wrote: "those who try to assist sexually abused children must be prepared to battle against incredulity, hostility, innuendo, and outright harassment. Worst of all ... being smothered by indifference and a conspiracy of silence" (Summit, 1982, pp. 127–128).

## THE SWING OF THE PENDULUM

Then it seemed the pendulum swung too far in the other direction. In his book *Trancework* (1990), Michael Yapko stated: "I am aware of clinicians too numerous to count who are 'molestation specialists,' who have a rudimentary checklist of 'signs of a molest victim.' These include poor self-esteem, sexual avoidance or apathy, relationship difficulties, unresolved anger towards one or both parents, and other such symptoms ... Then, in hypnosis, the clinician can ask leading questions: Are you alone with your (father, uncle, family friend)...? Is he touching you? Where is he touching you? Is it a touch, or does it feel like a fondle?" (p. 256).

Sometimes "memories" of satanic ritual abuse are instilled into the patient during trance. Eventually the person is told that the kind of abuse they suffer often takes place at the hands of a group of people, that "sexual and physical abuse is conducted as part of a ritual or ceremony ... Did they appear to wear dark robe-like garments and engage in chanting?... Were there dead, mutilated animals?"

The patient is invited to imagine even more lurid and gruesome scenes "giving an even greater understanding of how extensive the abuse has really been. The therapist explains that satanic ritual abuse is pervasive throughout the country, and that the patient is lucky to be alive and able to come to terms with what really happened" (Yapko, 1993, pp. 32–33).

### “CLINICIANS WALKING A MINEFIELD”

In a commentary on the use of hypnosis in uncovering memories of sexual abuse, Bloom (1994) began with the statement: “Clinicians sometimes walk a minefield when they work with repressed memory patients. In psychotherapy, where the basic tenet is *first, do no harm*, it is suggested that false memories may result from premature assumptions, inept questioning, and loss of objectivity in the face of intense abreactions” (pp. 173–178).

An indication of the innumerable crises which have attended the unfolding of allegedly repressed memories in the U.S.A. is the report by Perry (1994) that the “False Memory Syndrome Foundation of Philadelphia, after 21 months of existence, has been contacted by over 10,000 people reporting such a false accusation” (p. 451).

Clinicians recovering repressed memories of sexual traumas during hypnosis are eliciting what Donald Spence (1982) called “narrative truth,” which may or may not resemble historical truth. Corroborative evidence for the latter is rarely available, nor is it essential for worthwhile therapy.

The malleability of memories, especially during trance, is the feature which enables some practitioners to manufacture false memories. The same malleability makes it possible in hypnosis for the traumatic narrative to be “rewritten,” so that it assumes a more acceptable form.

#### Case Example

A nursing sister, aged 31, complained both her sleep and her sex life were seriously affected by a fearful feeling of being “held down.” Recently, during sex she had a flashback of being sexually molested by an older brother. During hypnosis, which she requested, she is eight and he is 15 and six feet tall. He is in her room in pyjamas, ready to play a game with which he has tormented her in the past. He calls it “squash.” Now he is lying on top of her, pinning her down, while he rubs his penis against her bare torso. He is also penetrating her digitally; she is frightened and crying, asking him to stop. After a while I suggest to her, “Wouldn’t it be better to feel anger rather than fear,” and she agrees. Upon my suggestion she begins accusing him, in a loud voice. Then I suggest she is very strong and can easily roll him off, which she does, and he falls to the floor. She says that he looks bewildered. The procedure is repeated several times, and again during subsequent sessions, until it loses negative affect. Later, the issue of forgiveness of her brother arose, especially as she has been on the best of terms with him for many years. She said that nothing would change and the matter would never be raised. She was seen twice more at monthly intervals to further her self-hypnosis training. The feeling of being held down had not bothered her since. Corroboration was not feasible in this case, but it would be essential where the intention is to take civil action against, or even just to confront, an alleged abuser. However, there is much to be said for the view that in the aftermath of successful therapy, there should be an absence

of motivation for either of these alternatives. In some cases it may be necessary to emphasise the destruction of family life which can follow *unproven* allegations against a parent or other family member.

