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CLINICAL AND EXPERIMENTAL HYPNOSIS**

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EDITORIAL

Editions of the journal in recent years have published a range of theoretical, research, and clinical articles, reflecting my intention to broaden the scope and appeal of the journal, to meet the needs and interests of members of ASH and subscribers. I hope this first edition for 1997 reflects my editorial policy.

The first manuscript is an invited paper from Steven Jay Lynn, PhD, from the Psychology Department of Binghamton University, New York, U.S.A., and his associate, Judith Pintar. Dr Lynn will be a Keynote Speaker at the forthcoming ASH Annual Congress, being held in Perth, 7–12 September 1997. His invited paper presents a framework for understanding the nature of dissociative disorders, and the apparent epidemic in their occurrence in recent years, based upon a narrative model from social psychology. I am sure you will find his paper interesting. I also urge you to attend the Annual Congress, being held in Perth and take the opportunity to hear Dr Lynn in person. His curriculum vitae can be found in the first ASH Federal Newsletter published in 1997.

This edition of the journal contains the final conclusions of the Working Party established by the American Psychological Association to investigate theoretical and clinical issues related to memories of childhood abuse. The report addresses implications for clinical training and practice that are of relevance to all practitioners.

Continuing the theme of recovered memories, Peter Sheehan from the University of Queensland examines trends in research themes in the major hypnosis journals, then addresses experimental, conceptual, and clinical issues in the area of recovered memories.

The first article with a clinical theme is that reported by Burkhard Peter. He discusses the use of hypnosis in the treatment of cancer pain and relates his specific techniques in a series of case vignettes. This article is republished from *Hypnos: Swedish Journal of Hypnosis in Psychotherapy and Psychosomatic Medicine*, with permission of the Editor.

Two Australian authors have case studies included in this edition. Patricia Burgess reports the use of hypnosis in the treatment of headaches. Malcolm Desland describes the use of hypnosis in her treatment of a case of post-traumatic stress disorder following sexual abuse. The final clinical report in this edition is an article describing the use of hypnosis in obstetrics, published by Carolyn Sauer and Marc Oster from California, U.S.A.

In Case Notes, Kathryn Gow describes how indirect techniques can be integrated with NLP scripts, to maximise their effectiveness. The edition concludes with book reviews undertaken by members of the Society. I recommend the journal to you and hope it is of interest and clinical use to each reader.

Barry J. Evans
Monash University
May 1997

A SOCIAL NARRATIVE MODEL OF DISSOCIATIVE IDENTITY DISORDER

Steven Jay Lynn

Binghamton University

Judith Pintar

University of Illinois

This paper is based on a commentary on a talk that was delivered by Sherrill Mulhern at the Nato Symposium on Recollections of Childhood Trauma, Port de Bourgenay, France, 1996. Her talk presented a sociological and anthropological perspective on the history of multiple personality disorder (MPD, now dissociative identity disorder) and its treatment. In this paper, which touches on a number of themes introduced by Dr Mulhern, we advance a narrative model or framework for understanding certain aspects of serious dissociative disorders. An expanded version of this paper will be published in the forthcoming book, *Recollections of Childhood Trauma: Scientific, Research, and Clinical Practice*, Don Read and D. Stephen Lindsay (Eds.).

Our model owes a debt to a body of psychological literature (e.g., Meichenbaum & Fong, 1993; Sarbin, 1986; Spence, 1984) that can be loosely identified as narrative social psychology, which considers personal identity, not just as an attribute of an individual, but as a dynamic process constructed within social relationships through the mechanism of shared narratives. These narratives give personal identity continuity in the past and the future. When a woman becomes a mother, for instance, what determines the extent of her identification with motherhood will include her memories of her own mother, as well as cultural images and discourse about motherhood. Most importantly, others will treat her as a mother, and will expect her to act in a “motherlike” way, defined by shared narratives. In this way, identity is constructed and maintained through relationships. Motherhood is performed.

An interesting aspect of our social identities is that we can have many such roles, which can exist together without discontinuity. A woman can be a mother, a daughter, a doctor, and a wife, a complex set of roles which may wear her out, but will probably not confuse her sense of herself. A child who is sexually abused, on the other hand, finds herself in the position of having experiences which not only exist outside of shared social narratives, but which blatantly contradict them. Elsewhere (Lynn, Pintar, & Rhue, in press; Rhue, Lynn, & Pintar, 1996) we have suggested that the phenomenon of dissociated identity may be a straightforward reflection of traumatic and contradictory social conditions; in other words, if personal identity is constructed through social relations, and if those social relations are ruptured in traumatic fashion, then the construction of identity is accordingly disrupted. In this view, the dissociation itself is not a pathology, but the particular manifestation of a normal cognitive capacity under abnormal circumstances.

A narrative view of dissociation — in contrast to mechanistic conceptualisations which locate the phenomenon within an individual as a symptom of a disorder, or as a defence mechanism outliving its usefulness — locates the phenomenon in the social relations of the victim, both at the moment of the trauma, and as a continuing or recurring process. We might ask the question, if identity is constructed within social relations, what type of social relations would lead to the subjective experience of multiple or partial selves? In attempting to answer this question, it is necessary to distinguish in greater detail between dissociated multiple identities, and the multiple identities we all experience that are merely complex.

A child who lives in separate households may develop a complex sense of self that encompasses two distinct narratives: “I am a responsible big sister” in one household and “I am just a little kid” in the other. This is a multiple personal narrative, but it is occurring within a larger social narrative which may be stressful, but is not traumatic. The child has toys and clothes at Mum’s and different toys and clothes at Dad’s, and she can bring the toys from Dad’s house to Mum’s house if she wants to. But what if she is being abused at Dad’s house? There are still two personal narratives, but something is different: what Dad is doing is no longer reflected in a shared social narrative. What does the child do now? Who is she when she’s with her Dad? Not the same person she is when she is with her Mum where personal and social narratives match. She cannot bring Dad’s toys with her to Mum’s house. She may say that she “split” at that point, but the crucial thing to note is that the world split first.

The social narrative upon and through which she constructed her identity ruptured. It lost coherence and consistency. We would suggest that rather than being a way to separate from reality, dissociation may well be, under some circumstances, a way to bring identity in line with those circumstances. Trapped between a broad social narrative that says, “fathers care for their daughters and don’t hurt them” and a personal narrative based on the experience of being repeatedly raped by her father, the child’s construction of a multiple identity is

a realistic reflection of her actual social condition, and her subjective experience of having many selves which appears to be a distortion of reality, may be an accurate reflection of lived experience.

Multiplicity is perhaps the only way that both narratives can be true at the same time. She can be both a nine-year-old school girl and her father's lover. It may be true, as many have postulated, that pathology arises because she cannot "integrate" the two identities within one coherent self. But the reason the identities cannot co-exist is that the social world does not acknowledge that they might both be true. It may be accurate to suggest that the world and she are mutually dissociated from one another.

The important point to note is that what the experience of trauma disrupts is not identity itself but the social process through which identity is constructed. Correspondingly, in this view, the phenomenon of multiplicity is not so much a disorder of identity, but a disorder of identity construction. The suggestion that multiplicity is in part, or whole, iatrogenic becomes less surprising (though no less problematic) in this light. Multiple identity, like unitary identity, is performed, that is to say it is dynamically constructed through social relationships.

Therapists treating multiples share with their clients a narrative about identity that includes a belief in the existence of MPD/DID (dissociative identity disorder, the current nomenclature for what was once multiple personality disorder). They engage in discussions with alters, developing relationships with them within which the alters come alive. The therapist–client relationship may not be the only one in which the alters perform, but is often the most important one.

The meaning of whether therapists convince their clients that they are multiples varies as a function of what the client believes in advance. If the client believes "Oh, I'm not a multiple; that's just a mood that I'm in sometimes," that's one thing. It's another if the client's belief is "Oh, I'm not a multiple; Jane is a physically distinct other person, rather than another personality." In the first case, the therapist's effort can legitimately be construed as iatrogenic creation of MPD. In the second, it can be construed as countering a delusion and not at all iatrogenic, but a reflection of the subjective conviction of multiplicity.

The process in which multiple identities are constructed or maintained within the discourse of a therapeutic relationship will be even more powerful in a relationship between therapists and their highly suggestible and fantasy-prone clients. Research in our laboratory (Lynn, Rhue, & Green, 1988) has shown there are many parallels between persons with a profound history of fantasy involvements that date to early childhood. Indeed, when we look at what measures of dissociation index, one prominent component is fantasy and imaginative proclivities. Fantasy-prone persons report that they play with imaginary companions during childhood, often pretend to be other people during times of stress, report out-of-body experiences to deal with traumatic and non-traumatic experiences, and create absorbing imaginative narratives during which time stands in abeyance. In short, we might say they dissociate.

These individuals are also more suggestible, even in non-hypnotic situations, than their less fantasy-prone counterparts. To say that a client is suggestible is also to say he or she is particularly sensitive to the immediate social relationship, so that the influence of a hypnotherapist can override other pre-existing social beliefs; for instance, if the therapist suggests that a woman's arm is getting lighter and will rise on its own, that narrative suggestion replaces, at least for the moment, the shared social belief that arms do not ordinarily do that.

In ordinary conversations, many of us talk about ourselves as having different parts or as feeling as if one part of ourselves is in conflict with another part. So suggestions for one part to "come out" in the context of psychotherapy or hypnosis may, in fact, conform more closely to one's ordinary experience of oneself than the feeling of nonvolition and involuntariness that often accompanies responses to hypnotic suggestions for one's arm to rise, for example.

