

## **THE USE OF HYPNOSIS WITH DERMATOLOGICAL CONDITIONS**

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This case illustrates the use of hypnosis in the management of two distressing dermatological conditions: hydradenitis suppuritiva and multiple contact dermatitis. The use of the relaxation response, combined with a symptom-oriented approach, has enabled this patient to use imagery and creativity to achieve control of the conditions and sustain general health and well-being.

### **PRESENTING PROBLEM**

Julie, aged 39 years, complained of increasing discomfort from her vinyl and nickel allergies. She also mentioned the beginning of a small inflamed lesion in her right axilla and noted a requirement for more frequent applications of increasingly potent topical steroid creams, which, at times, were not effective. Julie had suffered from an itchy rash when in contact with vinyl (and to a lesser degree, leather) since the age of about 18 years. This seemed to have coincided with the onset of a nickel allergy, particularly noticed on contact with jewellery. The vinyl allergy mainly affected her thighs and buttocks and was often aggravated by wearing pantyhose. Over the years, Julie had managed to take precautions to protect herself from discomfort (and often embarrassment) by minimising the use of pantyhose and carrying a towel to cover seats.

A dermatologist identified the sensitising agents and the most significant agents of these, nickel/cobalt (in jewellery), formaldehyde resins (used in glues for both rubber and leather) and parabens (preservative in creams, which may have explained the apparent resistance at times to topical medications). However, Julie's management of the dermatitis remained unchanged. The second problem, which, at the time, seemed overshadowed by her multiple allergies was the mild inflammation in her right axilla. This seemed intermittent and Julie was content to continue with medicated antiseptic washes and, when

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necessary, to avoid the use of deodorants. Blood biochemistry and haematology studies including blood sugar levels were normal, the only exception being a cholesterol problem which was familial.

Over the next few months this condition ran a fluctuating course and then Julie returned with a large area of painful infection in her right axilla and general malaise. A diagnosis of hydradenitis suppuritiva was made. She mentioned insomnia and some anxiety associated with her younger son's hospitalisation for arthroscopy. She commenced antibiotics but over the next four-and-a-half months, despite general skin care and both oral and topical antibiotics, the condition failed to settle. A sinus had developed and discharged frequently. Julie experienced two episodes of fever and malaise. She needed to place tissues in her clothing to mop up the moisture. A surgeon's opinion at this time was to pursue conservative management, rather than invasive excision of the offending sweat glands. Long-term oral antibiotic use was not acceptable, as Julie was already experiencing gastrointestinal symptoms and thrush.

We explored further the role that anxiety might be playing in the maintenance and aggravation of her symptoms and the possibility of mobilising internal resources for healing. Julie was very receptive to the idea of hypnosis.

## **HISTORY**

Julie was a slightly obese woman, intelligent and well presented, with a very warm style of communication. She was the second born of identical twins. The delivery and perinatal period were uneventful, as were her childhood and development. She had an adopted sister and, in general, there were good relationships within the family. She had a family history of hyperlipidaemia.

She described herself as a bit of a worrier, independent, liking to be in control, a good organiser, and a tidy person. Her past medical history was related mainly to skin allergies. An appendectomy was performed at 19 years of age.

Julie was a good achiever at school, later working in hospital laboratories. She was in a stable marriage and had two adolescent boys. Her interests were mainly in the areas of handicrafts, dressmaking, and needlework. She enjoyed designing and making her own clothes and taught handicrafts one day each week. Her family had an interest in archery and Julie was a keen participant.

## **SUITABILITY FOR HYPNOTIC PROCEDURES**

After the usual explanation of hypnosis and demystifying myths, I attempted to further increase Julie's expectation for success by elaborating on her creativity and natural talents. There are several articles in the hypnosis literature, including those by Walker (1984) about imaginative involvement and creativity and the association with hypnotisability. Julie had a high capacity for absorption and daydreaming, the latter fitting in with her own idea of hypnosis.

No formal susceptibility scale rating was carried out, but I asked Julie to describe in detail her sewing room and one of her favourite creations. She entered a light trance with her eyes open. I congratulated her once again on her natural talents, especially her visual and kinaesthetic imagery and added my belief that, because of her motivation to succeed, she would be able to use her own resources to achieve a positive outcome.

### **RATIONALE FOR THE USE OF HYPNOSIS WITH THIS PATIENT**

There have been many recorded experiments and clinical reports in the literature, of the reduction of skin sensitivity and resolution of skin infections following the use of hypnotic procedures. The skin and the nervous system have their origins in the same embryonic layer, the ectoderm, and in the words of Crasilneck and Hall (1975), a strong connection exists between emotional factors and changes in the skin.

The symptom-oriented approach has been shown to alleviate many conditions (Gibson & Heap, 1991; Hartland, 1982) and many clinicians have observed that the hypnotic state alone (possibly the relaxation response with the generalised decrease in sympathetic nervous system activity) beneficially affects the responses in the skin (Hartland, 1982).

### **GOALS OF MANAGEMENT**

1. To assist in raising Julie's anxiety threshold;
2. For Julie to control the chronic infection (hydradenitis suppuritiva) in her right axilla and to minimise chances of recurrence; and
3. For Julie to control the contact dermatitis by reducing the allergic response.

In using hypnosis I planned to:

1. Use the relaxation response in its own right but also as a supportive technique in anxiety management;
2. Increase response to suggestion for ego-strengthening and to use post-hypnotic suggestions for healing and well-being;
3. Create alterations in the autonomic nervous system;
4. Communicate with deeper levels of awareness if the symptoms appeared to be fulfilling an unconscious emotional need.

### **TECHNIQUES**

Julie and I had established good rapport and I believed that I understood her levels of communication. I planned to use her capacity for imaginative involvement and structure a symptom-oriented approach around the use of metaphors. I also planned to incorporate direct suggestion and imagery to describe basic anatomy and the physiological processes that may bring about healing. The overall approach was to include a blend of permissive and direct suggestions to maximise the use of Julie's internal mechanisms and so allow her a sense of mastery.

## SESSION 1

Julie presented somewhat distressed at this first planned hypnotic session, several events contributing to this state. Her older son had been involved in a car accident (not major and no injuries were sustained); there were ongoing issues with an interstate carrier over the negligent handling of a valuable and sentimental item of furniture; and the bank manager was causing some difficulties in a financial settlement matter. Julie had developed initial and terminal insomnia and once again she had noticed a flare-up in her symptoms in her right axilla. By now she had established a strong connection with anxiety.

This first session was to allow Julie to experience and understand more about the state of hypnosis and for me to assess her areas of strength on which to structure further therapy. Julie entered trance quickly following eye fixation and distraction and the use of indirect suggestion for further conscious/unconscious dissociation. The trance was deepened by use of progressive relaxation. I followed this with a metaphor for "harmony and order," utilising Julie's internal frame of reference, particularly her focused style of attention and linear style of thinking. Using guided imagery, I invited her to go with me to a material and haberdashery store which I knew she regularly visited. I was familiar with the general layout and contents and had noted, in particular, the fine details and names of the exotic fabrics. The theme of the metaphor was on fabrics as coverings, some their coarseness or fineness, strength and suppleness of fabrics, neatness, and the directions of individual designs and prints. I asked Julie to note how she could smooth out folds in a particular piece of fabric and how pleasing it was to see it devoid of creases and ridges. I guided her through all the sewing accessories, with special emphasis on the threads and how "they needed to be used in just the right way, the lines of stitching just the right direction, to give just the right strength and function to the finished garment." Interspersed throughout the story were ongoing suggestions for seeing and feeling "the harmony of this place." I allowed Julie a quiet time to purchase some fabric and if necessary, a pattern, "although with your talents you probably already know what to do."

When she was ready to leave the store, I invited her to make use of a rubbish bin outside in which to dump any burdens that might interfere with her progress. This was followed by ego-strengthening based on Hartland (1982), modified to a more permissive style with special emphasis on distancing herself from the car accident and allowing others to play a part in the resolution of current conflicts. I suggested increased susceptibility for hypnosis during future visits.

Discussion revealed a very detailed involvement in the experience with a particular capacity for visual imagery and kinaesthetic involvement. Julie commented on her amazement at the experience inside the shop, everything seemed to be in its right place and very easy to access. She had made good use of the rubbish bin and felt very relaxed and comfortable.

**SESSION 2**

At this session I had planned to impart basic knowledge of anatomy and pathology and to build specific healing imagery. However, while she reported that she was sleeping better and was more able to put previous worries aside, there had been another distressing incident. Her younger son, aged 12 years, and another child had been physically assaulted by a teacher and her son had sustained a loin bruising and was suffering headaches and nausea. We were able to work through a lot of issues relating to this event and I subsequently treated her son (in hypnosis) for ongoing distress, enabling him to resolve his anxieties.

I felt that this session should be devoted to further relaxation and ego-strengthening. Following induction, I used guided visual imagery, involving movement of water in a stream and detailed focus on several of nature's smaller creatures: butterflies and ladybeetles continued the theme of harmony. The ladybeetle was given the task of walking over an obstacle in its pathway. Once again I used Hartland's (1982) ego-strengthening technique and modified it to suit the current situation, emphasising the need to focus on one issue at a time and having strength to cope methodically and systematically with what could eventuate in the investigation. I instructed Julie in the "red balloon" technique (Hammond, 1990) and taught her self-hypnosis, which she practised and understood before leaving the surgery. I ratified this trance with an arm levitation, linking her success with an understanding of the power of her unconscious mind in enabling her body to respond to suggestions.

Discussion revealed once again an intense involvement in the experience, with colours being very vivid. She reported feeling an inner strength and a sense of the need for control.

**SESSION 3**

Julie presented with a more composed and positive attitude. She was practising self-hypnosis daily, sometimes more than once a day. She admitted being more confident in her own abilities and more able to state her opinions, particularly with regard to the abuse incident. She was making good use of the balloon and rubbish bin techniques. The skin in her right axilla was definitely less inflamed, dry, and more comfortable.