### **Hypnosis and False Memories**

Flynn (1994) stated in the popular press in the U.S.A., hypnosis is “painted” as the cause of the “false memory syndrome” even though it appears to be involved in only a small number of cases which have been through the courts. According to Schefflin (1994b): “So far there are about 70 cases at the appellate level in the U.S.A. raising repressed memory issues. Interestingly, only three of these mention hypnosis and, in none of these cases, is hypnosis alleged to be the cause of the false memories ... Nevertheless, it is hypnosis which is under attack” (p. 200). There are many more than 70 cases in other jurisdictions and trauma-focused therapists use many techniques other than formal hypnosis on subjects who dissociate readily. The question of spontaneous trance resulting from interrogation and methods other than traditional hypnosis is discussed by Schefflin (1994a, p. 36).

### **Lawsuits Against Therapists**

A major civil issue, states Schefflin (1994b), concerns those accused of abuse bringing suit against their accusers’ therapists, especially if the patient recants. This has already led to large sums being paid to parents and “is still likely to lead to hundreds, and possibly thousands, of similar lawsuits against therapists. Mental health professionals around the country are nervous that this third-party liability will send malpractice rates through the ceiling and drive therapists out of the market of counselling real child-abuse victims.” Furthermore, parents with children in therapy may fear being falsely accused of molestation and real victims of child abuse will ask themselves: How can my story be believed when so many accusations are false? (p. 200)

However, “the majority of courts in the U.S.A. have been receptive to repressed memory claims.” Barriers such as the statute of limitations, which could prevent claims by adults, can be overcome by a “delayed discovery” rule which is followed in most states. Where there is a difficulty with respect to the repressed memory claim, the courts will often take the view that “to protect parents or relatives at the expense of the children works an intolerable perversion of justice” (Shefflin, 1994a, p. 41).

### **The Robust Repression Hypothesis**

Ofshe and Singer (1994) suggested a relatively small but significant percentage of mental health practitioners in the U.S.A. are focusing on childhood trauma. They are identified pejoratively as “recovered-memory” therapists, rather like Yapko’s “molestation specialists.” They are said to lead adult, usually female, patients to produce pseudomemories generated by a variety of trance-inducing

techniques such as formal hypnotic induction, guided visualisation, or relaxation with leading questions or fantasy versions repeated over and over until the contents are internalised and believed to be true.

Psychotherapists practising recovered-memory therapy “predicate the existence of their treatment on a newly-claimed powerful form of repression ... We refer to the hypothesised mental mechanism as ‘robust repression’ and call attention to the absence of evidence documenting its validity” (p. 391).

It is claimed that robust repression differs from any other form of repression. Rather than dissociating an intolerable memory, the robust form instantaneously represses discrete, perhaps decades-long instances of abuse, which are henceforth unavailable to consciousness—until treated by the recovered-memory specialist who manufactured them.

In some cases there have been recovered bizarre beliefs which include sexual victimisation by secret networks of satanic cults, of forced pregnancies with babies taken away and killed (Ofshe & Singer, 1994; Ofshe & Watters, 1993).

### **Abuse by Satanic Cults**

The publication of *Michelle Remembers* (Smith & Pazder, 1980), revealed in Michelle’s hypnosis-generated life history massive abuse by a satanic cult and demons who performed miracles. This book was widely distributed through Canada and the U.S.A. and was said to have become part of the propaganda used by the Evangelical Christian Movement prominent in American social and political life during the 1980s (Mulhern, 1994: Spanos, Burgess, & Burgess 1994.) “This movement, reinvigorated the mythology of Satanism—the idea that there exists a powerful but secret international satanic conspiracy which carries out heinous crimes [such as] kidnapping, torture, and the sexual abuse of countless children as well as mass murder, forced pregnancy, and cannibalism” (Spanos et al., 1994, p. 440).

In a survey of psychotherapists across the United States, Bottoms, Shaver, and Goodman (1991) found that 70% of respondents indicated having no contacts with patients who reported ritual abuse memories. A small minority (12%), however, reported treating large numbers of such patients. The findings gave grounds for the belief that the smaller number played an active part in shaping the ritual abuse memories of their patients.

According to Mulhern (1994): “Memories of satanic blood rituals only emerge after the patient has been involved in the process of recovering memories for an extended period of time.” (p. 278).