The majority of hypnotisable participants can easily get in touch with so-called hidden parts of the mind, or "hidden observers" that can comment on imaginative and hypnotic dreams and age regression suggestions and afterward report complete or partial amnesia for what the "hidden part" revealed during hypnosis, awake imagining, and relaxed non-hypnotic conditions (Mare, Lynn, Kvaal, Segal, & Sivec, 1994). It is not likely, however, that suggestibility or imaginative tendencies alone can explain why an individual would take on and participate in the ongoing construction of multiple identities. It may be necessary for the therapist and the relationship to provide incentives (e.g., feeling of being special, meeting important needs of the client and therapist, and so forth) for construing the self in terms of having multiple, discrete identities, a conceptualisation reinforced and legitimised by therapeutic procedures (e.g., repeated suggestions for alters to emerge during hypnosis) that give fibre and body to nascent aspects of the self.

However, another, yet by no means mutually exclusive possibility, is that the narrative of multiple identity that underlies DID may be comfortable to many survivors of traumatic abuse because it fits their subjective experience of their disrupted identities more closely than the dominant cultural narrative of ordinary unitary identity which assumes non-traumatic social conditions and relations. A woman who accepts the diagnosis of DID and engages in complex interactions through a group of altered personalities cannot be said simply to be "faking it," unless we are willing to consider our more mundane construction of unitary identity to be fake as well. The bottom line is that identity is a malleable narrative construct, exquisitely sensitive to social conditions.

In attempting to outline the ways in which social and cultural forces acted together to "create" multiple personality disorder as a category of psychological distress, Mulhern (in press) persuasively argues that the medicalisation of child abuse shifted the locus of control over the meaning of traumatic experience from the survivors of the trauma to a "corps of experts;" with the resulting shift in interest from remembered stories of abuse to repressed memories, accessed only with the help of these experts. Memories of abuse became, in short, a "mediated

discourse.” An intrinsic part of that discourse is the process of diagnosis. There is a self-recursive irony in the diagnosis of DID as an “identity disorder” since the dynamic process of diagnosis itself confers identity.

In diagnosing physical illnesses, Western medicine traditionally has maintained a distinction between sickness and wounding. There is a big difference between having arthritis in the knuckles, and having a sore thumb because you hit yourself with a hammer. The pain may be comparable, but the sickness confers identity (you have become an arthritis sufferer) in a way that the wounding does not. A patient who learns that she has cancer, for instance, becomes at that moment a “cancer patient,” a label that comes with a lot of baggage. Relationships will be negotiated, and she will have to decide to what extent she wishes to take on or reject this label as an aspect of personal identity, to identify with other cancer patients as a group. Identity after remission involves a similar process of negotiation, both internal and external, as she decides whether she wants to think about herself as a “recovered cancer patient” or just as an ordinary person again, the person she was before the cancer.

The distinction between sickness and wounding exists in the treatment of mental health problems, but it is a slippery one. In coming to speak about the consequences of psychological trauma in medical terms, the symptoms of psychological wounding become a sickness, so that a woman diagnosed as DID is not only suffering from having been abused, but from the fact that she is now “a multiple.” A psychiatric diagnosis actually confers identity in a much more powerful way than a medical diagnosis. A psychiatric patient, especially one who is diagnosed as having an identity disorder, is under an exceptionally strong compulsion to identify with the category of diagnosis since multiplicity is not something you have, like cancer; it is something you are. The existence of an authoritative diagnosis for DID creates a contested category of identity increasingly contingent on the criteria of spontaneity and non-volition, so that we now must distinguish between real multiples, those who are faking it, and those whose personalities are iatrogenic concoctions.

A patient’s identification with the diagnosis is made more likely when it is a contested status. MPD and now DID are trendy diagnoses which may, in some instances, bring more or better attention from mental health workers and insurance companies. A diagnosis of DID also provides a boost of self-esteem since multiples are supposed to be creative individuals with high IQs. Examined through the lens of multiplicity, behaviours such as self-mutilation, promiscuity and infantile regressions which in other contexts may have been viewed as repugnant or deviant, can come to be seen as understandable, and even heroic. Another factor that may have encouraged identification with the disorder was the political climate of “identity politics” during the 1980s, when it became fashionable and politically expedient to identify with membership of a group with a grievance. As survivors of sexual abuse organised, so did the subgroups who identified themselves as multiples or as survivors of satanic abuse. When one is born into a racial minority and membership is uncontested, membership

in these psychological communities requires evidence of shared suffering and identification with the community involves conscious choice.

As we implied earlier, identification with a diagnosis also results from the therapeutic relationship, a culturally constructed relationship that has both medical and what we might call ritual components. The ritual aspect of therapy is particularly explicit when hypnosis is involved. And the rhetoric of “belief” in debates about multiplicity lends the whole discussion a mythical tone: “Do we believe in false memories?”, “Do we believe in multiplicity?”, “Do we believe in the existence of satanic cults?” Diagnosis acts on these beliefs and confers a status change in identity. To be pronounced a multiple by a medical authority invokes a sanction of the spoken word, in much the same way that a priest can pronounce a couple to be married. With that kind of authoritative power a psychiatrist can “create” a multiple, at the moment of diagnosis, in the same way that the leader of a possession cult can decide whether a possession is authentic by identifying and authenticating the appearance of a particular spirit. The “diagnosis” confers upon the possessed individual a change in status within the cult. The combination of medical and religious structure and authority makes the therapeutic relationship into a powerful mechanism of socialisation.

Mulhern’s analysis of the historical, cultural and sociological mechanisms that facilitated the construction of the MPD model is a clarion call for self-reflection. For researchers, this means greater awareness of the historical biases and cultural influences that may affect the way that theoretical models are developed; for clinicians it means coming to terms with the fact that in spite of our best intentions our methods can hurt as well as heal. We think it is fair to say that the diagnosis of multiplicity — with its narrative of separation and integration, can be a useful therapeutic tool for a few patients, but that for most patients it opens a veritable Pandora’s box, and can lead to an exacerbation of symptoms, a breakdown of relationships and social networks and a tangled conflation of fantasy images with actual memories.

To believe unconditionally in clients’ recovered memories, of satanic ritual abuse, for example, can be as damaging to them as it is to write off their authentic memories as oedipal-based fantasies. It is simply bad therapy to fail to recognise the highly suggestible nature of the subsample of abuse survivors who can be identified as fantasy-prone. It is also a mistake to suggest to dissociative clients that multiplicity is a category of identity that one can be, rather than a narrative of identity that one can use. There is a world of difference between saying to a client, “The experience of trauma made you feel as if you were three people, let’s imagine what they would say to one another,” and saying “The experience of trauma made you into three people, let me talk to them.”

Multiplicity is a narrative of identity that is compelling for certain trauma survivors because it comes closer to reflecting their subjective experience of self than other shared social narratives. It becomes problematic when it ceases to be just a useful metaphor, and becomes (through the process of evaluation/

suggestion/iatrogenic procedures leading to a medical diagnosis) a category of identification. This is especially dangerous for those whose presenting symptoms have to do with disruptions in identity to begin with. It appears, in this light, that the “epidemic” of DID during the last twenty years is not the deliberate product of a conspiratorial movement of therapists to construct a chronic disorder in a highly suggestible and fantasy-prone subpopulation, but the byproduct of a compelling metaphor run wild.

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FINAL CONCLUSIONS OF THE APA WORKING GROUP ON INVESTIGATION OF MEMORIES OF CHILDHOOD ABUSE

Working Party of the American Psychological Association

The following document is the Final Report of the Working Party established by the American Psychological Association [APA] to investigate memories of childhood abuse and how these, if they exist, can be validly accessed in therapy.

The APA Working Party commenced its deliberations in 1993, to review the current scientific literature and identify future research and training needs regarding the evaluation of memories of childhood abuse. Members of the Working Party were Drs Judith Alpert, Laura Brown, Stephen Ceci, Christine Courtois, Elizabeth Loftus, and Peter Ornstein.

The Final Report of the Working Party, reproduced below, was presented to the APA Board of Directors on 14 February 1996. The preface to the report notes that the report does not offer any “solution” to the problem of adult memories of childhood abuse. It does, however, offer a clear and concrete delineation of the issues, what research we need, and the differences that must be reconciled for the science and profession of psychology to attend responsibly to the dilemmas posed by adult memories of childhood abuse.

It is clear from the Working Party’s Final Report that consensus on many issues could not be reached. At the same time, it provides a pragmatic and immediately applicable document that the Working Party hopes will contribute to a widespread questioning of the divisive discourse around this issue, to the ultimate benefit of the public the APA is committed to serve.

The Final Report is reproduced, with permission of the APA, to facilitate a similar debate among members of the Australian Society of Hypnosis.

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For a copy of the Final Report, contact Paul J. Donnelly Jr, Director, Public Interest Administration, Board Operations & Governance Communication, American Psychological Association, 750 First Street, NE, Washington DC 20002-4242 USA. Fax: 202 336 5723; Email: pzd:apa@email.apa.org

In this section (of the Final Report), we seek to set a context for the following documents by summarising our points of agreement and disagreement. We also articulate some of the implications of our deliberations for clinical practice, forensic practice, research, and training. Finally, we conclude with a plea for unity within our discipline.

WHERE DO WE STAND?