This would be the first session of hypnosis in which I would mention her skin problems. Following a rapid induction and deepening by counting, I asked Julie to review her progress so far, re-experiencing the feelings of "being capable, calm, confident and in control." I then proceeded with further ego-strengthening and invited her to use the balloon or rubbish bin techniques. Further therapy was as follows:

Today we have agreed that together we will work with imagery to enable you to take control of the problem. You can follow the basic guidelines of my suggestions and you can work out a way for these changes to take

place. I want you to imagine that area which has been a problem for some months. When skin becomes warm and heats up, moisture develops, sometimes excess moisture. If this happens, the normal number of skin bacteria begin to multiply. With these changes in temperature and moisture, the bacterial colonies become excessive and out of control.

Over the past months the area of skin has become damaged and irritated and the blood vessels have become worn out and thin, some even blocked. The resulting inflammation has produced hardening of your skin. Some of the normal bacterial colonies have become aggressive and out of harmony. White cells in your blood have needed to work twice as hard to reach the damaged skin and, in fact, some do not even get there at all because of the diminished number of functioning blood channels in the area. Most of the channels have become damaged and hardened.

White cells have an instinct for seeking out and destroying aggressive and invading bacteria, but they need to be carried in healthy blood and blood vessels, to the area where they are required. And because of the hardening of the skin, the sweat glands have begun to perform erratically and unpredictably, sometimes producing too much moisture, sometimes becoming blocked and inactive. And because of all this, the little nerve fibres have become irritable, easily irritated and aroused, producing the discomfort that you feel.

So, Julie, you can begin to see and understand why your skin does not look or feel right. In the working structures of the skin, things are not as they should be; there is disharmony.

Now, as you rest comfortably and safely in this state of hypnosis you have produced for yourself, you can recognise that your unconscious mind is ever present, waiting to guide your thoughts, feelings and actions: it is protective and it is wise. It will allow you to use your power of imagery to begin to heal the damaged tissue and to resolve the recurring infection. And you can begin right now, by picturing an area of skin, anywhere on your body, which is healthy, normal colour, normal texture and dry. Now really concentrate on that image of comfortable, normal dry skin where all the components are in harmony, just as they should be. And that picture will be stored in your unconscious mind and you will be able to refer to that picture of comfortable, normal dry skin whenever you wish.

Now, Julie, picture the area of damaged skin under your right arm, see and feel the hardened, thickened skin, the ridges, and the discomfort. Now still concentrating on that damaged skin, picture lots of little blood vessels, and flowing in them is healthy blood and healthy strong white cells. Now, in any way you wish, create a picture of blood vessels with clean, strong walls, the blood flowing unhindered, bringing nourishment to the cells and structures in the skin: the nerves are receiving good nutrition, the sweat glands are receiving good nutrition, and all parts of the skin can function at an optimal level for health and harmony. You will

notice that the colonies of normal skin bacteria are in just the correct proportions.

All this can begin to happen now as you use your powers of imagery to visualise these changes occurring and these changes can continue even after you leave here. Little by little every day, that area of skin under your right arm, that area of skin and all its components will become more and more nourished, more and more normal in texture, and more and more comfortable. These things will happen; just as I told you that your arm would move up last week, just as you know that you can relax very deeply: so these changes will happen in time.

Now visualise that area of normal skin you visualised a little while ago, dry clean texture, visualise that in place of the damaged skin. Now, because of the power of your unconscious mind, these changes will begin to happen little by little. Day by day changes will occur, so that in time your skin and all its components can become more comfortable. It is just possible, in time, for the other areas of your skin which cause trouble with rashes and irritability, to become calmer, cooler and all the tissues to become more efficient in function. As you notice changes occurring, you will tend to focus less on these problems and in time they will become less significant to you. They will play a less dominant part in your life.

This was followed by direct suggestions for comfort at a special dinner meeting which Julie had to attend. She envisaged being focused more on enjoyment of the evening and detached from other issues. I concluded the session with further progressive suggestions for continuing to detach from past issues and moving forward with a sense of optimism for health and well-being.

Discussion revealed Julie's involvement in creating healing imagery with intense detail for colour and content. She reported feeling a change of skin sensation as she "opened up the blood channels."

#### **SESSION 4**

It was now three weeks since Julie's first session of hypnosis. The skin in her right axilla was dry and there were no symptoms or signs of inflammation. She was now wearing deodorant and, since her successful dinner party, had been able to wear pantyhose. This was quite an achievement as it was now December. Julie had continued her twice-daily practice of hypnosis and was now using her own direct suggestions to attend to her immune system: "as my immune system becomes stronger, I will react less and less to contact with vinyl, and in time my allergy will occupy less and less of my thoughts." She had added in her own kinaesthetic sense in that every time she focused on her axilla she noticed a tingling sensation, which she associated with healing changes.

## **PROGRESS AND OUTCOME**

I reviewed Julie one month later. She reported no further inflammatory changes and had noticed that her vinyl allergy was almost non-existent, "in fact, I rarely think of it now." She had been able to wear jewellery that had been put away for ten years or more. The school issue was managed with a confident and assertive attitude, despite a very unsatisfactory outcome.

Early in 1996 Julie suffered a musculo-ligamentous strain of her lower back and seemed to be making slow progress with physiotherapy and exercises. I instructed her in the use of her hypnotic skills as adjunct to treatment. In hypnosis, I reinforced the relaxation response, asked her to review her talents and past achievements, and showed her a "spa bath" technique (added to the warm water is a coloured pain-relieving liquid) with suggestions for "feeling the increasing warmth and comfort" and keeping any discomfort that was needed for her protection. She progressed well, with mobility and comfort returning in a few weeks.

It is now 11 months since Julie's first experience with hypnosis. She still practises regularly, usually every alternate day. She has had two minor inflammatory episodes in her right axilla (a slight reddening of the skin and some discomfort) associated once again with anxiety. In these instances she has "stepped up" her practice and resolved the condition in about one week. The imagery has changed somewhat, in that individual blood channels have merged and Julie now just "floods the whole area with fresh blood." She continues suggestions for her immune system and for maintenance of general coping skills. Julie has had no further problems with her skin allergies and dermatitis.

## **USE OF HYPNOSIS IN OTHER MEDICAL CONDITIONS**

As mentioned previously, Julie has familial hyperlipidaemia which she has managed over the years with dietary adjustments. While her levels have never been excessively high, there is ongoing concern because her mother already has significant coronary artery disease. Julie has incorporated her own scripts for lowering cholesterol with self-hypnosis. These have involved "washing the blood," a sort of pseudo-scientific dialysis, and cleaning and visualising clear arteries. Progressive studies this year have shown that she has significantly lowered her total cholesterol and low-density lipoproteins (considered to contribute a risk factor for coronary artery disease) to normal values. Her high-density lipoprotein and triglyceride levels have always been within the normal range.

Julie presented mid-year for advice concerning a lump on her forehead. While it had been present for some time, it appeared to be growing and was now the size of a pea. I was unsure of the diagnosis, but thought it was benign, possibly a seborrhoeic keratosis. However, it obviously required attention by an expert and probably removal. I suggested that Julie return to consult a plastic



surgeon who had removed another facial lesion some years ago. As Julie was rather anxious about the thought of the local anaesthetic, I suggested she use her relaxation "by her creek." When she made her appointment she was to inform the specialist of her intentions to use hypnosis, for relaxation, not analgesia. Julie telephoned a few days later to say that her intentions had not been favourably received and, in fact, they would be disallowed. I suggested another specialist I felt would have a positive attitude.

Before the appointment date, Julie returned to inform me that she had solved the problem and saved herself inconvenience and expense. The lesion had completely disappeared and in its place was a slightly red area, somewhat larger than the original lesion. The appearance was that of a superficial burn without scabbing. She had visually and kinaesthetically re-experienced a previous occasion when a doctor had applied CO<sub>2</sub> snow (a mixture of dry ice and acetone) to lesions on her back. It was of interest to note that the changes in the forehead lesion followed similar lines to the expected reaction to "snow."

### COMMENTS ON THERAPY

Julie managed to achieve for herself all three goals of the original management plan. Brown and Fromm (1987) have a firm conviction that the belief in one's ability to participate in the hypnotic experience is important for outcome. Julie is undoubtedly a high capacity subject with the ability for intense visual and kinaesthetic involvement. Once given the lead she was able to utilise and build upon her own internal strengths. She was able to achieve success where chemical methods for management of her skin conditions were proving inadequate.

Hydratinitis suppuritiva is a suppurating inflammatory or infective condition of the sweat glands and can be particularly resistant to treatment. Problems often arise from long-term use of oral antibiotics which are often prescribed empirically. Surgical excision is an option but not one to be entered into lightly.

Chronic contact dermatitis is always a frustration for patient and medical practitioner alike. There is a certain degree of anticipatory anxiety and this was certainly well developed in Julie's case. Often the daily routine revolves around the applications of topical steroids.

Julie has been able to incorporate hypnosis into her daily routines and to give new depth and meaning to what she already knew how to do. She has extended this into other medical conditions.

I believe that Julie began making the necessary changes after the first hypnotic session and was able to build upon success imagery and truisms. Hartland (1982) strongly emphasises the use of ego-strengthening suggestions in all dermatology problems. Julie received two heavy doses of ego-strengthening before I began specific suggestions for symptom relief. I believe that the more permissive approach initially was important for Julie because by her own admission she "needed to be in control." She did not appear to have any

secondary gain factors and the outcome suggests that the symptoms are not fulfilling an unconscious emotional need. Gibson and Heap (1991) make the comment that if patients are going to respond to a symptom-oriented approach they will do so early in treatment. They also comment that those patients who do well are likely to be those who are well motivated and are committed to practising self-hypnosis on a regular basis.

As Rossi (1986) points out, any rapid healing suggests that the autonomic and immune systems must have been activated to allow the healing to take place, by quick mobilisation of white cells in the bloodstream. There is a recognised system within the brain (limbic-hypothalamic system) which modulates biological activity in response to belief and suggestions. Julie had total belief and was able to mobilise a healing response by activating the systems of mind-body communication.