### **The Bunbury Trial**

Towards the close of 1994, in the town of Bunbury in Western Australia, a criminal court jury had to decide on the validity of charges based on repressed memories of the sexual abuse of daughters by a father. It was a legal landmark, the first case of its kind in this country.

When the trial began the two sisters, the accusers, were aged 34 and 29, with three and four children respectively. The accused father, aged 65, was a retired headmaster and elder of the Open Brethren Church. The names of the sisters and the father have so far been suppressed.

Much of the evidence which was reported is relevant to the "recovered" memories of sexual abuse and satanic cult torture described above.

To quote from the report by an observer, Bettina Arndt (1994): "They [the sisters] alleged in horrific detail abuse by their father. The allegations included infants involved in satanic scenes with groups of men chanting phrases about lambs being slain, a cross marked with blood on the child's body, sodomy and vaginal penetrations with a crucifix. Later incidents involved rape with screwdrivers, sticks, workshop tools and an electric drill and a knife repeatedly jabbed inside the vagina ... both sisters also gave records of crude abortions performed in a pine plantation, one with a coat-hanger ... the reported memories of abuse involved [in addition to the father] the women's grandfather, two uncles, two brothers and their mother."

The defence was able to contradict a good deal of the evidence. For example, a photograph of the backyard of the house taken at the time where much of the abuse was testified to have occurred showed it to be exposed to the view of curious neighbours. A few months after the younger sister claimed she was raped by her father, she had written a birthday card for him which was tendered in court. It read: "To my wonderful Dad ... We love you heaps and heaps."

The women's therapist, Perth psychologist John Manners (a member of the Australian Psychological Society with a masters psychology degree), had focused his seven years of therapy with the older sister from the beginning on possible sexual abuse. Apparently, it was not until after the first year that she recovered her first memory of being sexually abused by her father in childhood.

Two years later, her younger sister had her first putative memory of sexual abuse and, by 1993, both women were said to have begun their memories of satanic abuse. Their health had deteriorated and Mr Manners believed that their return to full health depended on searching deeper and deeper for the increasingly bizarre material he subsequently recovered.

He testified he believed that all their memories were true; even the older sister's recall as a two-year-old of being sodomised by a number of men was as true as her later memories. Evidence was given she had entered therapy after suffering post-natal depression, followed by considerable stress involved in caring for three children under five. There were also sexual difficulties.

Forensic psychologist Professor Donald Thomson presented the orthodox view that recovered memories of repressed traumas including sexual assaults could not be accepted as authentic without independent corroboration.

In his final address to the jury, Justice Seaman of the Supreme Court emphasised the importance of looking for corroboration rather than convicting solely on the evidence from repressed memories.

The jury deliberated for four days. The judge was asked by the foreman on

the third day: "Can a verdict be delivered solely on a gut feeling, even if there is evidence to the contrary?" In the resulting verdict the accused was acquitted on 15 of the 42 charges and the jury was split on the remaining 27.

The jury failed to agree largely on the most vital issue. As Arndt (1994) stated succinctly in her summing up to the trial: "Arguments about the validity of repressed memories barely surfaced in the trial of the man whose name was suppressed."

On 30 December 1994, the Director of Public Prosecutions in Western Australia announced there would be no retrial of the case. He did not believe a second jury would be in better position to deliver a verdict than the deadlocked panel.

Schefflin (1994a) remarked that: "At the present time, patients risk not getting valid, competent and essential hypnotherapy, and hypnotherapists risk malpractice liability" (p. 39). He also stated: "In the next few years, courts will be flooded with false memory cases. Some will implicate hypnosis, others will not" (p. 43). There is no reason to doubt that in due course the full force of the problem will reach Australia.

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## **HYPNOSIS IN THE TREATMENT OF PLANTAR WARTS**

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This case describes Ali, a nine-year-old female who was referred by her GP for hypnosis treatment for warts on her hands, face, and feet. Several topical chemotherapy treatments had been tried but the warts had recurred and continued to spread. Ali attended appointments with her mother who, along with their GP, was positive about hypnosis as a treatment for the condition. A complication of the warts was that Ali had become increasingly self-conscious and was upset about teasing from friends at school. Hypnosis was successfully used and all warts vanished. Twelve months after treatment there had been no recurrence of warts.