Inspection of the reviews and commentaries in the Final Report will indicate that we are in agreement concerning a number of key points. Indeed, as indicated in the Working Group's Interim Report, we agree on the following:

1. Controversies regarding adult recollections should not be allowed to obscure the fact that child sexual abuse is a complex and pervasive problem in America that has historically gone unacknowledged.
2. Most people who were sexually abused as children remember all or part of what happened to them.
3. It is possible for memories of abuse that have been forgotten for a long time to be remembered.
4. It is also possible to construct convincing pseudomemories for events that never occurred.
5. There are gaps in our knowledge about the processes that lead to accurate and inaccurate recollections of childhood abuse.

As important as these areas of agreement are, it is equally, if not more important, to acknowledge frankly that we differ markedly on a wide range of issues. At the core, the clinical and research subgroups have fundamentally differing views of the nature of memory. These contrasting conceptions of memory have led to debate concerning: (a) the constructive nature of memory and the accuracy with which any events can be remembered over extended delays; (b) the tentative mechanisms that may underlie delayed remembering; (c) the presumed "special" status of memories of traumatic events; (d) the relevance of the basic memory and developmental literatures for understanding the recall of stressful events; (e) the rules of evidence by which we can test hypotheses about the consequences of trauma and the nature of remembering, (f) the frequency with which pseudomemories may be created by suggestion, both within and outside of therapy; and (g) the ease with which, in the absence of external corroborative evidence, "real" and pseudomemories may be distinguished.

WHERE DO WE GO?

Given this characterisation of our understanding of the critical issues, how do we proceed from here? And what are the implications of these documents for research, practice, training, and forensic psychology? As suggested above, one of the most consistent observations emerging from our deliberations has to do

with the very divergent epistemologies and definitions utilised by psychologists who study memory and those who study and treat the effects of trauma. Although there are exceptions, we frequently do not speak the same professional language or define phenomena in the same manner; we read different journals and books, and attend different specialty meetings; and each group finds useful and compelling studies that the other group sees as problematic and questionable.

Many of the difficulties that we have encountered in attempting to achieve consensus reflect these profound epistemological differences, a phenomenon which has been previously documented in studies comparing psychological scientists and psychological practitioners (Caddy, 1981; Dawes, 1994; Kalinkowitz, 1978). If we are to go forward toward the development of productive research that will be found to be credible by both scientists and practitioners, and toward the promotion of clinical practice that is psychological science, some steps must be taken to resolve these epistemological differences and develop consensual definitions about what is being studied and discussed.

To begin, it is essential to address fundamental differences between the two subgroups in terms of basic definitions of the issues under investigation. Thus, for example, it is necessary to consider the two groups' contrasting views of the nature of early trauma and the young child's representation of various types of sexual abuse. Accordingly, one important implication of our deliberations is that psychologists who work in the field of trauma and those who study memory would benefit from working collaboratively to (a) develop paradigms for research, (b) search for consensual definitions of constructs that speak to the issue of how trauma affects memory, and (c) develop models that will be scientifically sound while being well-grounded in the realities of clinical practice. No matter how well designed, a study that equates stressful experiences that are socially sanctioned with those involving pain, betrayal, and loss of safety will be found less credible by those who treat the survivors of the latter, just as texts on treatment, no matter how therapeutically useful they may seem based on the author's anecdotal observations, will lack credibility to scientists when what is clinically suggested violates the data available through research.

Some studies of therapists (Poole, Lindsay, Memon, & Bull, 1995; Yapko, 1994) have criticised practitioners for their lack of knowledge of the workings of memory and their willingness to endorse techniques that might implant suggestions. An alternative view of this state of affairs might be that, based on their experience, which is a powerful source of data for practising clinicians, many therapists have developed beliefs about techniques that they feel are clinically effective in reducing the distress of trauma survivors. Future research is needed to evaluate the validity of these beliefs and to better inform both practitioners and researchers as to the characterisation of "useful" as opposed to "risky" approaches to interventions.

The epistemological foundation from which one evaluates clinical outcomes or research findings affects the meaning given to those outcomes/findings.

Because the entire Working Group converges on the belief that a science-informed practice will be the most effective strategy for treatment, we believe that practice-informed research will enhance the integration of knowledge about memory into the overall field of trauma treatment. This direction in research may also help us to answer the still unclear questions about the nature of various observed human behaviours in response to trauma.

IMPLICATIONS FOR PRACTICE

The deliberations of the Working Group strongly underscore the importance of a careful and science-based preparation for professional practice in psychology. Many possible errors in working with adult survivors, or with clients who present as recovering memories of childhood abuse, could be avoided if the therapist were well-grounded in developmental psychology (particularly developmental psychopathology and cognitive development), cognitive psychology (especially the study of memory), and research on trauma (with an emphasis on the range of responses to interpersonal violence). Both the scientist–practitioner (PhD) and scholar–practitioner (PsyD) models of training embrace this necessity. Given the very high rates of histories of some kinds of interpersonal violence among the patient population (Jacobson & Richardson, 1987), all doctoral level training programmes in professional psychology, including those whose primary focus is the training of clinical researchers, should ensure that students are exposed to formal coursework and supervised practica in which the role of interpersonal violence as a risk factor for psychopathology is central. Currently practising psychologists, if lacking in these knowledge bases, should be encouraged to pursue formal continuing professional education on these topics. Care should be taken to ensure that instructors (and course curricula) reflect a science knowledge base as well as high-quality clinical practice.

A second important implication of our findings for clinical practice is that care, caution, and consistency should be utilised in working with any client, and particularly one who experiences what is believed (by either client or therapist) to be a recovered memory of trauma. Moreover, clients in all circumstances must be given information about possible treatment strategies and should in turn provide informed consent for treatment. As with any intervention, clients have the right to know both risks and benefits of procedures used by a therapist. Careful histories should be taken from all clients, and questions about the entire range of risk factors, including but not limited to a history of sexual abuse, must be asked of all new clients, not only those whose symptoms arouse suspicions of abuse in a clinician. This is because such suspicion may be unfounded, while genuine experiences of interpersonal violence may never be volunteered by clients with such histories whose symptoms do not conform to a clinician's beliefs about the sequelae of abuse. Questions should be phrased in a non-

leading manner, and in the most open-ended way possible, in order to promote a more behaviourally descriptive and less affectively laden introduction of this difficult topic into the history-taking process.

When clients report what they phenomenologically experience as memories of previously unrecalled trauma, therapists should take a number of steps to avoid imposing a particular version of reality on these experiences and to reduce risks of the creation of pseudomemories. If these materials are intrusive and create problems for the client's functioning, the first goal of treatment should be stabilisation and containment following the recommendations of many experts in the field of trauma treatment. It is important to remember that the goal of therapy is not archaeology; recollection of trauma is only helpful insofar as it is integrated into a therapy emphasising improvement of functioning. Therapists should avoid endorsing such retrievals as either clearly truthful or clearly confabulated. Instead, the focus should be on aiding the client in developing his or her own sense of what is real and truthful. Clients can be encouraged to search for information that would add to their ability to find themselves credible (e.g., contemporaneous writings, reports of third parties), and to carefully weigh the evidence. Therapists should carefully consider all alternative hypotheses, including: (a) that the retrieved material is a reasonably accurate memory of real events; (b) that it is a distorted memory of real events, with distortions due to developmental factors or source contaminations; (c) that it is a confabulation emerging from underlying psychopathology or difficulties with reality testing; (d) that it is a pseudomemory emerging from exposure to suggestions; or (e) that it is a form of self-suggestion emerging from the client's internal suggestive mechanisms.

Clients who seek hypnosis as a means of retrieving or confirming their recollections should be advised that it is not an appropriate procedure for this goal because of the serious risk that pseudomemories may be created in trance states and of the related risk due to increased confidence in those memories. Clients should also be informed that the use of hypnosis could jeopardise any future legal actions they might wish to take. Moreover, in those situations in which hypnosis is employed, it is necessary to interpret the client's responses in light of parallel measures of suggestibility and proneness to fantasy.

As indicated above, it can be helpful to seek corroborative evidence for claims of sexual abuse. Nonetheless, denials by alleged perpetrators should also not be taken as evidence that the client is experiencing other than an accurate recollection. Indeed, known perpetrators of child sexual abuse can also deny and lie about their behaviours, even in the presence of physical evidence that incontrovertibly links them to the abuse, and sometimes tell their victims that the abuse "never happened" or should be forgotten. Finally, while there are no statistics available on its prevalence, it is known that on occasion, adults who report recovering memories will lie, particularly when the constellation of motives (fear, embarrassment, desire to protect loved ones, desire for revenge) outweighs the incentives to tell the truth.

In some states, persons who have recovered memories of childhood sexual abuse are eligible for crime victims' compensation if they report the alleged abuse to the police in a timely fashion. They are then treated as any other victims/witnesses of a crime. When resources for treatment are in short supply, this course may be attractive to both client and therapist as a means of ensuring payment for therapy. However, both parties need to be especially cautious in making assertions to legal authorities as to the factual basis of recent recollections. Such actions may prematurely commit both therapist and client to a particular interpretation of the information reported by the client, and may commit a client in some instances to testifying in a resulting criminal case, should the report fall within statutory limits. Thus, therapists should explore a variety of other alternatives with the client before embarking on this particular course.