### CAUTIONARY ADVICE

There is no doubt that Julie has used her talents for her own health and well-being and will probably do so for the rest of her life. The "removal" of the skin lesion prompted us to discuss the need for respect for her talents. While this lesion was almost certainly benign and only good has been done by its "removal," it has been a reminder to me that one should never underestimate the abilities and enthusiasm of high capacity subjects in the use of self-hypnosis, and a reminder of the need to give the necessary caution for appropriate applications of hypnosis for self-healing.

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## **HYPNOSIS IN THE MANAGEMENT OF PAIN OF ORAL MUCOSITIS ASSOCIATED WITH HIGH DOSE THERAPY FOR CANCER**

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Oral mucositis occurs almost as an inevitable consequence of high dose therapy (HDT) in malignancies. Continuous narcotic infusions are usually necessary to control the intense pain. The majority of patients are unable to tolerate any oral intake until the mucositis resolves. Two patients, one with multiple myeloma and one with chronic myeloid leukaemia underwent HDT. Prior to starting therapy, each was taught self-hypnosis to control their pain. Both patients reported less pain than anticipated and one required no narcotic analgesia even though the physical signs of severe mucositis were present. Objective measurements of pain were recorded regularly using a visual analogue scale and these units were found to decrease as the mucositis improved. This preliminary finding suggests that hypnosis is an easily taught and applied technique that may be a useful, non-toxic, inexpensive adjunct to standard analgesia.

Mucositis occurs as an almost inevitable side effect of the treatment of various malignancies involving the procedure known as bone marrow transplantation (BMT).

Patients are given very high doses of chemotherapy and radiotherapy (HDT) and then, in autologous transplantation, infused with their own bone marrow. Alternatively, the patient is given closely matched bone marrow from a donor, usually a close blood relative, in an allogeneic transplant.

Before the BMT "takes," the patient suffers acute inflammation of the oral mucosa due to the lack of immunity and a direct toxic effect of the HDT. This mucositis is so painful, most patients cannot eat solid foods, can barely swallow liquids, and are seriously disinclined to talk. To control the intense pain and distress, it is usual for patients to require morphine delivered by a self-monitored continuous intravenous infusion.

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My very special thanks to Dr Noemi Horvath, Senior Clinical Haematologist, Acting Director Clinical Haematology and BMT Unit, Institute of Medical and Veterinary Science/Royal Adelaide Hospital.

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Eight patients were invited to take part in this small pilot study aimed at assessing whether hypnosis was a useful addition to the standard medical management protocol for oral mucositis. Of the eight patients seen, the two reported here completed all the stages of hypnotic training and medical therapies. The others, because of medical complications, dropped out.

## **CASE REPORTS**

Mr A. L. was a 57-year-old retired electronics engineer, first diagnosed as having multiple myeloma (MM) in November 1990. Myeloma is a neoplasm of plasma cells in the bone marrow.

One day while playing golf, Mr A. L. developed a pain in his chest and initially thought he had strained some muscles driving off the tee. The pain persisted, rather than improving, and he saw his family practitioner. When the pain failed to improve, Mr A. L. was referred to physician and finally a haematologist. The diagnosis was confirmed by examination of a bone marrow aspirate.

Bone pain is one of the commonest initial symptoms of multiple myeloma and often occurs in ribs or vertebrae which can also be weakened through osteolytic lesions. By the end of 1990 Mr A. L. had suffered broken bones twice in unusual circumstances. Once he sneezed and fractured his upper spine. On a second occasion, he rolled over in bed and fractured his lower spine.

The second patient, Mrs B. S., was a 53-year-old housewife. Her presentation in December 1993 was less dramatic. A state championship level lawn bowler, she became excessively tired and eventually went to her family GP. A blood test showed she was anaemic and had a highly elevated white blood count, well in excess of 100,000+ cells.

Referral to a haematologist followed and a diagnosis of chronic myeloid leukaemia (CML) was confirmed by bone marrow examination and chromosome studies. CML is a neoplasm of the granulocytic series of the white blood cells.

Both Mr A. L. and Mrs B. S. were placed on the waiting list to have bone marrow transplants. Mr A. L. was to receive an autologous, and Mrs B. S. an allogeneic, transplant.

## **HYPNOTIC PROCEDURE**

Standard medical and psychological histories were taken. Each patient was then assessed using the Stanford Hypnotic Clinical Scale (SHCS) (Hilgard & Hilgard, 1983). Subjects can score 0-1, low; 2-3, medium; and 4-5, high susceptibility. Both Mr A. L. and Mrs B. S. scored in the 2-3 range.

About four weeks prior to beginning medical treatment, both patients were taught hypnosis/self-hypnosis using a simple eye fixation/distraction induction. At the start, the inductions, including deepening by arm levitation and progressive muscle relaxation, took approximately 20-30 minutes.

Throughout this training period, emphasis was placed on the self-inductive aspect both patients would be using at home and later when in hospital. As the patients' confidence developed, a briefer self-induction was taught. This brief version, while only taking about 60 seconds to complete, was a critical step in the therapy process. The patients learned they could initiate self-relief measures quickly and did not have to suffer any prolonged periods of discomfort. Typical suggestions used during the training period included taking themselves to a special sanctuary "where nothing bothered them and nothing disturbed them." Alternatively they were instructed how to use specific metaphors to reduce or change the pain experience in some way.

Education about the physical and psychological nature of the pain experience and its modifiability by hypnotic manipulation had already been provided.

The final step before the bone marrow transplant took place was to demonstrate the use of the visual analogue pain scale (VAS). This simple device consists of a 10-cm line with zero at one end and 10 at the other. The patient estimates the level of pain they are experiencing and marks the scale at specified times. The distance along the line from zero is measured to give a number indicating the pain intensity (Huskisson, 1974).

Days preceding the actual bone marrow transplant are designated as though a countdown is occurring, that is, five days before the BMT is day -5 and so on. The day of the BMT itself is called day 0 (zero). The days following BMT are thus day +1, day +2, day +3, etc.

Mr A. L. and Mrs B. S. were duly admitted and had their bone marrow transplants.

## **PROGRESS**

The high dose therapy and bone marrow transplant procedures took place without incident. Because their diagnoses were not identical, Mr A. L. and Mrs B. S. received slightly different high dose therapies but as expected the oral mucositis appeared on about the third and fourth days after the bone marrow transplant. This corresponded with the lowest levels of their neutrophil count, before the transplanted bone marrow had "taken" and before each patient had begun to generate new white blood cells.

The pain experienced by patients usually corresponds to the severity of the mucositis, which is gauged according to how many surfaces of the mouth are affected. One cheek equals 25%, two 50%, plus floor or roof of mouth 75%, and whole of oral cavity, 100%. One hundred per cent involvement usually means the pain is extreme.

I visited each patient at the beginning of high dose therapy and at regular intervals subsequently. During these visits I reviewed the pain levels which they had experienced and recorded using the visual analogue pain scale. I did a hypnotic session for pain relief if they requested it.

Morphine dosage used by the patient was recorded by the nursing staff.

## **OBSERVATIONS**

Mr A. L. had 100% mucositis involvement of his mouth but, according to nursing staff records, he did not use as much morphine as the average patient with this severity of mucositis. His total was approximately three-quarters of average, which can reach about 120 mg per 24 hours.

On day +3 Mr A. L. used morphine at a rate of 2 mg/hour and peaked briefly on day +5 at 5 mg/hour. It then declined over the next seven days and by day +12 Mr A. L. was using no morphine at all.

His pain scores showed a similar pattern. On day +4, his average score that day was 5.6. It peaked at 6.6 on day +5 then gradually decreased to less than 2 by day +8. By day +12, Mr A. L. only complained of mild discomfort, a level he said not worth recording on the visual analogue pain scale.

Mrs B. S. also had 100% mucositis, but surprised the medical and nursing staff by not requesting or using any morphine whatsoever. She reported some discomfort, but only requested paracetamol and did not even use very much of this minor analgesic. She did not complete the visual analogue pain scale as her discomfort was so minor.

## **CONCLUSIONS**

Pain is the most feared consequence of cancer. Until relatively recently, the medical fraternity seemed reluctant to use flexibly and to its greatest advantage, the most potent drug in its armoury, morphine. That resistance is now diminishing as the psychology of pain is better elucidated and understood (Melzack, 1990; Sternbach, 1986) and multidisciplinary team approaches to pain control have been developed. These teams usually contain anaesthetists, physicians, neurosurgeons, psychiatrists, psychologists, and social workers. These latter three professional groups provide for the bio-psychosocial needs of the patient (Foley, 1985; Wain 1992).

Reports of hypnotic intervention in cancer pain have appeared sporadically (Barber & Gitelson, 1980; Cangello, 1961; Hilgard & Hilgard, 1983; Levitan, 1992) but none of these authors specifically addresses the pain of mucositis.

With increasing knowledge of the neurophysiology of pain (Melzack, 1990), the combined use of adequate doses of morphine and hypnosis should promote optimal relief of the various discomforts associated with cancer and its treatments.

Two patients reporting less than average pain and using less than average total dosage of morphine do not represent conclusive evidence of the usefulness of hypnotic intervention in mucositis pain management, but the present data do support the report of Syrjala, Cummings, and Donaldson (1992).

The techniques used were simple, suggesting that complicated approaches are not necessary, (Crasilneck, 1995; Hargadon, Bowers, & Woody, 1995). While a sample size of two is far too small and there may be other uncontrolled

variables influencing this outcome, a trend is indicated which warrants further verification in a rigorously designed controlled study.

### Postscript

Mr A. L. had approximately 18 months of good health after his first bone marrow transplant and then relapsed. He underwent a second bone marrow transplant with 12 months remission before developing pneumocystis carinii pneumonia from which he died. Mrs B. S. is alive and still very well.

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## **TRAUMA AND TREATMENT WITH HYPNOSIS**

**David Willshire**

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I first saw Mrs A, a 39-year-old woman, in May 1993, ten months after the incident for which she was seeking treatment. She was suffering post-traumatic stress disorder after witnessing an accident where a boy was struck by a train and cut in half. Her main symptom was phobic anxiety. Treatment included systematic desensitisation, sensory awareness relaxation, and ego-enhancing suggestions. Hypnosis enhanced these treatment strategies. We met 13 times, and terminated in September 1993. Sessions were, on average, of one hour's duration.