### **PRESENTING PROBLEM**

Ali was a nine-year-old female who was referred by the family GP for hypnosis treatment for warts. Her mother, a nursing sister, had asked the GP for treatment suggestions after trying several types of topical chemotherapy, which had been without effect. Ali's mother was keen to try any treatment that was "not too medically invasive." The GP recommended hypnosis, as he was confident about the efficacy of hypnosis for immunodeficient children with warts.

Both mother and GP also felt that something needed to be done quickly as Ali was becoming increasingly unhappy about the warts, as other children at school were calling her names and teasing her about them.

While most of the warts were on her hands and feet, she had one on her chin, which she particularly focused on. She expressed sadness that none of the other treatments tried to date had worked and was frightened that she might be stuck with the warts. This was particularly upsetting to her, as she hated being teased by other children, spoiling her enjoyment of school and her school friends.



## **PERSONAL HISTORY**

Ali is the middle child of three children. She has an older brother and younger sister. Her father is a businessman, her mother a nurse, and both parents currently work. The fraternal grandparents provide much care and support to the children and live-in at the family home two to three nights a week. Ali and her sister attend the local primary school while her older brother attends a private boys' grammar school.

Ali is a shy child who is reported to be very bright and good at her school work. She particularly likes to read and write stories. She makes friends easily but, as mentioned, was currently suffering at school because of name-calling and teasing about the numerous warts on her hands and the one on her chin.

Ali is of average height and weight for her age. She was well-groomed and although a little reserved on initial presentation, she interacted in a thoughtful and cooperative way and could clearly express her concerns.

## **MEDICAL AND PSYCHIATRIC HISTORY**

Ali's medical history provides the usual array of childhood illnesses, but she has had no significant illnesses. She wears glasses to correct short-sightedness. There is no history of any psychiatric illness in the family. Ali's distress regarding the teasing by her peers at school was starting to affect her confidence and she indicated she would be much happier if the warts could be eradicated. Her fear was that they would remain or get worse, in which case she doubted her ability to continue enjoying school and said she would not want to keep attending. To date, Ali's distress about the warts had not manifested any further than requests to her parents to find something to get rid of them, and the expression of her unhappiness about teasing from peers. There were no obvious signs of clinical depression.

## **CLINICAL SESSIONS**

### **Session 1**

Ali attended with her mother. After a general history was taken, we discussed the efficacy of hypnosis as a treatment for warts. Ali's mother was keen for her to try a treatment that was not medically invasive and she also believed that hypnosis treatment would give Ali more confidence, as she would be participating in the process and thereby helping herself. Numerous studies (Scott, 1960; Sinclair-Gieben & Chalmers, 1959; Surman, Gottlieb, Hackett, & Silverberg, 1973; Tasini & Hackett, 1977) have shown particularly impressive effects in the application of hypnosis to the treatment of warts, so I was able to give reassurance to Ali and her mother that hypnosis was an appropriate form of treatment, and that we should expect a relatively quick and effective result. I based this approach on the advice of Hammond (1990), who noted: "The

successful impact of words and imagination on warts is of particular import considering the increasingly widespread routine use of powerful chemotherapy agents to treat warts" (p. 220).

Ali's mother suggested she would leave the room to enable Ali to present her case for herself and for us to do the hypnosis. Ali then showed me the warts she would like to have vanish: on her chin, the thumb of her left hand, three warts on the index finger of her right hand, four warts on the middle finger of her right hand, four warts on the sole of her right foot, and two warts on the sole of her left foot.

We included the plantar warts in the treatment, based on Crasilneck & Hall's (1985a) successful treatment (a month of weekly hypnotic suggestion) of such warts. While the cosmetic factor was not a consideration here, physical discomfort can occur and Ali had clearly indicated she would be happier without them. She reiterated she wanted to get rid of the warts because of the name-calling ("wartie") and teasing by her friends. I reassured her I thought she and I could achieve her desired goal with hypnosis and that, if necessary, we would keep trying until we found something that worked for her.

The areas for treatment were defined as: (a) self-worth and confidence issues, and (b) immunodeficiency for warts. The rationale for this approach was based on the finding that the use of hypnosis in the treatment of warts in adults and children points to the possibility that hypnosis may somehow bolster immunologic response (Burrows & Dennerstein, 1980) and that hypnosis allows the motivated and believing client to be convinced more uncritically that improvement is possible (Kroger, 1984). As with most wart patients, Ali did not seem to have any significant psychopathology, although the warts were, in themselves, a source of anxiety (Crasilneck & Hall, 1985a). The majority of case studies suggest three to four sessions is sufficient.