In short, a responsible path for therapists to pursue is one in which clients are empowered to be the authority about their own lives and reality, where the emphasis is on recovery and function, and where memories of trauma are viewed within the context of what one might tentatively assume to be a post-traumatic response. This approach, however, may mean that clients occasionally reach conclusions about what may have happened to them that we find difficult to accept. Nonetheless, respect for the dignity of adults who seek treatment must inevitably temper therapists' efforts at reality testing. Therapists need to eschew the roles of advocate, detective, or ultimate arbiter of reality, unless the veracity of the material being constructed/retrieved becomes important for either therapeutic or legal reasons.

IMPLICATIONS FOR FORENSIC PRACTITIONERS

The role of the forensic psychologist is that of an educator to the triers of fact, the judge and jury. In that capacity, forensic psychologists, in general, should avoid attempting to speak to the ultimate issue (i.e., guilt or innocence) in a case, because they usually are not in a position to know the truth. Forensic psychologists should always exercise caution, temper the degree of certainty with which they offer their testimony, and be aware of both the problems and the strengths of their methodologies. How, then can forensic experts practise responsibly in cases where questions of recovered memories of childhood abuse are involved?

First, whenever possible, therapists should avoid serving as expert forensic witnesses in the cases involving clients whom they are treating. This is consistent with APA ethical standards and with guidelines published by the Division 41 of APA (Psychology and Law — AP/LS) for forensic practice. Experts, moreover, should confine their testimony to their specific areas of expertise and knowledge. For example, questions of the appropriate standard of care would ordinarily be the purview of those trained in the fields of professional psychology; this might be distinguished from expert testimony about risks of a specific therapeutic

technique when the technique or practice being considered is one in which scientists' findings could be applicable (e.g., the risks of using hypnosis to bolster a memory). When evaluating a person who alleges having recalled memories of childhood abuse, forensic experts should utilise all possible sources of information, and not rely solely upon the self-report of either plaintiff or defendant. Possible sources of suggestion and contamination should be explored rigorously. Because there is no one syndrome or symptom pattern associated with a history of childhood sexual abuse, care should be utilised in making inferences from the symptoms to the credibility of a plaintiff's report.

In cases involving complaints against therapists who are alleged to have created pseudomemories of sexual abuse, similar care should be taken by forensic psychologists to rely on a variety of sources of information and to search for the convergent validity of data. Reports by clients of what has occurred in therapy may or may not be accurate; reports by therapists about what transpired in therapy may or may not be accurate; and reports by third parties who were not present at the treatment may or may not be accurate. When feasible, expert clinical opinions should be based upon direct or videotaped observation, and not simply reviews of written or audiotaped materials.

IMPLICATIONS FOR RESEARCH AND TRAINING

Just as the Working Group has endorsed the value of a scientifically informed approach to practice, its members also endorse the value of a practice-informed approach to research. There is much to be gained by both researchers and practitioners when their respective insights cross-fertilise each other's professional activities.

For researchers, this means incorporating into their designs as many of the ingredients of real-world trauma as is ethically and practically permissible, and learning from clinicians about those phenomena that require further study. In this regard, in recent years there has developed a large body of naturalistic empirical research that stands at the interface between the domains of memory and trauma. Examples include Wagenaar and Groeneweg's (1990) study of Dutch concentration camp survivors' memories of victimisation; Parker, Bahrack, Lundy, Fivush, and Levitt's (1995) study of child survivors of Hurricane Andrew; both Merritt, Ornstein, and Spicker's (1994) and Goodman, Quas, Batterman-Faunce, Riddlesberger, and Kuhn's (1994) explorations of children's bladder catheterisation; and Eisen, Goodman, and Qin's (1995) study of the susceptibility of sexually abused children to sexual suggestions. More recently there have also been studies of the neurobiological substrates of memory for traumatic events (Bremer, Randall, Scott, Bronen, Seibyl, et al., 1995; Yehuda, Kahana, Binder-Byrnes, Southwick, Mason, et al., 1995). Nonetheless, there is a clear need for more of this sort of research, particularly as it applies to the phenomenon of repetitive boundary violations within the family setting, in which a number of complex person-situation variables are at play.

For practice-oriented students, cross-fertilisation means that training faculty needs to ensure that they are well grounded not only in the substance of scientific psychology but also in its core values (e.g., the pursuit of “proof by disproof” as the strongest means of knowing). For research-oriented students, this means some degree of orientation to the limitations of generalisability of research findings to clinical applications, and a familiarity with clinically observed phenomena that require further study. In an ideal world, all graduate trainees, whether in practice or scientific research, would be exposed to each other’s ideas, readings, and experiences, and would thus acquire a common vocabulary and shared knowledge base.

Too often, members of each group develop in what amounts to a culture of isolation from the other group’s knowledge and experiences. To some extent, this is the unhappy consequence of increased specialisation and the need for increasingly prolonged and focused apprenticeships to acquire the tools of each of these psychological trades. Presently, the sheer amount of domain-specific knowledge that must be learned to be considered competent in science or practice is enormous, and enjoinders to learn even more may seem unrealistic in view of the real limits of time and resources. Fortunately, there are ways of solving this dilemma that can expose each group to phenomena without requiring additional curricula, but merely a reorganisation of what is already in place in many programmes. What we have in mind is the use of critical case studies in training that bridge both groups’ interests.

As an example, the issue before us — the recovered-memory debate — is a window through which the generic chasm can be bridged. Both clinical and research trainees can be exposed to the type of argument and data contained in this Working Group Report as a means of not only acquainting them with the specifics of this particular debate, but far more importantly of inculcating a sense that the world is full of phenomena that require a consideration of both groups’ perspectives. Clinical students, as well as those studying both cognitive and developmental psychology, would benefit from a consideration of the issues that have animated this debate, and it could be couched in the context of existing coursework.

This case study approach, moreover, can also serve to teach valuable lessons about professional behaviours that are and are not consistent with standards of good practice or good science. From our perspective, there are signs everywhere of psychologists making public pronouncements on matters of importance, based on anecdotes and impressions rather than on systematic empirical evidence, challenged by alternative explanations. When researchers and clinicians espouse views in public, including courtrooms, they have the highest responsibility to make clear to their audiences the limits to generalisation of their conclusions, all known threats to the external validity of their information-gathering procedures and/or clinical interpretations, and the results of attempts to test alternative explanations. These professional behaviours can be illustrated readily in the context of this and other important debates.

A FINAL STATEMENT

We wish to end on a note with which we can all agree. The members of the Working Group, individually and collectively, bemoan the increasing “Balkanisation” of psychology, a development that has surely made our tasks more difficult as we have attempted to bridge across powerful gaps of understanding. Our discipline has spawned many psychologies, often disconnected from each other, and both the cortical and ethical glues that ought to have connected them seem to have been neglected. We are fast becoming a collection of psychologies, each uninformed by the data and epistemologies of the others; in short, we are pluribus, but not unum. And, most critically, we need to change dramatically if psychology as a discipline seeks to lead the way in avoiding harm to all those who are affected by the consequences of both accurate and false recollections of abuse.

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RECOVERED MEMORIES: SOME CLINICAL AND EXPERIMENTAL CHALLENGES

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This article examines memory distortion in hypnosis and imbeds its significance and that of the relevant field (forensic hypnosis) into the context of international comparative data that have been collected from an analysis of the hypnotic literature in the last decade. One issue, in particular, stands out from this analysis — recovered memories. This finding emphasises the growing importance of the need to reconcile clinical concerns and experimental findings from the laboratory setting. The recovered memory debate has profound theoretical, empirical and professional importance and shows up the tensions in the clinical–laboratory interface. Preliminary data are discussed which attempt an analysis of the phenomenon in a relatively neutral fashion so to provide limited base-rate data to facilitate that interface.

This article attempts first to place its concerns within a brief review of contemporary trends in hypnosis research. I choose to define the term “contemporary” in terms of major themes in research occurring since the 1985 review of the field of hypnosis by John Kihlstrom in the *Annual Review of Psychology*. Then I shall move to the issue of recovered memories, pointing out some of the major experimental, conceptual, and clinical challenges.

In introducing my topic in this way, I want to comment comparatively on research in hypnosis viewed internationally over the last decade. I will talk to the nature of hypnosis and memory, then focus on recovered memories in particular, to present some suggestive and controversial data.

COMPARATIVE ANALYSIS OF THE FIELD SINCE 1985¹

From Kihlstrom’s review (which covers publications up to 1983), one acquires a significant understanding of some of the shifts which occur in fields of interest

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and controversy over time. The original review (Kihlstrom, 1985) was divided into many sections.