### **PRESENTING PROBLEM**

Mrs A worked in part-time employment in the city several days a week and usually drove to her local railway station, where she caught the train. On 2 July 1992, she had parked her car as usual, bought her ticket, walked through the gates and onto the platform, and looked up to see a 14-year-old schoolboy crossing the tracks at the pedestrian walkway. As she found out later, he was on his way to meet his girlfriend. It appeared that he was also probably confused and did not realise that there was a train coming from the other direction. He was hit by the city-bound train, thrown in the air and literally cut in half. Mrs A found herself unable to look away, and witnessed the entire sequence of events, along with several other people on the platform. She and other witnesses were detained for several hours at the railway station, and subsequently at the police station. Her husband was away at a conference for another fortnight and she told him there was no need to return early. She later found out that the deceased boy had attended the same primary school as her son, and his family lived near to where she lived, but they had never met. She did not go to the funeral, feeling that she would be unable to cope.

Following the incident, Mrs A had many dreams about it, and also of people being cut in half. She described being upset a few months after the incident, when her recollection of events had become hazy, and had rung the police to



refresh her memory. Following the accident, she had been unable to return to the railway station, or drive through the railway crossing where the accident had happened. She described having made one attempt to drive through the railway crossing but “froze,” stopping her car on the tracks. The tooting of cars behind her finally prompted her to “unfreeze,” and continue on. Immediately following the accident, and for several months afterwards, she had been unable to even drive across other railway lines, but prior to coming for hypnosis this problem had resolved. While she was unable to catch a train from the station where the incident had occurred, she was able to catch a train several stations nearer the city. Her phobia about returning to the station in question was troublesome in other ways: she was unable to take her children to the doctor, as his surgery was across the road from the station, and the road through the railway crossing was also the family’s major route in travelling towards the city and their local supermarket. Mrs A said that her husband and children were somewhat “fed up” with her problem (they had to make major detours if travelling in the vicinity of the station, and he had to take the children to the doctor). In the first session, she said that she wanted to be able to go back to the station without thinking about the accident — to keep it out of her mind and “not feel closed in.” She said that it “seems silly I can’t go back” and that she had “never, ever gone back there” since the accident (other than her attempt to drive through the crossing). She said her problem was really beginning to inconvenience her. “I get frustrated and anxious, and want to go back there, but I can’t.”

## **HISTORY**

Mrs A’s mother died in 1982 of cancer. Her father was retired and had been living in Queensland since 1987. She has one brother, two years older than her. She said that she had attended 13 different primary schools in Victoria (her father’s work entailed setting up new businesses), but only the one secondary school. After completing fifth form, she began work in the secretarial field. She met her husband when she was 18, and they were married three years later. He is a professional, and their relationship is apparently reasonably good. They have three children: boys aged 13 and 11, and a daughter aged five. Mrs A ceased work when her first child was born, and resumed work about three-and-a-half years ago, in a secretarial position in the city. She had recently commenced learning meditation and found it quite useful for relaxation.

## **ASSESSMENT AND DIAGNOSIS**

Assessment indicated that Mrs A satisfied the DSM-IV (American Psychiatric Association, 1994) criteria for Post Traumatic Stress Disorder (rather than Specific Phobia, although the main symptom with which she presented was a phobic anxiety). She was not suffering from any comorbid disorders such as depressive disorder or substance abuse, and she did not evidence any suicidal

ideation (Calhoun & Resick, 1993). She obtained a score of 3 on the Stanford Hypnotic Clinical Scale (SHCS) (Morgan and Hilgard, 1975), suggesting moderate hypnotisability. She noted that she had felt "some resistance" toward describing the dream she had to me, and also that it was an active "fantasy" rather than a dream. She did not respond to the post-hypnotic suggestion.

## **GOALS**

Mrs A saw her goals as being able to return to the station and recommence travelling by train to work. Being able to return to the area would also allow her to take the children to the doctor's surgery across the road from the station.

## **THERAPEUTIC APPROACH**

As Mrs A was seeing another counsellor for "personal issues," and as her husband was a colleague of mine, she was unwilling to look very deeply at other issues in her life. We thus took a quite focused approach to her presenting problem. However, it did appear that Mrs A's self-esteem was relatively poor; this seemed to have been exacerbated by her feelings of inability in successfully managing her reactions to the trauma she had experienced.

Mrs A had been avoiding the scene of the incident for some time, due to great anxiety at the thought of doing so, but wished, for very practical reasons, to return there. Controlled exposure to trauma-related stimuli (Creamer, Burgess, Buckingham, & Pattison, 1989) was a necessary part of treatment. Owing to the intensity, extent and duration of her anxiety, it was not possible to simply do this *in vivo*. Imaginal systematic desensitisation (Clarke & Jackson, 1983; Hawton, Salkovskis, Kirk & Clark, 1989; Wolpe, 1958) was decided upon as the main therapeutic approach to be employed in dealing with her phobic anxiety.

Hypnosis was used to facilitate this exposure, as well as for relaxation and ego-strengthening purposes. In addition to systematic desensitisation, a breathing technique, coping self-statements (Meichenbaum, 1977), cue-controlled relaxation (Clarke & Jackson, 1983, p. 312), ego-strengthening suggestions, and meditation were also used. Sensory awareness relaxation (Clarke & Jackson, 1983, pp. 78–81) was used as the basis of the hypnotic induction.

### **Systematic desensitisation**

A "geographical" desensitisation, based on a geographical "graded hierarchy," was used, rather than desensitising her to the event. Treatment was based on the notion of approaching rather than avoiding what she feared, through "graded exposure." This procedure would present her with the opportunity of learning that the situation she feared was not dangerous, by reversing her tendency to avoid the phobic situation (i.e., the railway station). Assessment indicated that avoidance of the phobic situation was the major maintaining factor. The

procedure would be conducted first in imagination, with subsequent exposure in vivo.

She was instructed to raise her little finger while hypnotised to indicate to me when her anxiety had become too great to manage, at which time suggestions for greater relaxation and taking control could be reinforced (e.g., “OK, just allow your car to gently pull into the kerb, letting your eyes close while the scene in front of you fades from sight ... concentrate again on your breathing ... relaxing ... letting go with each breath out”). Once her little finger was lowered, either the scene could be reintroduced or the hypnosis session concluded.

### **Breathing Relaxation**

A short breathing relaxation was provided (e.g., “Breathe in, hold your breath, let it out slowly, becoming more and more relaxed with each breath out”). This could be used at times when she might be confronted with overwhelming anxiety.

### **Coping Self-Statements**

Coping self-statements were developed to assist Mrs A before, during, and after the various steps on the graded hierarchy, as well as for when the situation might become potentially overwhelming (Meichenbaum, 1977).

### **Meditation**

Mrs A had recently commenced learning a Buddhist concentrative meditation involving a focused attentional posture (e.g., awareness of the breath) (Fromm & Hurt, 1980), so it was decided to incorporate this into the treatment programme. In this type of meditation, the meditator is advised to “let go of any thoughts that arise” and return to one’s focus of attention (e.g., the breath). This could be seen as a combination of both progressive relaxation and coping self-statements, leading to a detached attitude toward intrusive stimuli, to provide an effective means of preventing anxiety.

### **Sensory Awareness Relaxation (SAR)**

While the SAR (Appendix A) is usually used as a means of helping difficult clients relinquish excessively critical attitudes toward hypnosis (Clarke & Jackson, 1983), it was decided to use it as an induction in its own right, as she appeared much less resistant to this than to the more formal induction presented to her in the previous session, and reported having felt “hypnotised” following the SAR. The SAR also develops a “yes set,” and is conducive to embedding ego-enhancing suggestions and coping self-statements.

### **Ego-Enhancing Suggestions**

These were embedded into the SAR, to reinforce Mrs A's ability to cope, and her strengths in general.

### **Cue-Controlled Relaxation** (e.g., Clarke & Jackson, 1983, p. 312)

During and following the hypnotic induction, suggestions were made that she could return at other times to the feeling of deep relaxation that she was presently experiencing, by pressing her thumb and forefinger together as a reminder of just how relaxed she was feeling.

### **SESSION 1**

This session comprised problem definition and history taking. I also requested that she show me the location of the railway station in a local street directory and the route that she used to take when she drove there. Besides providing me with necessary information, this also necessitated some exposure on her part.

Between the first and second session, a similar accident occurred at the same railway crossing, involving the death of two children. Mrs A reported re-experiencing strong emotions associated with the initial event (she felt slightly numbed, distressed, and hypervigilant). She also reported that her son had needed to be seen by the doctor, but she had been unable to take him (her husband did so, as he had done during the past 10 months).

### **SESSION 2**

Assessment and diagnosis were completed during this session. Mrs A's hypnotisability was assessed also, using the SHCS (see earlier).

Mrs A was provided with information and a rationale about personal reactions to trauma and it was suggested to her that her symptoms were "a normal reaction to an abnormal event" as well as giving reassurance that she was not "crazy." Information and a rationale of the treatment approach to be used were also given.

The rationale for systematic desensitisation, including the notions of "avoidance," and how it can maintain the anxiety, and "graded exposure," were presented, by means of analogy with having been scared by a dog. The idea of confronting the fear, step by step, in manageable stages, was given (i.e., one would approach the dog step by step, allowing one's fear to subside before attempting to get closer). The meditation technique of "letting go" of thoughts was reinforced as a means of dealing with any intrusive or negative thoughts that might arise during the systematic desensitisation, or at other times, as well as promoting her sense of cognitive control. She was reminded that while one cannot readily control what arises in the mind, some control can be exercised over whether one continues to think about it or not.

After Mrs A provided a further, more detailed description of the location of the incident and the route she usually took to get there, I resolved to see it for myself, by driving along the same route, so I would have a detailed picture (perhaps even more detailed than hers) that could be fed back to her during the imaginal systematic desensitisation. It was possible that this might also stimulate her interest in returning to the area. I subsequently drove to the station, parked in the car park and went up on the platform, taking notes as I went.