Ali expressed interest in being hypnotised and was more than willing to start the process. For this first session, the suggestions of Hammond (1990) were used as a guideline. The induction was direct and brief: "Let yourself feel relaxed and tired all over. Imagine doing something you like to do. Think of doing it now, and how much fun it is." Time was taken to ensure Ali was relaxed and enjoying the trance. Then I gave a direct suggestion about feeling her hand, the one she writes with, tingle and then become lighter until it rises up. As Ali's hand rose, another direct suggestion about feeling very relaxed and good was given, and then permission to let her hand come down. A direct post-hypnotic suggestion that "The warts will feel dry, they will then turn brown, and fall off and not trouble you any more," was given. The warts on her chin, hands, and feet were mentioned in conjunction with the post-hypnotic suggestion for atrophy of the warts.

Given Ali's motivation, I suggested she could practise this technique (self-hypnosis) when she was lying in bed at night, just before she went to sleep, and that this may help speed up the process. Counting from 1 to 5 was used to terminate trance. Ali was a good responsive hypnotic subject, as evidenced by

her hand raising, and her comment that, to her surprise, her hand had felt tingly as suggested. She said she had enjoyed the experience and would practise by herself, although she was looking forward to another session.

## **Session 2**

Ali presented with her mother, who commented on how much the child had enjoyed her first hypnosis session and how much more positive and confident she was, believing the warts would go soon.

From the information given by Ali and her mother, it seemed that although all warts (as listed in session 1) were still present, Ali noticed them less. Ali said she had practised the technique for atrophy of the warts most nights. She seemed less anxious and indicated she was looking forward to the hypnosis. Ali's mother left the room as Ali indicated she liked to relax and close her eyes for the hypnosis without anyone watching her. The script used in session 1 was repeated, with the added suggestion that Ali could practise self-hypnosis when she was comfortable and relaxed.

On termination of trance Ali again reported enjoying the experience and commented that she thought some of the warts had "started to go brown."

## **Session 3**

Ali attended with her mother. She was pleased to report one wart on her right hand index finger had completely gone. Ali indicated that for her, this meant she could now be totally confident that all the warts would go very soon. I reinforced this view and suggested it was only a matter of time before they would vanish. I also suggested we could do something a bit stronger in our hypnosis to speed up their disappearance. I outlined for Ali the ideosensory suggestions for wart removal from Hammond (1990, p. 224) and she readily agreed to this technique. Before trance was induced, I explained to Ali that I would lightly outline all warts on her chin, hands, and feet with a pencil as we worked.

Trance was induced by asking Ali to relax, take gentle breaths here and there to deepen trance, and imagine doing something she liked to do. Post-hypnotic suggestions were given that already one wart had gone and all the others would disappear very soon, as I outlined each one lightly with a pencil.

As I outlined the warts on her chin, one on left thumb, the six on the fingers of her right hand, four on the sole of her right foot, and two on the sole of her left foot, I added the suggestions, "That the warts begin to feel very cool ... cool ... slightly cold ... as you feel this, nod your head ... good ... the warts are going to leave very shortly." I also suggested the warts would feel slightly cool for a day or so and, as the coolness fades, the warts would begin to disappear. Termination of trance was achieved by counting from 1 to 10.

#### **Session 4**

Ali reported that, while she still had the same number of warts as in the previous session, she thought they were smaller, going brown, and disappearing. At this stage I had a minor concern that Ali may have a secondary gain emerging, that is, continued hypnosis sessions which she said she found particularly pleasant and interesting. Therefore, I discussed with Ali the possibility of terminating treatment soon, as I too believed that the warts were going (two had virtually disappeared) and we probably only needed to give them one more treatment for them to disappear completely. Ali agreed to this plan. All visible warts were gently outlined with a pencil and direct post-hypnotic suggestions of coolness and the warts disappearing were given. Again, it was suggested that the coolness would persist for a couple of days and, as it faded, the warts would also fade.

Since Ali and I were confident that the warts had started to disappear and that this process would continue, we agreed on a follow-up visit in approximately one month.