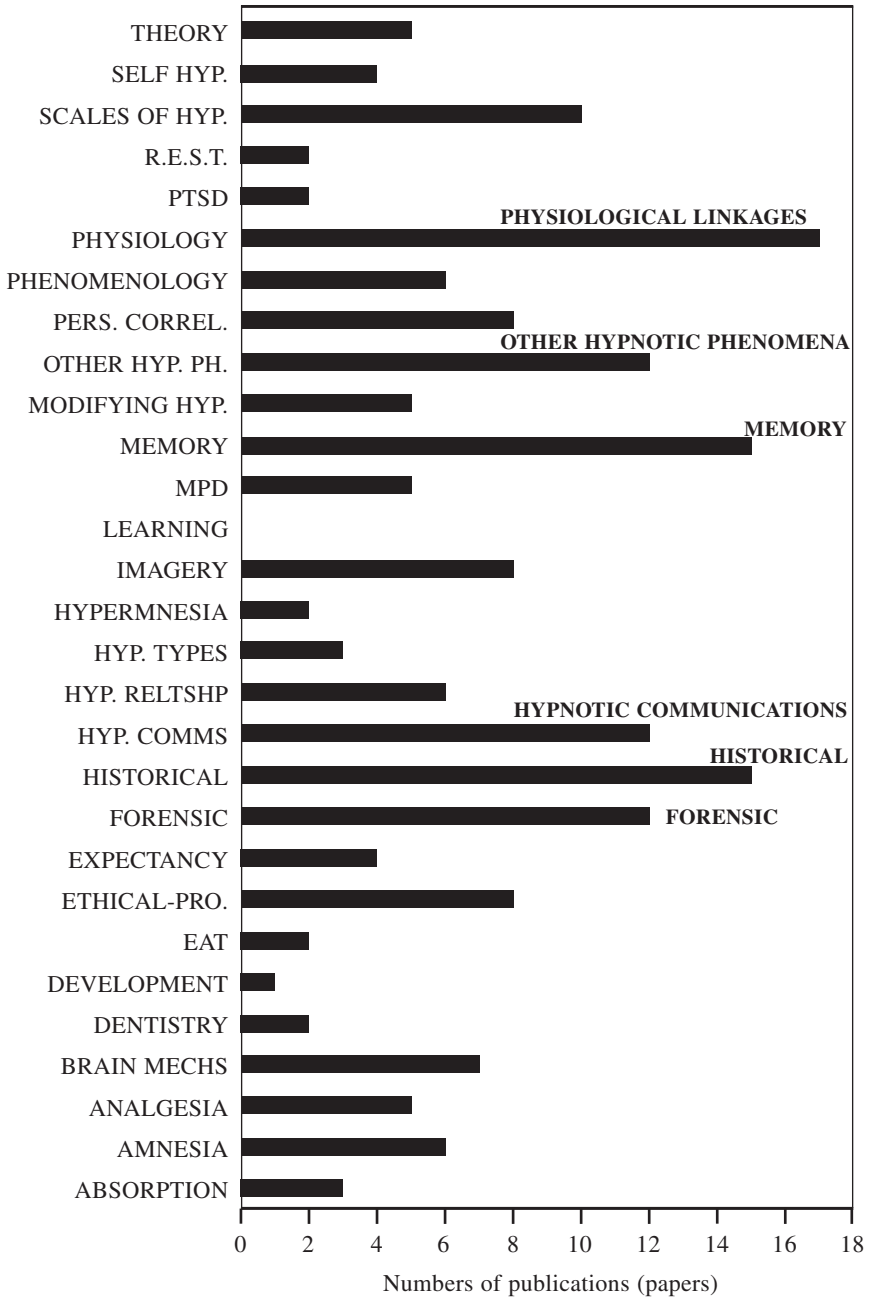
Table 1 gives the major content areas in hypnosis journals for the period 1986–1995. The journals analysed are: the *American Journal of Clinical Hypnosis*, the *Australian Journal of Clinical and Experimental Hypnosis*, the *International Journal of Clinical and Experimental Hypnosis (IJCEH)*, and *Contemporary Hypnosis* (previously known as the *British Journal of Experimental and Clinical Hypnosis*). An overwhelming number of publications classified under health and mental health treatment have been excluded. The classification shown in Table 1 is quite similar to the content area covered in Kihlstrom's review; only 11 of the categories are actually distinct. Figure 1 shows the distribution of content areas in the *IJCEH* (the most international of the journals). The modal themes illustrated in this figure are physiological linkages

Table 1 Content Categories Drawn From the Literature in the Last Decade

1	Absorption
2	Amnesia
3	Analgesia
4	Brain mechanisms*
5	Development of hypnotisability
6	Ethical/professional issues*
7	Expectancy effects*
8	Forensic issues*
9	Historical aspects
10	Hypnotic communications*
11	Hypnotic relationship*
12	Hypnotic types
13	Hypermnesia
14	Imagery
15	Immune functioning*
16	MPD
17	Memory
18	Modifying hypnotisability*
19	Other hypnotic phenomena
20	Personality correlates
21	Phenomenology/EAT*
22	Physiological links*
23	PTSD
24	Scales of hypnotisability
25	Self-hypnosis
26	Sports hypnosis*
27	Statistics/psychometrics

* Rapidly expanding/new categories in the decade since Kihlstrom's review article,

Figure 1: Analysis of Contents of *International Journal of Clinical & Experimental Hypnosis* 1986–1995



(17 articles); historical aspects and memory (15 in each category); and hypnotic communications, other hypnotic phenomena and forensic issues (12 in each category).

Table 2 takes the Psych LIT Classification Scheme and applies it to the field of hypnosis. Immediately it is obvious how much research in hypnosis really interrelates with major domains in the study of psychology as a whole. Figure 2 shows the content of our own journal and Figure 3 contrasts the number of articles in *IJCEH* and *AJCEH*. Finally, Figure 4 shows the numbers of publications for Australia as a percentage of the world.

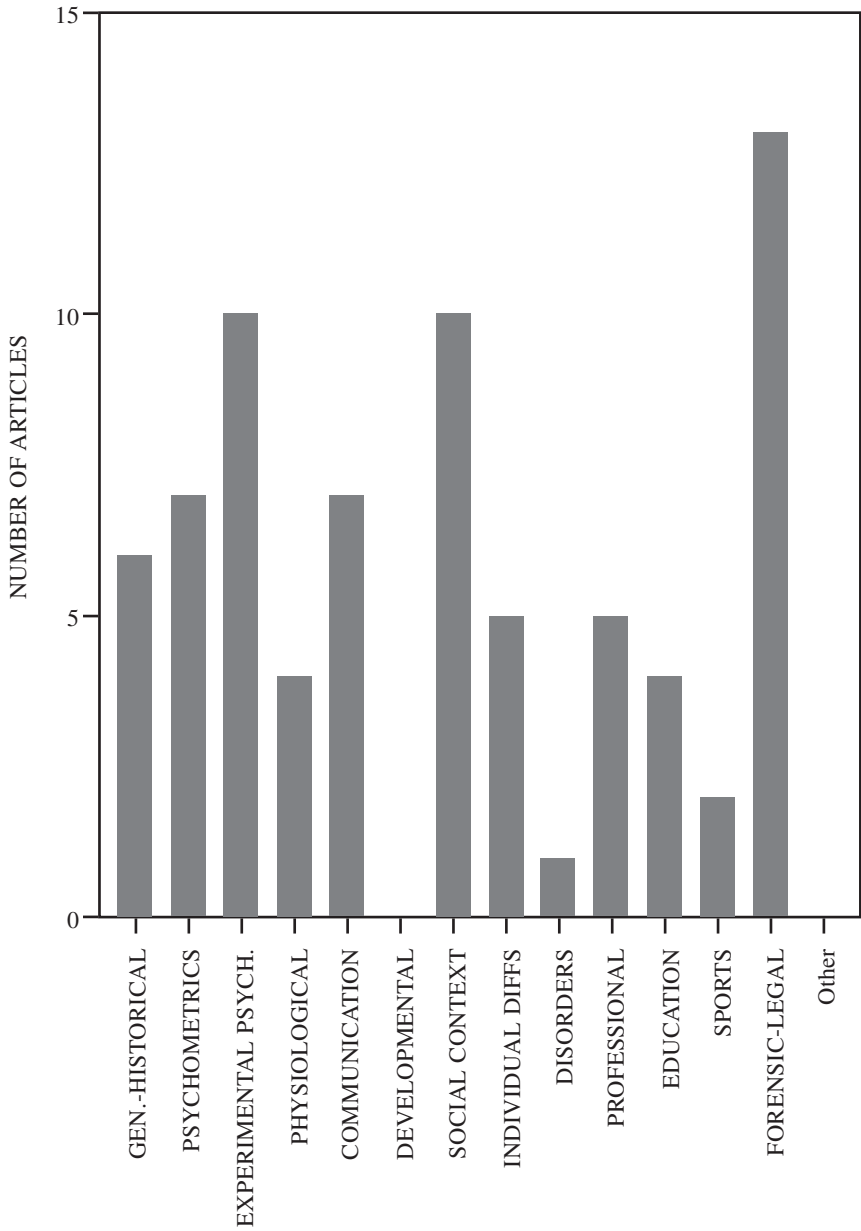
I have analysed the literature in three of our major journals. There are differences in the reporting patterns of journals and some obvious arbitrariness

Table 2 The Psych LIT Classification Scheme* as Applied to the Major Areas of Hypnosis Literature

21	General Psychology Historical aspects and debate on underlying nature of hypnosis
22	Psychometrics, Statistics, Methodology Scales of hypnotisability, absorption, imagery; experimental methods
23	Human Experimental Psychology Experimental work on hypnotic phenomena: analgesia, memory effects, perceptual distortions
25	Physiological Psychology, Neuroscience Brain processes — EEG rhythms and diurnal rhythms
26	Communication Systems Hypnotic communications; induction types
28	Developmental Psychology Development of “high” hypnotisability; ageing and hypnotisability
29	Social Processes, Social Issues The hypnotic relationship
30	Social Psychology Beliefs, attitudes and expectancy effects; experimental demand effects
31	Personality Psychology Individual differences in hypnotisability; hypnotisability correlates
32	Psychological/Physical Disorders Mental/physical disorders and hypnosis
33	Health/Mental Health Treatment and Prevention Medical, dental hypnosis; hypnotherapy; hypnotic interventions
34	Professional Psychology/Health Personnel Issues Professional and ethical issues in use of hypnosis by professionals
35	Educational Psychology Modifications of hypnotisability; learning enhancement
37	Sport Psychology and Leisure Hypnosis in sport
42	Forensic Psychology and Legal Issues Forensic hypnosis, hypnosis and the law