### **SESSION 3**

A "special place" — a calm, relaxing scene of her own choice was devised (a scene involving bush, blue sky, birds, grass, lying on her back on a sloping hill). A breathing relaxation was then presented, followed by the sensory awareness relaxation (SAR), and then deepening (Clarke & Jackson, 1983) was added (e.g., counting down from 1 to 10 with each breath out, leading down to her "special place.") Cue-controlled relaxation (e.g., Clarke & Jackson, 1983, p. 312), involving the pressing together of her thumb and forefinger was then introduced.

We again looked at the concept of systematic desensitisation, and the need to construct a graded hierarchy, starting from her "special place" which was rated at 0% subjective units of distress (SUDS). Next, the point at which she just began to feel uneasy was nominated (e.g., as she drives up R-Road and reaches its intersection with S-Road). This point was selected so as to be easy enough for her to be able to attempt to confront it, but sufficiently hard enough to produce some anxiety. It was left until the next session to build the hierarchy a little further. The rest of the session was spent in discussing the issue of control, which was of concern to her in other areas of life. It was reiterated to her that she would remain in control throughout hypnosis sessions.

### **SESSION 4**

The session commenced with a short breathing relaxation, the SAR, and deepening, leading to her being in her "special place." The notion that she remained in control was also suggested several times during this, as it was clearly such an important issue for her. Mrs A noted that she had found hypnosis more relaxing than her meditation practice, in which she found intrusive thoughts harder to manage.

Work on constructing a graded hierarchy continued: the end point was to be able to stand on the platform with a train pulling in to the station, with pedestrians darting across the crossing and seeing someone in the same place as the boy when he was hit by the train. As the hierarchy was constructed, she described her thoughts, feelings, and behaviour as she approached the railway station (in imagination). She described feeling "closed in ... tightening up";

having a battle in her mind of “will I go on ... I won’t” and “won’t” seems to win; feeling fearful of her feelings. Mrs A said that when it happened she “lost control ... was hysterical, trembling, as if it was not real; fearful of it happening again.” She also mentioned feeling anxious at the thought of seeing the same lady working in the ticket-box as on the day of the accident. It was agreed that Mrs A would complete the 10-step hierarchy for homework (a desensitisation procedure in itself), rating herself on a SUDS scale of 0 to 100%.

## **SESSION 5**

The session again commenced with breathing, SAR and deepening, to her “special place.” Mrs A said she had used the cue-controlled relaxation technique during the week, and found it helpful (while travelling on an aeroplane). She had also completed her homework, but produced a 17-step hierarchy which was somewhat skewed in the latter stages, appearing to reflect her great reluctance in approaching the last few feared scenes. Time was spent in discussing and streamlining her hierarchy to 10 evenly spaced steps.

Her hierarchy was:

1. at the corner of R-Road and S-Road;
2. turning the corner into S-Road;
3. driving down S-Road, looking toward the station car park;
4. turning right into T-Avenue;
5. turning left into the car park and parking the car;
6. getting out of the car, walking up the ramp to the ticket box;
7. buying a ticket;
8. turning around and heading toward the platform gate;
9. walking through the gate and on to the platform;
10. standing still on the railway platform, looking at the spot where the boy was killed, as a train pulls into the station.

Some time was spent discussing her strengths; making indirect suggestions about having “forgotten” that she had faced difficult situations before with success. While discussing the process of hypnosis that we would be using during the course of systematic desensitisation, I went over the suggestions I had made and would be making.

## **SESSION 6**

This session coincided with the anniversary of the accident one year earlier. Mrs A spent some time talking about how she was feeling: sad, especially for the boy’s family, and fearful when she arrived at work earlier in the day that someone might have rung in saying they were late due to a train accident.

After the breathing, SAR, and deepening, to her “special place” had occurred, the imaginal systematic desensitisation was commenced. She reached step four in the hierarchy before it was clear that she could manage no further in this session (as indicated by finger raising).

As noted above, I was able to give a very detailed description of the route along which she would travel to the station, so was able to add "enticing" statements such as she "might be interested to see the shops on the right-hand side and notice if they have changed at all," or briefly describe an interesting feature that I had noticed, in addition to using words such as "curious," "wonder," and so on, to stimulate her curiosity about returning to the area. At the end of the session, Mrs A remarked that she was somewhat curious to find out how the area had changed since she was last there.

For homework, Mrs A agreed to make a "real life" attempt to drive along part or all of the route that she had imagined during this session.

## **SESSION 7**

Mrs A reported feeling guilty at not having attempted anything in vivo, but she was encouraged to not punish herself (e.g., "you'll do what you need to do when you're good and ready").

Positive, reinforcing statements were given to her during the induction and while hypnotised, including the reminder that she was in control, that she was doing it at her pace and not mine, and that she'd do it when she was ready. She was also reminded to congratulate herself on any success, and to not be hard on herself for not achieving what she thought she should (i.e., coping self-statements). The suggestion that any thoughts or feelings which arise would pass away was reiterated. While moving through her hierarchy in imagination, the differences between the present and the time of the incident were highlighted (e.g., the weather; changes in scenery, such as roadworks; the possibility that shops in the small shopping centre along the route might have changed; etc.). This session, she completed step five in her hierarchy.

She was also given a handout describing examples of coping self-statements for dealing with stressful situations. Several that were relevant to her situation were prepared.

## **SESSION 8**

During the week, Mrs A had driven down S-Road, and into the car park, where she had sat for a while, relaxing. She had also, on another day, driven past the station. During this session, in imagination, she managed to walk on to the station platform. She noted several strong images, even flashbacks, but used some of the prepared coping self-statements to help manage, as well as reminding herself that it was "now, and not then."

## **SESSION 9**

Mrs A had not done any more in vivo work, saying she had been too busy. In imagination, we again went through the hierarchy until she was standing on the platform looking at the spot where the accident occurred. At the suggestion that

a train was coming she signalled her unwillingness to continue. Interestingly, she said later that she had averted her gaze away from the train and toward some people on her left (i.e., used distraction). It was interesting to notice her head turn while under hypnosis, corresponding to that direction.

#### **SESSION 10**

Mrs A reported that she had returned to the station during the week, and had actually stood on the platform, but left when she heard the sound of an approaching train. She also reported that she had driven there earlier in the week and had followed the instruction step by step, to the extent that she got out of the car, leaving her keys locked inside, with the result that she had to wait in the car park for nearly an hour while the RACV attended and opened her car. This, while inadvertently providing her with prolonged exposure, highlighted the importance of being very careful of what one says to people while hypnotised (I had neglected to suggest that she take the keys from the ignition before getting out and locking the door! Needless to say, this was stressed in subsequent sessions).

#### **SESSION 11**

Mrs A had again returned to the station and stood on the platform. Following discussion with Mrs A, the original hierarchy was amended, to enable her to leave the station, walk through the pedestrian gateway of the railway crossing, across the tracks and to her bank, as this was a task she also wished to be able to perform. This was performed under hypnosis during the session. She later told me that a train had been coming while she was standing on the platform in the session, but that my suggestion that the gates were up, with cars and people crossing through (in response to her raised finger) had helped avert any significant anxiety.

#### **SESSION 12**

During the week, Mrs A had been to the shopping centre adjacent to the railway station, by driving through the railway crossing. She said she had managed this with relatively little anxiety. Under hypnosis, at her request, she re-enacted getting off the train from the city (as she would upon her return from work), crossing over the railway tracks and heading towards the car park and her car.

#### **SESSION 13**

Mrs A attended, feeling very pleased with herself. Her car had broken down during the week, so she had successfully caught the train to work and returned by train. Several days later, she had actually walked through the pedestrian gateway of the railway crossing, holding her daughter's hand. She reported



having momentarily "frozen," but then successfully walked through. After having done some shopping, she returned the same way. At this point, Mrs A decided to discontinue sessions, with the proviso of re-attending should the need arise. We spent some time looking at the overall process that she had undertaken, with an emphasis on the possibility of making changes in one's life and how one might go about it (for instance, breaking apparently insurmountable problems down into smaller, manageable steps).

## **FOLLOW-UP**

Mrs A did not need to re-attend, as she did not experience any setbacks in her progress. Follow-up at three and six months indicated that treatment had been completely successful. Recently (in early 1995), another two children were killed under similar circumstances at the same railway crossing. Inquiries through Mrs A's husband indicated that, while she had been quite upset by this event, she had not re-experienced any of her previous symptoms.

## **RETROSPECTIVE COMMENTS**

As Spiegel and Spiegel (1978) have pointed out, hypnosis is not a treatment in itself but a way of enhancing treatment strategies. In this case, it was used to enhance a systematic desensitisation procedure, which might well have been conducted without the use of hypnosis. However, its efficacy was likely to have been enhanced by Mrs A's expectation that hypnosis would be helpful. Furthermore, Mrs A stated that she had found the hypnosis very relaxing (more so than her meditation), and it enabled ego-strengthening suggestions to be given. It was also pleasing to see Mrs A generalise what she had learnt to other areas in her life, and the confidence she appeared to have gained in dealing with this difficult problem.

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## APPENDIX A

### Sensory Awareness Relaxation

Just sit comfortably in the chair and listen very carefully to what I am going to be saying to you. I'm going to try a series of experiments with you. Each experiment will be in the form of a question. Each question is answerable by either "yes" or "no," but it won't be necessary for you to say "yes" or "no" out loud or even perhaps to yourself, because the answer to each question will be your own particular reaction to each question. All this will become very clear as we proceed. Just remember to listen to the question that I pose to you and do not be bothered by the unusual nature of some of them. Let yourself react to each question. However you react is fine. There really is no right or wrong way. Let your own reaction to each question be your answer to each question.