#### **Review Session**

All warts on Ali's hands, feet, and chin were completely gone, except for one on her right middle finger, which appeared to be regressing. Ali said she was working on this last one herself and described a self-hypnosis process which had been suggested to her in an earlier session. She was absolutely confident that this last wart would disappear along with the others. Ali and her mother were delighted with the result. The child was again confident and happy at school with her friends, and in fact got some enjoyment telling family and friends about the treatment and the disappearance of her warts.

I was confident of her ability to use self-hypnotic suggestions. Nevertheless, Ali and her mother were advised to contact me if there was any resistance or if the one remaining wart had not completely disappeared within a month.

#### **FOLLOW-UP**

A telephone call was made 12 months after the final session. Ali's mother reported there had been no recurrence of any warts and that the last wart had disappeared soon after the review session.

#### **COMMENTS IN RETROSPECT**

Direct methods of induction and direct post-hypnotic suggestions were used for this case, for a month of weekly hypnosis sessions. Although I have a preference for indirect techniques, direct ones were used, as Ali was a keen and cooperative subject who indicated good hypnotisability (e.g., hand raised and lowered, reported feelings of coolness on skin, in response to suggestions, etc.). It would also seem that children with warts respond particularly well to direct

suggestions. Ali responded well as all warts were virtually gone four weeks after the final hypnosis session. Self-hypnosis was also encouraged between sessions and on the last remaining wart which had started to regress.

These results are consistent with those of Ullman, and Ullman and Dudek (both cited in Crasilneck & Hall, 1985b, 1985c) who conducted an extensive study on removal of warts by hypnotic suggestion. Over half the good hypnotic subjects showed complete remission of warts within four weeks after the therapeutic suggestions were given.

It is interesting to note that two slightly different direct post-hypnotic suggestions were used. The first was that the warts would feel dry, turn brown, and disappear (two sessions), while the second involved outlining them with a pencil, suggesting coolness and the warts disappearing as the coolness faded (two sessions).

It is difficult to assess if one suggestion was more efficacious than the other, although Crasilneck and Hall (1985a) reported it is possible that suggestions of coldness have some effect on the vasomotor activity in the region of the warts, although this has not been studied to their knowledge.

From the case studies presented in the literature, and this experience, I feel confident about suggesting a brief hypnosis treatment plan for children suffering with warts. Results appear to be quickly obtainable and lasting, particularly with good hypnotic subjects.

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## BOOK REVIEWS

**Psychobiology of Mind-Body Healing: New Concepts of Therapeutic Hypnosis** (rev. ed.). Ernest L. Rossi. Evanston, IL.: W.W. Norton, 1993. xvii + 362. US\$39.00, hardback.

The subtitle of this book really tells its story. Rossi has not revised the earlier (1986) edition but written an original book in which he integrates a modified concept of Selye's general adaptation syndrome with Erickson's view of the experimental and psychoneurophysiological basis of hypnotherapy.

This is a book for physiologists, biologists, and practitioners of therapeutic hypnosis with some degree of sophistication. It is not an easy book to read because it is almost in the nature of a reference textbook.

It is made up of two sections. Section One, 100 pages, deals with mind-body communication and introduces concepts such as information transduction and state-dependent learning in mind-body healing and hypnosis. The role of the hypothalamic system as the anatomical connecting link between mind and body and the reformulation of Selye's GAS as a two- as opposed to three-stage response to chronic stress are dealt with here. Ten teaching tutorials are included in the last chapter of this section entitled "New Language of Mind-Body Communication." These are for the clinical practitioner of hypnosis and each is summarised in the series of steps for their application. Circadian and ultradian rhythms figure extensively as forms of healing response in self-hypnosis.

Section Two, 200 pages, presents state of the art information on the interaction of the nervous, endocrine, immune, and neuropeptide systems, each of which is the subject of a chapter. This section's chapter on the immune system deals with viruses on the frontier of psychoimmunology and with mind modulation of the immune system to fight each particular virus.

Throughout the 10 chapters there are a dozen figures and half that number of tables. Case examples, both Erickson's and from the author's own practice, are to be found in most chapters. Thirty pages of references and an 18-page author and subject index complete this book. The book offers a two-page summary of its content in the form of 10 insights into the changes in our understanding of the human condition.

EMILIA RENOUF, Clinical psychologist, Sydney.