* Numbered and in bold

Figure 2: Contents of *AJCEH* 1986–1995



Categories based on Psych LIT classification scheme

Figure 3: Comparison of Contents of *AJCEH* and *IJCEH* 1986–1995

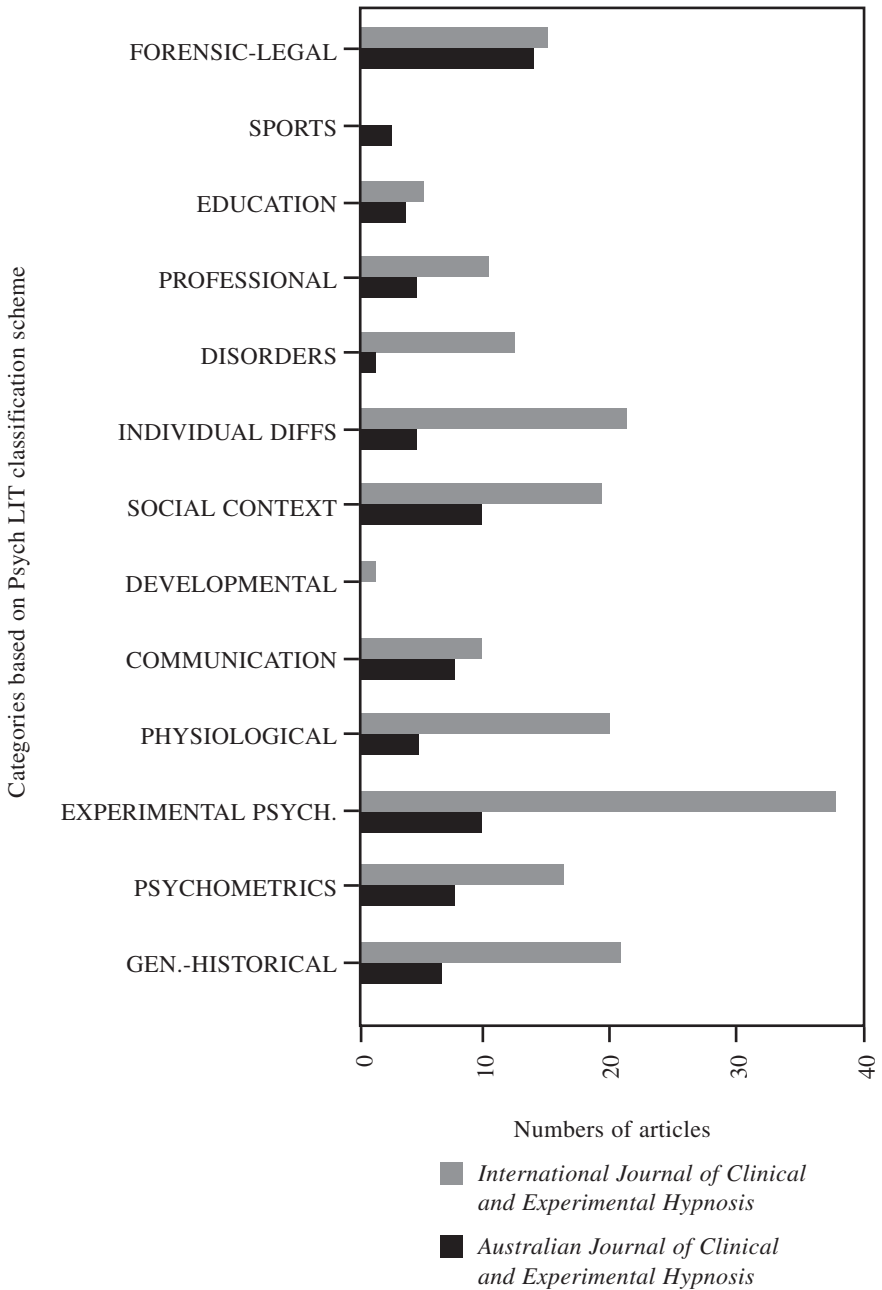
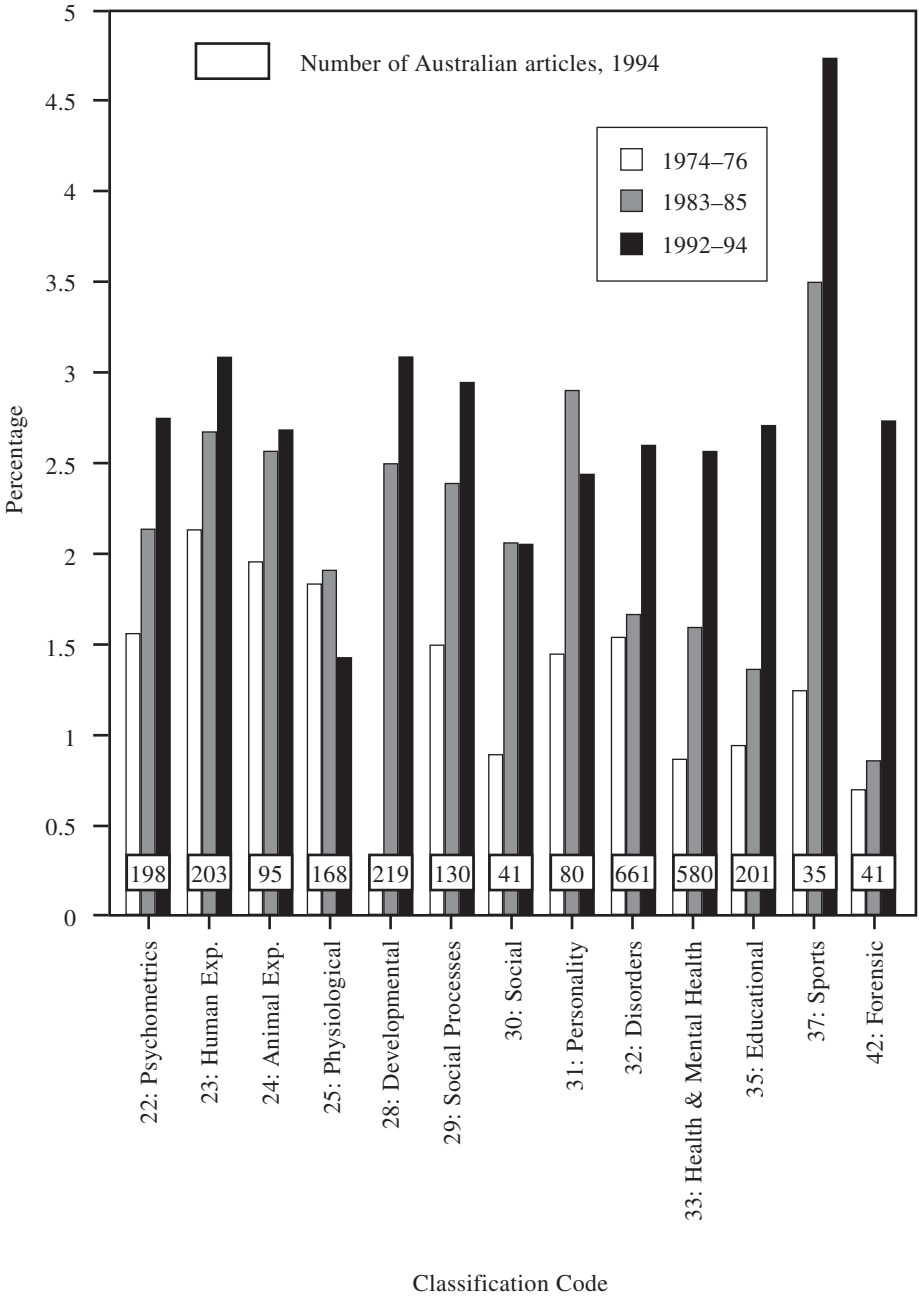


Figure 4: Numbers of Publications: Australia as a Percentage of World



on my part in the choice of classification categories, but certain major themes nevertheless emerge from the data which present an overview to my later observations.

The major trends in research hypnosis from this analysis are: the history and nature of hypnosis, individual differences in responsivity, experiments on hypnotic phenomena, social influences on hypnosis, and forensic issues and legal concerns (which are related to the theme I will elaborate). Table 3 lists in summary form those emerging issues as important in the comparison of the 1985 review with the content analysis conducted of the three main hypnosis journals. Issues 2, 4 and 5 are the most relevant ones to recovered memories. Comparison of the data on hypnosis with trends reflected in the number of psychology publications in the world (see Figure 4) show that hypnosis is idiosyncratic with its continuing emphasis on its history and debate about the underlying nature of the construct of hypnosis, issues concerning individual differences in susceptibility, and forensic hypnosis. It is largely the field of forensic hypnosis that incorporates the significance of recovered memories.

Given the importance, comparatively speaking, of these forensic issues and the practical implications of memory data, I want to focus first on memory as a contemporary issue of major significance.