Is it possible for you to *allow* you eyes to close? (10 second pause = #)

If they are not yet closed you may close them now. (5 second pause)

Can you be aware of the point at which the back of your head comes in contact with the chair?#

Is it possible for you to imagine the space between your eyes?#

Is it possible for you to be aware how close your breath comes to the back of your eyes every time you inhale?#

Can you imagine that you are looking at something that is very far away?#

Is it possible for you to be aware of where your arms are in contact with the chair? (5 second pause) And can you be aware of the points at which your arms lose contact with the chair?#

Is either your left or right foot resting on the floor, and if either or both of them are, can you feel the floor beneath your foot?#

Can you imagine in your mind's eye a beautiful flower suspended a few feet in front of you?# Is it possible for you to close the lids of your inner eye so you can no longer see the flower?#

Is it possible for you to be aware of the space within your mouth?# And can

you be aware of the position of your tongue within your mouth?#

Is it possible for you to feel even the slightest breeze against your cheek?#

Are you aware of one of your arms being heavier than the other?#

Is there a tingling or feeling of numbness in one of your hands?#

Are you aware of one of your arms being more relaxed than the other?#

Is it possible for you to notice any change in the temperature of your body?#

Is your left arm warmer than your right?#

Is it possible for you to feel like a rag doll?#

Can you be aware of your left forearm? (5 seconds) Can you feel any tightness in it?#

Is it possible for you to imagine something that is *very pleasant* for you?#

Can you feel yourself floating as if on a cloud? (5 seconds) Or are you feeling much too heavy for that?#

Can your arms feel very heavy as if they were stuck in honey?#

Is it possible for you to imagine once again that you are looking at something that is very far away?#

Is there a heaviness coming into your legs?#

Is it possible for you to imagine yourself floating in warm water?#

Can you feel the weight of your body in the chair?#

Can you allow yourself just to drift along lazily?#

Is it possible to feel your face getting very soft?#

Is it possible for you to imagine in your mind's eye another beautiful flower?# Can you notice what colour the flower is if you see one?# Can you close the lids of your inner eye so as you no longer see the flower?#

Is it possible to notice whether one of your arms is heavier than the other?#

And can you notice whether one of your legs is heavier than the other?#

## **SELF-EMPOWERMENT AND THE 15-MINUTE SOLUTION**

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Rapid-change therapeutic techniques are becoming increasingly popular and in this article four of these, deriving from the work of the neuro-linguistic programmers — the switch, anchoring a positive feeling, installing belief, and rapid trance induction — are linked in order to provide a treatment intervention occupying a time period of 15 minutes. Three case studies involving examination anxiety, weight loss, and fear of public speaking are used to illustrate how the techniques might be applied.

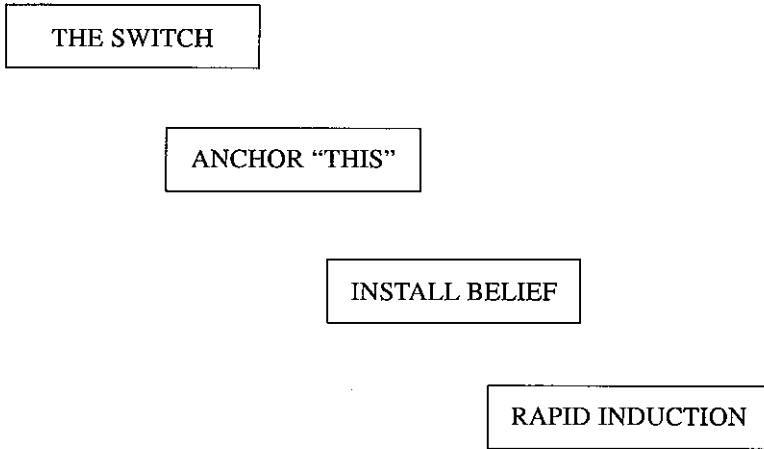
### **INTRODUCTION**

It has long been thought that change must take place slowly as a long-term process. This view is the legacy of the depth psychology and psycho-analytic tradition. Some years ago an outstanding figure in the field of psycho-analysis conducted a seminar telling of the marvellous result with short-term treatment whereby rapid improvement had taken place. However, her definition of short-term was five years of hypno-analysis with four sessions per week. It also transpired that the patient had previously been treated by conventional psycho-analysis for a period of eight years. This seemed a very odd definition of short-term therapy.

Bandler (1993) believes change must be effected very quickly and that, for example, it is easier to cure a phobia in 10 minutes than in five years. The human mind, he asserts, learns quickly, not slowly. Accordingly, he teaches and describes virtually instant change techniques which can be of great value to therapists. I have combined several of these techniques with another suggested by Zarro and Blum (1989) in order to achieve, with a variety of individuals, what I have termed the 15-minute solution. Because of its brevity, the approach is easy to learn. It may then be applied to alleviate a wide range of problems.

## THE 15-MINUTE CHANGE TECHNIQUE

The combination of techniques, in the order in which they are used, may be diagrammed in the following manner.



### The Switch

This method (Zarro & Blum, 1989) is a variant on the Swish technique described by Bandler (1985) in earlier work. The patient begins with the picture of unwanted behaviour which is made large, colourful and bright. A more desired behaviour is pictured in black and white, occupying the bottom right-hand corner of this picture. When the therapist claps hands as a signal, the patient switches the two pictures, changing their size and colour. After this switch, the two pictures are reset to their original format. This process is continued until the patient is unable to reset the pictures. The small black and white picture of the unwanted behaviour is then moved up high to the patient's left, down to the lower left, placed on edge and spun like a top. As it spins it is made grey and dim, shrinking down to postage-stamp size. It is then moved up to the patient's right, placed a few inches or centimetres in front of his or her face, shifted to a similar distance over his or her head, and again shifted to the same distance behind his or her head. As it is moved further and further behind the patient's head, it finally reaches a point where it disappears. The wanted picture is made small and gradually expanded until it becomes life-size. At the same time, the colour and brightness are turned up to reflect the very bright future that lies ahead.

### **Anchoring With “This”**

Patients are asked to think of something wonderful. This technique follows the switch procedure, that is, developing the wonderful-feeling memory of the positive picture they used at that time. With closed eyes they take the picture associated with this experience and make “this” bigger; make “this” brighter; make “this” more colourful; intensify “this” in every way.

Accordingly, the feeling is retained by the verbal anchor of “this.” A kinaesthetic anchor — say placing together the thumb and first two fingers of the non-dominant hand — could also be used. Patients are then asked to close their eyes and think of some negative situations where they feel uneasy about their behaviour. As each negative situation is recalled they are to feel “this” and trigger their kinaesthetic anchor. It is quite likely that they will no longer find these situations so negative. They could even become enjoyable.

### **Install Belief**

Patients are asked to think of something in which they absolutely believe. “Tomorrow the sun will rise” could be such a belief. A belief that could or could not be true, that is, a doubt, is also identified. Each of these is considered one at a time and the differences between them observed. In particular, the patient describes where they locate the beliefs in their minds. Is one directly in front and the other up to the left? Is one up high and the other lower down? Other submodalities (Bandler, 1985), such as the brightness, distance, clarity, colour, size, shape, and movement of each belief are identified and the differences between them noted. If voices, sounds or feelings are involved these differences are observed also, until both the unquestioned belief and the doubtful belief are clearly distinguished from each other. The doubtful belief is slowly moved away into the horizon until it hits a point. Then it is pulled back very quickly into the position where the strong and powerful belief is located. It is then made identical to the strong and powerful belief in terms of size, colour, brightness, and closeness. This must be done very suddenly so it seems to slot into place with a physical impact.

### **Rapid Induction**

The patient’s hand is passed in front of their eyes. The patient is to look at their hand, observing the changing focus of eyes, taking a deep breath, relaxing, closing the eyes and going all the way down into trance. It is suggested the hand will remain where it is initially, then the patient will let it go down only at the speed that they are ready to learn something of importance. Also, the patient is asked to retrieve a positive feeling from the switch. With each breath he or she is to go deeper and deeper, enjoying the process of knowing they can learn from the unconscious at this moment. As the hand moves down slowly, the therapist suggests the unconscious will take the good feeling, spreading it through mind

and body as the patient really learns about going into a deep trance.

## CASE STUDIES

### **Shane and Examination Anxiety**

Shane is a 15-year-old high school student who experienced excessive examination anxiety. Although quite a capable student he was unable to reproduce at examinations the ability he displayed in assignments completed during the year. His case was more serious than usual for he became virtually physically paralysed in the examination room, often writing only a few sentences or a single mathematical problem. His sense of being on trial created anxiety which prevented him thinking coherently.

It was the image of himself frozen physically at a desk gazing blankly at the examination paper that he chose as the starting point for his switch. The desired image was of himself writing fluently, the words flowing effortlessly from his pen. It took nine switches before he was unable to reset to the starting point of the large, colourful frozen image and the small, dark black and white image of the effortless writer. Also, he had to move back the tiny postage-stamp image which resulted from his spinning for a long way before it finally vanished. He was then very happy to anchor his very positive image with "this" together with the kinaesthetic anchor of touching his ear lobe, something, from the expression on his face, that he enjoyed very much. These feelings were used to change his memory of previous negative examination experiences.

Installing the belief of himself as one who handles examinations with ease took several repetitions. Several changes of the desired belief were necessary before Shane decided upon "I look forward to examinations as a challenge, the opportunity to demonstrate how well I can do." I had some doubts about using this belief, but it worked well for Shane, and he was able to install it powerfully. He then enjoyed the trance state feelings associated with handling examinations really well, learning from his unconscious everything he needed to know to ensure future success.

Monitoring of Shane's examination results indicated that the 15-minute treatment had produced the desired effect. Over the next two terms, his marks improved dramatically and he passed all his subjects quite comfortably. This was in strong contrast to previous results where consistent failure had stemmed from his inability to put his knowledge in writing because his anxiety was interfering with his cognitive processes.

## **Jane and Weight Loss**

A second case study concerns Jane, a 31-year-old married woman with two children, who requested help in losing weight. Though she had a long history of dieting and had been a member of various "weight watcher" groups, she had not been able to achieve her desired target of 75 kilos. Her present weight of 92 kilos had remained relatively stable for the previous four years. Although, on occasions, she had been able to reduce weight to some extent through dieting she had never achieved the 75 kilo level which had been normal for her before the birth of her second child. Once the rigid control of dieting was relaxed, her weight returned close to 92 kilos within weeks.