**The Couples' Hypnotic Dance: Creating Ericksonian Strategies in Marital Therapy.** Carol J. Kershaw. New York: Brunner/Mazel. 1992. \$52.50 hardback.

The present volume comprises 10 systematically presented chapters that provide the reader with some innovative strategies deemed useful in couple/marital therapy.

In the first chapter, the author provides a definition of the hypnotic dance as "the patterned hypnotic interaction of two unconscious minds" (p. 1). Some useful information on trance phenomena is provided for the reader who may not be informed on the subject of hypnosis. The writer attempts to explain the role of imagination, memory, attention, and suggestibility in trance phenomena. A brief description of Ericksonian therapy is provided, with an emphasis on Erickson's use of the trance state in influencing both the intrapsychic and the intersychic dynamics in working with couples.

The next three chapters describe the patterns of hypnotic interactions that may be seen as a hypnotic dance between the couple; positive and negative trance states that may be coinduced by the partners; and some possible ways of constructing reality. For example, couples construct reality by attaching meaning out of *what* and *who* they experience. In Chapter 4 the author presents her model of psychotherapy (based, of course, on Erickson) and provides some useful insights into therapy for the reader.

In Chapter 5, a detailed account of Erickson's use of linguistic forms is explained and an hypnotic script for induction using these linguistic forms is offered. An induction script for couple therapy is included with a case example. The next chapter deals with the author's concept of assessing couples' dynamics and hypothesis building on the three levels of interaction, that is, systemic, interpersonal, and intrapsychic. The author details how hypothesis-building works in the practical setting of therapy. In Chapter 7, the author deals with the language of the unconscious: myths, symbols, rituals, images, and metaphors. Considerable attention is given to constructing and using metaphors in psychotherapy. Once again, a worksheet for metaphor construction is offered and accompanied by case examples.

The final three chapters deal with the application of trance phenomena with individual clients, discussing couples' issues, or in conjoint therapy. Chapter 9, the most instructive, deals with the role of trauma and its effects in marital relationships. Some theoretical explanations are offered but these offer little in the way of a new understanding of these processes. A comprehensive treatment protocol is offered, again followed with case examples. Chapter 10 briefly describes the role of chronic illness in marriages. The author sets out a treatment protocol, using the hypnotic dance, again relying heavily on Erickson's model of psychotherapy.

The aim of the book is to introduce the concept of the "hypnotic dance" into couples work and the author has succeeded in her endeavour. She has provided a sound theoretical framework and has also brought her clinical skills into an



understanding of couples therapy. The book is intended for those clinicians working with couples. However, some background in clinical hypnosis would be useful.

IVAN BAKICH, Marriage guidance, N.S.W.

**Hypnosis in the Treatment of Depressions: Strategies for Change.** Michael D. Yapko. New York: Brunner/Mazel. 1992. xvii + 202. \$46.95.

It is with a great deal of satisfaction that the reader will come to the end of this extremely interesting and useful book. It is highly recommended for any clinician in general medicine, psychology, or psychiatry who is dealing with patients with affective disturbance. Many of the ideas proposed are equally applicable to those with anxiety and adjustment disorders, as to those with depression. Clinicians reading this text can expect to find many useful ideas to apply to their patients.

The book commences with a discussion of the nature of depression. This is perhaps one of its weakest points; while criticising those of a biological or psychodynamic orientation, the author proposes an equally polemic unitary argument for the nature of depressed mood. Without evidence, he makes many assertions as to the nature and cause of depressive disorders. For example, Yapko proposes that the rise in the reported rate of depression is due to a real increase in the number of individuals experiencing depression. This may be so, but the author does not entertain the possibility that over the past 20 years improved diagnostic criteria have led to depression being recognised more frequently during consultations with the family physician. To account for the rise in depressive disorders, Yapko proposes a sociopolitical argument that includes the disturbance of family relationships, ambiguity of gender and identity roles, advancing technology, and immediate "now" orientation. All of these may be contributors to the aetiology and maintenance of depressed mood, but so may be many other factors. The author then suggests a cognitive model of depression, proposing that depression essentially arises through cognitive processes of the interpretation of, and coping with, life events. Although this approach is in line with contemporary thinking on the subject, Yapko is guilty of proposing a unitary approach to the depressive disorders, in much the same way the author has criticised those of other orientations.