MEMORY AS A CONTEMPORARY ISSUE

In the past, work in hypnosis has highlighted errors in memory that clearly depend upon a combination of social psychological variables, such as beliefs, attitudes, sets/expectations, and person-attributes (like imagery, imagination,

Table 3 Issues Arising From the Comparison of Kihlstrom's 1985 Review with the Content of 3 Main Hypnosis Journals (1986-1995)

1	The rise in the use of phenomenological data
2	The increased acceptance of the importance of social and contextual influences in the production of hypnotic responses
3	The inclusion of consciousness and self-consciousness as legitimate topics for study amongst "mainstream" experimental psychologists
4	The rise in the use of hypnosis and corresponding professional and ethical dilemmas in all applied (legal, medical and clinical) areas
5	The increase in numbers of professional and legal guidelines for the use of hypnosis
6	New areas of application of hypnosis in the sports and health fields
7	The emergence of cross-disciplinary studies on topics in hypnosis — in particular, attention, memory, and analgesia
8	The increasing numbers of experimental studies linking physiological systems functioning and hypnosis
9	Continuing controversy over the validity of the concept of susceptibility, and the nature of the hypnotic response.

absorption, automaticity, and dissociative ability). Posthypnotic amnesia, for example, appears to be not just a matter of subjects' abilities (Perry, 1992, p. 247). Amnesia has been referred to as "highly responsive to suggestions, enhancement and cancellation" (Hilgard, 1987, pp. 252–253). The specific thrust of recent research has, however, clearly focused upon particular hypnotically influenced memories, and their status in the legal setting.

Hypnotically Influenced Memories

The phenomenon of hypnotic hypermnesia, or enhanced memory accessibility under hypnosis, is of special interest both clinically and forensically. It has been investigated in the laboratory setting with inconsistent results. Research has attempted to unravel the effects of different variables, such as the type of material remembered and the process of recall. Using methodologies which eliminated reported hypermnesic effects of repeated recall, and "response bias" of highly susceptible subjects (Whitehouse, Dinges, E. Orne, & M. Orne, 1988), investigators such as Dinges, Whitehouse, Orne, Powell, Orne, et al. (1992), and Erdelyi (1994) have concluded that hypnosis *per se* does not improve memory for recent events.

It has been demonstrated, however, that whole memories (pseudomemories) can be implanted into a person's real-life autobiographically and even non-experienced events can occupy the minds of the young (Loftus, 1993). It is intriguing that one important feature of successful "implantations" is the type of relationship between the subject in the experiment and the source of the pseudomemory. One might conjecture that these special relationships of trust between person and source of the pseudomemory are also significantly involved in cases of false criminal confessions (Ofshe, 1992), the so-called "false-memory syndrome" and some cases of Multiple Personality Disorder. Belief in the authenticity of the information received may be a critical factor in the creation of the pseudomemory, supplementary to the suggestibility of the recipient of the information, or it may be inextricably involved in the phenomenon of suggestibility itself.

The repeated recall of inaccurate memories or pseudomemories does appear to increase a person's confidence in the accuracy of the memory. This fact has been borne out in the literature repeatedly, and has been shown to be the case even in subjects of low hypnotisability (Dinges et al., 1992; Pettinati, 1988).

Research evidence tends to suggest, therefore, that not only false, but actual memories can be distorted under hypnosis. It also implicates the major influence of social-contextual factors in the shaping of pseudomemories. However, hypnotisability, rather than other factors, seems to be the most probable indicator of whether a pseudomemory will be accepted (Labelle, Laurence, Nadon, & Perry, 1990; McConkey, 1992; Weekes, Lynn, Green, & Brentar, 1992).

Some combination of the greater hypnotisability of some people with other factors appears responsible for facilitating the production of pseudomemories.

Table 4 Major Inferences from Experimental Data Drawn on the Association between Memory and Hypnosis

1	No reliable memory enhancement effects occur either within single paradigms or across them.
2	Memory distortion effects are not unique to hypnosis.
3	A number of variables exist (adhering to context) that are influential in determining effects.
4	Patterns of effects depend on the means by which false information is communicated in the test situation.
5	Hypnotic skill is especially influential across different methodologies.
6	Confidence, in particular, is influential across paradigms with distorted memories frequently being reported confidently.

Note: Adapted from Sheehan (1994).

The literature warns that the variables involved in pseudomemory creation are complex, involving some combination of what is measured by inventories assessing “absorption,” those assessing some preference for imagining, and some interaction between the two (Labelle et al., 1990) as well as other contextual factors in relation to pseudomemory suggestion itself (Sheehan, Statham, & Jamieson, 1991). Table 4 sets out what I consider are the major inferences from the experimental data.

Let me turn now to explain my view of the nature of memory, and of hypnosis, before commenting more specifically on recovered memories.

THE NATURE OF HYPNOSIS AND MEMORY

The Nature of Hypnosis

The nature of hypnosis has been much debated in the literature (Kihlstrom, 1985; Lynn & Rhue, 1991; Orne, 1959). Nevertheless, there seems reasonable consensus about some of its defining properties. Although distortions typically occur, hypnosis can be said to occur when one person (the subject) experiences alterations in perception, memory, or mood in response to suggestions given by another person (the hypnotist). Although distortions can and do occur, hypnosis is essentially an experiential phenomenon wherein the hypnotist typically guides the subject to create a favourable situation for the display of his or her special capacities and skills. Substantial reliance has to be placed therefore on the subject’s self-report as to the nature of the experience.

Typically, however, susceptible subjects use their own capacities to respond appropriately (though at times constructively) to what the hypnotist is suggesting even though the content of these suggestions is false. This is not a view that is compatible with hypnosis recovering traces of original perception, and sits most comfortably with the perspective that memories retrieved in hypnosis are

products of hypnotised subjects' imaginative capacities at work. It does not say, however, that hypnosis is inherently distorting.

The Nature of Memory

Memory is equally a complex process. Suffice to say that it is a labile phenomenon with inherent plasticity that is clearly acknowledged in the literature (e.g., Annonn, 1988). It is influenced strongly by pre-existing representations (Echabe & Rovira, 1989), but post-event misinformation is also effective and known to lead to distortion of memory in both adults and children (e.g., Ceci, Ross & Toglia, 1987). The fact that memory is far from being reproductive is captured most aptly by Kihlstrom (1994) in his quote, "memory is not so much like reading a book as it is like writing one from fragmentary notes" (p. 341).

Recovered Memories

One of the key contemporary questions or issues in relation to memory and hypnosis is that of recovered memories. It is especially relevant in that it illustrates the complexity of the many factors affecting the association between memory and hypnosis.

It is a special category of hypnotically influenced memories and represents memories of events that may or may not have occurred and that are typically distant in time. McConkey (1995) and others (e.g., Ofshe, 1992) have commented on the explosion in literature on this controversial matter which has become a minefield of emotional issues. Let me attempt to summarily review that minefield. Table 5 sets out what we know in relation to recovered memories.

Table 5 Recovered Memory: What do we Know?

1	We know that child abuse and sexual trauma happen too frequently <i>no matter what</i> the frequency is.
2	We know that traumatic memories are formed in some ways that are different from normal memories.
3	We know that dissociation is a capacity that can be used defensively, giving rise to amnesia which may lift at a later time.
4	We know that memory can be highly reliable, we know that memory can be highly unreliable, and we know that memory can be influenced by a variety of factors, including suggestion and misinformation.
5	We know that people can be influenced by others even to the extreme. We know that misinformation provided by credible authorities with no apparent motive to deceive can be absorbed and responded to as though it were true.

Note: Adapted from Yapko (in press).

Evidence on recovered memories The concept of memory as a constructive and reconstructive process has important theoretical implications for the phenomenon of recovered memory which are canvassed well by Bowers and Farvolden (1996). What is remembered about an event is shaped by what was observed of that event, by conditions prevailing during attempts to remember, and by events occurring between the observation and the attempted remembering. It is essential therefore to recognise that memories can be altered, deleted, and created by events that occur during and after the time of encoding, during the period of storage, and during attempts at retrieval.

Repression and dissociation are key processes for some theories about the phenomenon. Importantly, however, they are also relevant to particular approaches to therapy. According to these processes, memories of traumatic events may be blocked out unconsciously and this leads to a person having no memory of those events. However, memories of traumatic events may become accessible at some later time. It is important to recognise that the scientific evidence does not allow precise statements to be made about a definite relationship between trauma and memory (McConkey & Sheehan, 1995), and the link between incidence of trauma and whether repression or dissociation is the key concept to use is not at all clear (see Bowers & Farvolden, 1996). Furthermore, the evidence tells us that memories reported spontaneously or following the use of special procedures in therapy may be accurate, inaccurate, fabricated, or a mixture of these. Belief can often be strong but it is not the yardstick of veracity; and the level of detail is not diagnostic of the truth of the recollections.

We know that sexual and/or physical abuse against children and adults is destructive of mental health, self-esteem, and personal relationships. It is also a fact that reports of abuse long after the events have occurred are difficult to prove or disprove in the majority of cases. Independent corroboration is for the most part impossible.

Looking summarily at the evidence, it is increasingly the case that individuals are entering therapy with no specific recollection of incest or molestation who, during the course of therapy, uncover detailed recollections of repeated sexual abuse by family members. Many of these people believe their recovered memories are veridical, and have taken legal action on the basis of these memories which have sometimes been recovered through hypnosis. There is now full-scale debate about these issues in the scientific, professional, and mass-market literature.