As we discussed Jane's weight problem, I asked her to think of herself as she was now. An image of herself wearing big, baggy unflattering clothes to a school meeting became her unwanted picture. She made it large, colourful, clear and bright, then thought of herself as she would like to be: dining out with her husband, wearing a glamorous dress in which she looked sleek and attractive. Placed down in the bottom corner of the big unwanted picture, this image was small and dim. Jane then engaged in the process of switching and resetting the two images. After the sixth such switch she was unable to reset back to the original situation. At this point she commenced moving the unwanted picture around the body, shrinking it and causing it to disappear.

Moving onto the second of the four techniques, Jane then thought of her desired picture, made it bigger, more colourful, clearer and more intense in every way. As she did so, I used the "this" anchor by saying "Intensify 'this,' make 'this' even more colourful, as you make your movements more animated, how good 'this' makes you feel." Once "this" had been linked to the positive image of herself, Jane closed her eyes and thought of an occasion on which she had overeaten. As she did so, she imaged herself pushing the food away and feeling "this." Other negative situations where she could be tempted to overeat were treated similarly. Each time she took some action to reject this extra food, she felt "this." Although I suggested the use of a kinaesthetic anchor as reinforcement, Jane felt this was unnecessary.

The third step in the 15-minute solution was to install within Jane the certain belief that she would be 75 kilos. If a person really believes that something is so, the chances of justifying that belief appear to be greatly increased (Gindes, 1951). So Jane compared her belief that the sun would come up tomorrow morning with her belief that she would weigh 75 kilos. The visual submodalities of location, distance, brightness, colour and size were different, as was the feeling engendered by the belief. Whereas the sun rising belief carried with it a sense of solidness, stability, the weight belief was associated with a feeling of nervousness, of hopelessness. The doubtful belief was pushed right out to the horizon until it was just a dot, then rapidly brought back into the certain belief location with a definite physical impact. It took on the kinaesthetic submodality of stability as well as the visual submodalities of being close, bright, very



colourful and quite large.

Finally, Jane's hand was raised and passed before her eyes as has been described earlier. As she went down into trance her hand sank slowly as the feeling of "this" pervaded her body, and her unconscious mind accepted that she would weigh 75 kilos. When her hand finally came to rest on her lap my final suggestion was made. "When your unconscious mind is willing to do everything that is necessary for you to weigh 75 kilos and to maintain that weight automatically and effortlessly, your eyes will open and you will come back with the certainty that this is what will happen." On this occasion Jane's eyes did open but, if they had not, I would have modified the suggestion, perhaps indicating that the unconscious mind would begin the process of moving her towards her desired weight.

From the time of our session together, Jane commenced losing a little weight each week. On several occasions she appeared to stabilise at a certain level. Then, after a week or two, she resumed discarding the unwanted kilos. The time taken to reach her desired weight was 27 weeks. At follow-up, six months later, she was within one kilo of that weight.

### **Gary and the Fear of Public Speaking**

Public speaking was an anxiety-provoking experience for 32-year-old Gary, a newly elected politician. Although he wanted to make politics his career, he was ambivalent because of his fear when faced with large groups of people. On an individual basis and with small groups he was highly articulate, but this diminished when presenting to a mass of people. He would lose concentration, repeat himself, forget the thread of his argument and, on occasions, stammer. Obviously, Gary's future prospects in parliament would be rather dim if he was not able to overcome this problem.

Using the 15-minute procedure, Gary made a switch between "seeing" himself stammering, uneasily speaking in the chamber and "seeing" himself speaking fluently, persuasively and powerfully to a huge election rally. He felt wonderful about his latter image and it took only three switches before he was unable to reset. He anchored very powerfully with "this" and a touch on the middle knuckle of his right hand then installed successfully the belief that he was a fluent speaker, irrespective of audience size. During trance, positive feelings spread to every part of his mind and body as he learned from his unconscious mind everything that was necessary so he could perform successfully.

Several days after completion of the treatment, Gary confidently made a short speech in the chamber. Over succeeding weeks his speeches became more frequent and longer. He displayed no sign of being intimidated by his audience and he approached impending public utterances with a sense of pleasurable anticipation. At a follow-up call to Gary, he expressed amazement at the rapid change to enjoyment of public speaking.

## DISCUSSION

The process described in these three cases took approximately 15 minutes. Although this may seem a very short period in which to handle problems such as examination anxiety, weight loss, and fear of public speaking, Talmon (1990) has indicated that single-session therapy can be extremely effective. Other studies (e.g., Jones & Vischi, 1979; Mumford, Schleisinger & Glass, 1984) provide support for Talmon's finding in their conclusion that length of treatment does not proportionally reflect therapeutic benefits.

It could be argued that the 15-minute treatment is not universally applicable because of its emphasis upon patients' ability to use visualisation. Some people may be unable to see images in their minds. If patients express an inability to "see" images, I ask them to describe to me what would be present in their minds if they actually did have this ability. They then proceed to describe the images in greater detail. It would appear they were able to "see" such images but did not realise that they were capable of doing so. Thus, I believe the approach is suitable for most patients.

This technique is comparable to many other psychotherapeutic approaches which make the assumption that an unconscious mind exists and is able to recall and learn from past memories. However, we must remember we are working with constructs and should beware of confusing them with reality. If we act as if the unconscious mind is capable of using past experience to promote present learning and that we achieve the outcomes we desire by this belief, then it is expedient to continue acting in this way. This is a very pragmatic approach, one frequently espoused by the neuro-linguistic programmers (e.g., Dilts, Grinder, Bandler, & DeLozier, 1980) and it is certainly one that has much to commend it in a hypnotherapeutic context.

The neuro-linguistic programmers have always claimed to achieve very positive results from the application of their approach. Experimental evidence to support these claims is lacking (e.g., Heep, 1987; Sharpley, 1987) although some have claimed that neuro-linguistic programming has not been adequately evaluated because of its complexity. However, although NLP principles are difficult to validate in the laboratory, clinicians have used many of their techniques with considerable enthusiasm for they do seem to produce desirable outcomes over a wide range of contexts (Stanton, 1988a, 1988b).

This schism between theory and clinical effectiveness is always with us. If the clinical techniques we use, and find to be effective in practice, are not validated by our all too imperfect "scientific" methods, they are held to be theoretically suspect. However, when the results of the past decades of experimental work with clinical techniques are considered, we could be in for a long wait before theoretical justification for approaches such as that outlined in the present article are forthcoming. Also, should a theory explaining the effectiveness of NLP techniques emerge from the laboratories, it is quite likely to be incorrect.

As psychological theories usually do turn out to be wrong or inadequate, it would seem counter-productive to ignore the value of using approaches such as the 15-minute solution, which does appear to help patients achieve the outcomes they desire both successfully and quickly. Replication will, of course, be necessary to find if other therapists using the method are able to achieve the results reported in this article. Not all patients may respond as positively as the three described, although the cases were chosen at random. In fact, since I have been using the 15-minute solution, it has been difficult to identify cases where patients have not been helped, to some extent at least, in the achievement of the changes they wished to make. Can we ask more of any clinical intervention?

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## **CASE NOTES**

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

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## **HYPNOSIS TO ALLEVIATE CLASSICALLY CONDITIONED FEAR OF CHOKING IN A CHILD**

**Christine H. Ffrench**

*Psychologist*

The client was a seven-year-old girl with no previous pathology. After being badly frightened by choking on some food, her eating had become problematic. Two sessions of hypnotherapy, in which the child's ability to imagine and make-believe were utilised, were conducted. The symptoms abated after the second session.

### **BACKGROUND**

The client was a seven-year-old female, Alexandra, who, six days previously, when eating her evening meal of meat and vegetables, had choked on some food which became lodged in her throat. She had managed to clear it herself and had been in no danger, but had been badly frightened by the event.

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**PRESENTING PROBLEM**

There had never been a problem with Alexandra's eating of the evening meal. In fact, she considered items such as mashed potatoes and peas among her favourite foods. Since the choking episode, her eating behaviour had been severely altered. She reported feeling scared she would choke and, therefore, could not swallow her food. Alexandra chewed a mouthful of food for seven to ten minutes, before going to the kitchen bin to spit it out. The problem was particularly severe with food similar to that on which she had choked, that is, meat and vegetables. In the six days since she had choked, she had not been able to swallow them.

The idiosyncratic nature of her response was evidenced in her ability to swallow food which would have been more difficult to swallow and more likely to cause choking than mashed potato, such as dry cereal. Alexandra was distressed at her inability to eat her usual range of foods normally, and it appeared that the conditioned response was generalising all food types.

**TREATMENT SESSION 1**

Alexandra was willing to attempt hypnosis. I explained to her that it involved my talking to her, and her feeling relaxed and calm. The session was held in the early evening, prior to Alexandra eating her evening meal.

As children tend not to want to shut their eyes, it was suggested to Alexandra she might like to focus on a spot on the ceiling but that, if her eyelids felt heavy, she could shut them. She did not shut her eyes during this first session.

I told Alexandra that if she really looked she would be able to see many fairies flying around the ceiling of the room, and that we all had a special fairy who protected us, who was always near to us to make sure that we don't come to any harm. I said that if she concentrated very hard, she would be able to see her own special fairy. When I asked Alexandra if she could see her, she said she could. I asked the fairy's name, and Alexandra replied "Georgina." I then asked her to describe the fairy, what she looked like, and what she was wearing. Alexandra said that she had shining gold hair and a sparkling dress of many colours, large wings, and fairy shoes. I suggested that Georgina also carried a wand.

I then told Alexandra that she could talk with her fairy if she wanted. If she didn't want to talk out loud, she could do it in her head, and Georgina would be able to hear her. I said that she could tell Georgina about anything she wanted, including things that might be worrying her, such as her problem with swallowing her food, and Georgina would be able to help her. I asked her to tell me when she had finished talking with Georgina for the moment.