Yapko then discusses the nature of hypnosis as presented by various researchers and clinicians and explains why depression and hypnosis have historically been considered "forbidden friends." He logically criticises the assertions of the past 40 years that have proposed potential risks in applying hypnosis to depressed patients. Just as these researchers and clinicians may be criticised for making sweeping assertions about the risks of hypnosis, the author makes equally sweeping assertions as to the applicability of hypnosis to this

disorder, without evaluating or demonstrating its effectiveness with appropriate evidence. Yapko highlights from individual case reports, including some of the erudite work of one of the greatest therapists, Milton H. Erickson, how hypnosis may be incorporated into the individual treatment of depression. The cognitive-behavioural framework and the superb utilisation techniques of Erickson are combined, but the author fails to provide evidence for the effectiveness of this combination other than anecdotal reports.

The very strength of the cognitive-behavioural approach to therapy has been its use of evaluation of treatment effectiveness. However, no evaluation is provided in this text.

Yapko notes, in partial contradiction of his own previous arguments, that any technique (including hypnosis) that has the potential to be therapeutic has an equal potential to be antitherapeutic. This is the same approach taken by many of the practitioners of hypnosis who have warned against its use with depression. They have highlighted the potential antitherapeutic effects that may result if poorly trained clinicians fail to understand their clients' or patients' needs or condition.

The author outlines very clearly the nature of hypnosis and the phenomena with which we are all familiar. He explores the way hypnosis can assist in the cognitive changes that have most recently been recognised as essential for the effective treatment of at least the majority of depressive disorders. Yapko discusses the few studies that have combined hypnosis with cognitive and other therapies and provides some extremely useful and thought-provoking illustrations of how hypnotically related thinking may contribute to the maintenance of depressed mood. For example, absorption in the negative events of the past, so frequently seen as a preoccupation of the depressed patient, may equally be framed as a form of self-induced age regression with revivification of the past distress. Patient withdrawal in the depressed state may equally be presented as a form of dissociative thinking.

The book then offers a model for the use of hypnosis and the utilisation techniques in a cognitive based treatment of depressed patients. This systematic account of hypnotically based cognitive work offers the clinician some exciting ideas that may be incorporated into therapy.

What is perhaps surprising, given the book's emphasis on the cognitive-behavioural framework, is that there is so little discussion of patients directly challenging their cognitions or the incorporation of cognitive-behavioural strategies with hypnosis. Indirect and metaphoric techniques are of considerable clinical importance, but the more direct techniques of cognitive restructuring also have demonstrated efficacy. Assisting the patients to think about their own thought processes equips them to deal with future abnormalities in thinking. It remains to be demonstrated that these less formal cognitive strategies are equally effective.

In conclusion, this book is highly recommended to the clinician who is interested in applying a flexible and creative approach to patient treatment. It

offers many ideas for the combination of hypnosis and utilisation techniques to achieve the cognitive change that is required in the treatment of most depressive disorders. The neglect of other cognitive approaches is regrettable, given the quality of the work it does incorporate.

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The review by Stanley is reprinted from the January 1995 *International Journal of Clinical and Experimental Hypnosis*. Copyrighted by the Society for Clinical and Experimental Hypnosis, January 1995.

*Australian Journal of Clinical Experimental Hypnosis*. Vol. 23, No. 2, 1995, p. 178.

## BOOKS AVAILABLE FOR REVIEW

The journal has available a small number of books for review by members of the Society and this number is expected to increase in the future. Readers interested in reviewing books should apply to the Editor. Reviews are subject to editorial review prior to publishing.

- Dennis K. Chong & Jennifer K. Smith  
Chong      *The Knife Without Pain: Communication and Hypnosis and the Blueprint of Language Structures for Surgery by Hypnosis.* Oakville, Canada: C-JADE Publications, 1994.
- Adam Crabtree      *From Mesmer to Freud: Magnetic Sleep and the Roots of Psychological Healing.* New Haven: Yale University Press, 1993.
- Gordon Milne      *Hypnosis and the Art of Self-Therapy.* Melbourne: Lothian Books, 1994.
- Colin A. Ross      *The Osiris Complex: Case Studies in Multiple Personality Disorder.* Toronto: University of Toronto Press, 1994.