I gave Alexandra a few moments to have this conversation, which she did silently. I then suggested to her that if she now listened, Georgina would tell her how she would help her to eat her food calmly, feeling relaxed, so that the food would slip down her throat like a snowball sliding gently down a slope. I

suggested Georgina would stroke Alexandra's throat with her magic wand to keep it smooth and relaxed, so that the food would slide down easily. Alexandra did so, and I could see her nod her head. She then said that Georgina had stopped speaking, so I repeated the above suggestions by asking if that was what Georgina had said, to reinforce them for Alexandra.

I suggested it was time to say goodbye to Georgina, but that Alexandra could talk to her in her head any time she was feeling a little nervous about something. I then asked her to say goodbye, and to tell me when Georgina had gone.

After she had done so, I brought Alexandra out of trance. She reported feeling relaxed, and a little tired. She later ate her dinner of meat, mashed potatoes, and peas without any difficulty. She chewed for an appropriate time, swallowed without difficulty, and did not spit any in the bin. Her sense of achievement at doing this reinforced the behaviour.

## TREATMENT SESSION 2

The next day, Alexandra still expressed concern regarding swallowing food and had reverted to chewing it for longer periods than was appropriate. A second hypnosis session was therefore conducted.

Alexandra asked if, this time, she could have an adventure with Georgina and if Georgina could have some friends with her.

I put Alexandra into trance, again by eye fixation with the suggestion she could shut her eyes if she wanted, which she immediately did. I asked her to tell me when she could see Georgina and to describe to me how she was looking this time. When I asked her if she had any friends with her, Alexandra said she did, and that they were two butterflies called Sally and Rose. She was able to describe their appearance in detail. To make the experience as enjoyable as possible for Alexandra, I asked her where she would like to go with Georgina, Sally, and Rose and offered some suggestions. Alexandra chose Peter Pan's island. I then asked her to feel Georgina putting wings on her back and described to her how she was flying with Georgina, Sally, and Rose, and asked her what she was able to see. She described a night-time scene and so we explored that for a few moments.

When she appeared comfortable with that, I suggested it was now daytime and she could see Peter Pan's island. She landed with her three friends, with the reassurance that Captain Hook had long since gone, so the island was a safe place to be. We then went on a journey of discovery, after which it was time to have dinner with Wendy and the Lost Boys. Images of feeling herself eating her normal evening meal comfortably, with Georgina always there to keep her safe from harm, were then integrated into the story. After a while, Alexandra felt she would like some fun food too, so this was arranged. This part of the fantasy ended the scene, and Alexandra was asked to imagine herself saying goodbye to Peter, Wendy, and the Lost Boys, and flying home with Georgina, Sally, and Rose.

When Alexandra felt she had arrived home, it was suggested to her she could feel Georgina taking off the wings, but that she could travel like that again with Georgina whenever she wanted. She was then asked to say goodbye to Georgina, knowing she would return whenever Alexandra wanted, and that Georgina would always look after her and protect her. Alexandra was then brought out of trance.

### **FOLLOW-UP**

Ten days after the second session, there have been no problems with Alexandra's eating habits. She is very proud of her ability to eat without being worried about choking.

### **CONCLUSION**

Several aspects of hypnosis are demonstrated by these sessions with Alexandra. They illustrate the high hypnotisability of young children and their ability to fantasise (Olness & Gardner, 1988). Much of Alexandra's experience in both sessions was guided by her. As is common with children (Grove, 1995), she was able to fully enter the world of fantasy. It was then a simple process to weave the target behaviour into the story line. The experience became an enjoyable one for her, as evidenced by her enthusiasm for the second session.

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## BOOK REVIEWS

**The Osiris Complex: Case-Studies in Multiple Personality Disorder.** Colin A. Ross. Toronto: University of Toronto Press. 1994. US\$60.00 + postage and handling, cloth cover.

*The Osiris Complex* consists of a short introduction followed by 26 case studies — one case per chapter. The majority of the cases described are of people with dissociative identity disorder (multiple personality disorder) that Dr Ross has either treated or been consulted about since 1985.

Dr Ross develops, or rather sketches, the major thesis of the book in a surprisingly short introduction. He says that the purpose of the book, “is not simply to present interesting stories . . . It is to help foster an understanding of the relationship between childhood trauma and serious mental illness” (p. xiii). Ross believes that a trauma model of mental illness has a high level of explanatory power and he claims that such a model will soon rise to challenge the biological and analytical models so popular at the moment in psychiatry. Unfortunately, Ross cannot seriously contend that this current work represents such a challenge. He barely scrapes the surface of presenting such a model and his promise of more to come via the case studies is not fulfilled in any fashion.

The case studies themselves are extremely well written and thoroughly engaging. Ross presents both the successes and failures of his practice with due recognition that there is something to be learned from both. Apart from his tendency to be a bit heroic in the presentation of his role in some of the cases, the stories generally do not suffer from the “gee whiz” prurience of many authors writing about MPD. The cases are very useful at highlighting the fact that MPD is not a condition primarily suffered by intelligent, middle-class, Anglo-Saxon women. They also highlight the complex and difficult nature of such cases.

But Ross fails to really do anything here except present interesting stories. There are occasional excursions into slightly controversial areas, such as his views on the links between psychic phenomena and trauma, but there is no systematic pulling together of themes that could potentially provide the basis for a trauma paradigm. Ross himself seems ignorant of the literature in psychology relevant to the development of trauma models in relation to psychological disorders (e.g., Rachman, 1978) and relies heavily on his thesis that MPD is the sine qua non of the phenomena. To be fair to Ross, it must be said that he has already made out a coherent argument for the connection between trauma and



mental illness (Ross, 1989) yet it is puzzling as to why, in *The Osiris Complex*, the argument is so lightweight.

Overall, *The Osiris Complex* is worth reading if you have an interest in the dissociative disorders. It is very clear that a dissociative model relating trauma and the development of psychological disorders will soon develop to challenge the dominant paradigms in psychiatry and clinical psychology. But *The Osiris Complex* does not advance this process and it is disappointing that the avowed intention is so obviously missed. The book feels like a work in progress and it can only be hoped that Ross puts in a bit more work before he plans to lead a revolution.

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**Plato's Psychology** (2nd ed.). T. M. Robinson. Toronto: University of Toronto Press. 1995. US\$22.95, paperback; US\$60.00, hardback.

Some books are hard to read but you persist because the topic is simply interesting or adds to knowledge you already have.

After completing my perusal I am not sure why I persevered, as at the end, I know more about my own psychology than Plato's.

What made Robinson's book difficult? Virtually everything about it. The style of writing, the construction of the text, and the subject matter itself.

Robinson is Professor of Philosophy at the University of Toronto and wrote the first edition of this volume in 1970. This second edition followed in 1995 with the addition of further "reflections" (pp. xiii-xxxii). He says in the foreword to the first edition, the aim of the book is, "to give as lucid and comprehensive an account as possible of all that Plato has to say on the nature of psyche, personal and cosmic, in each of the dialogues" (p. ix).

Psyche translates with difficulty and may be taken as meaning soul, mind or person. Robinson finally opts for "soul" as being closest to Plato's meaning that suggests an "inner person." Robinson then proceeds to use what are generally regarded as Plato's "middle dialogues" to explore "the question of cosmic, rather than individual soul" (p. xiii).

We discover that the soul is different from the body. The former concerned with the world of ideas, the latter with the world of the senses (the beginnings of the mind-body problem two millennia ago!). We learn that the soul is immortal. That it is divisible into three parts, that is, tripartite. These parts roughly corresponding to reason, emotion, and desire. Also that the soul has

cognitive faculties and so on. Not being classically educated, the numerous illustrative words quoted in Greek, and occasionally Latin, did not help my understanding, so the various other subtleties of soul are beyond my ability to summarise and list.

Overall, I think this is a specialist book for postgraduate students of philosophy. Today, it is still easy to find parallels in empirical psychology to virtually any philosophical view of the mind. But given that modern psychology probably began with the establishment of Wilhelm Wundt's laboratory at the University of Leipzig in 1879, and since the early to mid-twentieth century, psychology and philosophy have become generally recognised as distinct academic disciplines, I suspect few current students or graduates would be very comfortable with how the word "psychology" is used in Robinson's title or his text.

What then is the relevance of this book to members of ASH who might be tempted by the title? In all honesty I must say that while the topic reawakened memories of my own struggles with philosophy over 30 years ago, as a clinician in 1996, I cannot see how the book will have any practical application in my work or the work done by most ASH members. The book was interesting, but there are other works easier to read and understand (see reading list).

#### READING LIST

Gaarder, J. (1995). *Sophie's world*. London: Phoenix House.

Gregory, R. L. (Ed.). (1987). *The Oxford companion to the mind*. Oxford: Oxford University Press.

Honderich, E. (Ed.). (1995). *The Oxford companion to philosophy*. Oxford: Oxford University Press.

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**Hypnosis and the Art of Self-Therapy.** Gordon Milne. Melbourne: Lothian Books. 1994. x + 182. \$19.95.

*Hypnosis and the Art of Self-Therapy* is a self-help book for the general reader with normal concerns. It includes a series of exercises designed for self-therapy.

The author, a well-known Queensland psychologist, has divided the book into five parts, grouped in two sections. In the first section, Part I presents a brief history of hypnosis and addresses the issue of hypnotic susceptibility. Part II presents some cases where hypnotherapy is used for pain control, control of bodily functions, hypertension, and phobias. The hazards of hypnotic compliance and misuses of hypnosis, both with pertinent examples, are presented in Part III. This first section concludes with a presentation on clinical

and forensic investigatory hypnosis as used for sexual assault clients and criminal proceedings. It gives the author an opportunity to talk about repressed memory cases in which he has been involved.

Whereas the first section is educational and, therefore, optional reading for the user of the book intent on learning how to practise hypnosis for their own purposes, the second section provides basic and advanced scripts, together with instructions about making one's own tapes. These scripts cover a range of common disorders and conditions, including sports performance and sex therapy. The author concludes with words of warning about departing from the instructions given or dehypnotising oneself adequately. His scripts are his own, evolved from years of experience.

This little book is a valuable addition to the existing range of self-therapy hypnosis books. The Bibliographical Notes are good and grouped by chapter. There is a brief author and subject index.

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## 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.

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