Serious questions remain in the literature about the validity of recovered memories (see research by Loftus and her associates; Loftus & Ketcham, 1994, for example). Major issues at stake include the validity of repression as a psychological mechanism, where there is substantial evidence that people can be very confident about the accuracy of their memories of past events even when those memories are wrong. Neisser's work with Nicole Harsch (Neisser & Harsch, 1992; see also Neisser, 1993) on the Challenger space shuttle disaster

illustrates compellingly that memory for emotionally charged events is widely inaccurate, despite the convictions people hold about them. That work convincingly demonstrates that personally memorable events occurring in the past are often not what they seem and can be entirely misleading in the manner in which they are reported. Memories of distant events and particularly memories of early childhood appear to be very susceptible to distortion and error. Further, it is the case that many victims of traumatic events do not repress events, but remember them and often report uncontrollable, intrusive memories about them. What distinguishes then for traumatised people, memories that can be retrieved (if sufficient effort is made), from memories that are seemingly permanently blocked (despite efforts at retrieval)? Evidence reported by Lindsay and Read (1994), implies that complete forgetting of childhood sexual abuse, whether through repression, dissociation, or normal forgetting, never actually occurs; rather, necessary caution is advocated in assuming any particular incidence rate for amnesia and in accepting or rejecting the recovered memories of an individual. As Loftus and her associates claim, although sexual abuse may be tragically common, the emerging culture of unearthing traumatic repressed memories may be creating as many problems as it is claimed to be solving.

The question of hypnotising a person who is involved in an actual memory event (to be later retrieved) has many potential difficulties. The laboratory evidence tells us that aptitude for trance is clearly a highly relevant variable, state instruction may be relevant, and lying is a possibility. Emotional involvement is clearly implicated in analysing the association of memory and hypnosis, and one major issue is how emotion can be handled in real-life settings when recovered memories are reported. Memories that are recovered are often given spontaneously and when they are associated with hypnosis they occur in a context where therapeutic questions may also be suggestive. These memories can be accurate, in error, or show a combination of both; and confidence in the memories, and the level of affect associated with them, offer no proof of literal accuracy.

Recovered Memory Therapy

The term “Recovered Memory Therapy” profiles a form of therapy that in formal terms does not exist. As a term it really refers to the recovery for therapeutic purposes of repressed memories of sexual abuse, such memories often being associated with reported satanic rituals and manifestations of Multiple Personality Disorder. It is a label that essentially has come to denote poor practice across a range of therapies, forgotten memories being the natural target of many different modes of treatment.

A forgotten instance of abuse in a history of abuse is not necessarily evidence of repression at work, and a number of issues are implicated: memories may be avoided, not just remain temporarily inaccessible, and some people may be more successful than others in that process of avoidance. Equally, there are

reports in therapy that can be trusted and reports which cannot. The problem is to know which is which and we have no precise way of making that discrimination — a problem that is exaggerated in its significance when many of us accept routinely that the important issue for therapy is the client's personal account of what has happened and what he or she is feeling about that now.

Therapy certainly can facilitate access to memories and produces memory reports, but it is also a mode of influence that inevitably transmits specific cues and suggestions about what is fitting, wanted, or appropriate to report. Therapy (like other influence techniques) can produce significant memory distortion while *at the same time* fresh memories can be retrieved that are true and reported. The essential problem is that we have no easy guarantee of the veracity of verbal reports offered in therapy, and past emotional events can rarely be corroborated independently to establish their truth value.

Because of the risks of suggestion and the many possibilities of distortion, special professional obligations exist when the memories being explored in therapy are associated with possible past abuse. This leads one to a major matter for consideration — the need for guidelines for practice.

Summary Comment

Let me provide a summary comment of the complex issues addressed so far.

Consider, for a moment, a man who remembers in therapy that he was abused sexually and recovers that recollection in therapy. His memory may be genuinely very difficult to retrieve. The events themselves, however, may have taken place in a state of normal or dissociated consciousness. Events that were encoded in an altered state of consciousness may be especially difficult to retrieve. If they are not, there are enormously strong motivations that exist for that person not to want to recall them.

Intervening between the original trauma and therapy is often a life span of experiences and other recollections. The person has been exposed to a myriad of events, suggestions, and experiences which have the potential to reshape and later correct recollections of what has, in fact, previously occurred. In therapy, there may be a grain of truth, as it were, in what is eventually remembered, but the facts could well be distorted, reshaped, embellished, or confabulated. What occurs makes eventual reporting far from the absolute truth.

Into the act of retrieval comes a professional, years later, who, in the task of interrogating (albeit supportively), is unwittingly influential in altering further recollections of those past events. Those events are then explored in a context where there are implicit or explicit cues about what should be remembered. That suggestion will occur is incontrovertible; and it is largely for this reason that guidelines for proper professional practice must be adopted, understood and practised.

CLINICALLY RELEVANT EXPERIMENTAL DATA

The data that I consider new and clinically relevant to the issues I've outlined come from a study in my own laboratory that used phenomenologically oriented techniques to explore subjects' base-rate responses to leading questions that suggested incorrect answers. The methodology employed was based on Susan Whitehead's adaptation of the Experiential Analysis Technique (EAT; Sheehan & McConkey, 1982) and the procedural extensions of Eva Bányai and her associates (Bányai, 1991; Bányai, Gosi-Gerguss, Vágó, Varga, & Horváth, 1990). The thrust of the work was geared to isolate the parameters and processes associated with subjects' personal responses to misleading questions.

The questions themselves were embedded into the hypnotic setting as part of the hypnotic session. High- and low-susceptible subjects were asked (with no other cue to suggest a confirmatory reply was wanted) whether they noticed "the person coming into the room a while back." They were then asked whether it was true that they seemed a little upset at the time, and then whether they knew "who came in." A fourth, post-hypnotic question, asked subjects "Did anyone come into the room a while back?" Analysis of subjects' responses to these four questions focused on memory accuracy and confidence in the proposition that a person had come into the room. The latter measure endorsed subjects' confusion level at the time, confusion in recall being an accepted symptom in the hypnotic literature of developing delusory thinking. The questions themselves were designed to elicit an increasing commitment to a state of affairs that didn't happen, but also repeated events so as to place increasing pressure on both high- and low-susceptible subjects to shift whatever was their previous response.

The core rationale of the study was to explore the extent to which clinically relevant answers could be elicited in an entirely neutral laboratory context where "personal" response was not only inappropriate to the context, but not at all expected by the hypnotist who administered the questions. In all of these senses, the design was intended to supply a base-rate measure for clinically relevant responses occurring in a non-therapeutic context. It used leading questions in a hypnotic setting which would have different significance if the context were clinical (not experimental). In so far as the research examines the incidence of the acceptance of ambiguously phrased leading questions, the results bear meaningfully on the current theoretical debate about the construction of false memories and possibly on the clinical phenomenon of recovered memory, in particular.

The overall hypothesis of the work is a subtle one. It was predicted that questions in the experimental setting, which might be expected to produce a high incidence of acceptance in the clinical setting, will not produce a high rate of acceptance because of the social constraints of the experimental setting itself. However, where distortion is evidenced — and it is a moot question really as to what that rate will be — it was hypothesised that it will occur most strongly for high-susceptible subjects, and subjects in hypnosis. Although some parallel can

be expected between the results for accuracy and confidence, the experimental literature indicates the value of separately examining the pattern of differences among subjects with respect to both these measures.

Tables 6 and 7 set out the experimental data for the accuracy and confidence measures.

Data in Table 6 show that the first of the questions produced no confirmatory response whatsoever but by the fourth (repeated) question, four out of 25 subjects acquiesced — all of them highly susceptible to hypnosis. By the third question, one of these subjects had already shifted response to acquiesce (in hypnosis). The conflicting nature of subjects' responses, however, is heavily evidenced in the data. To the third question ("Do you know who came in?"), four subjects said they were perfectly confident that a person entered the room, but at least three-quarters of this same group denied this. And the same variable pattern of response is evident for the confidence data. My point is that what simply looks inconsistent in an experimental context could be interpreted as dynamically meaningful in a therapeutic one.

The overall pattern of the data tells us clinically relevant responses in a neutral context are possible (for susceptible subjects particularly) when suggestive cues are present and the repetition of the questions reinforces the subject's acquiescence. It is not too hazardous to conclude that in a clinical — more relevant — context where that same repetition exists, the rate of acquisition and confusion would be much higher — enough, one might say, to highlight a genuine forensic problem.

Table 6 Frequency of Distorted (Yes) Responses for Four Misleading Questions

	Yes	No	D/K or Response unclear	Total
Question 1: (Did you notice?)				
High	0	25	0	25
Low	0	24	0	24
Total	0	49	0	49
Question 2: (Were you upset?)				
High	7	16	2	25
Low	0	22	2	24
Total	7	38	4	49
Question 3: (Do you know who came in?)				
High	1	24	0	24
Low	0	24	0	25
Total	1	48	0	49
Question 4 (Post-hypnotic): (Did anyone come into the room a while back?)				
High	4	20	1	25
Low	0	24	0	24
Total	4	44	1	49

Table 7 Frequency of Confidence Judgments

Question 1: (Did you notice?)							
	1	2	3	4	5+	Split rating/ confused rescuer?	Total
High	8	10	2	3	0	2	25
Low	22	0	0	0	0	2	24
Total	30	10	2	3	0	4	49

Question 2: (Were you upset?)							
	1	2	3	4	5+	None of the numbers	Total
High	10	6	5	3	1	0	25
Low	23	0	0	0	0	1	24
Total	33	6	5	3	1	1	49

Question 3: (Do you know who came in?)							
	1	2	3	4	5+	-	Total
High	8	7	4	2	4	-	25
Low	23	1	0	0	0	-	24
Total	31	8	4	2	4	-	49

Question 4 (Post-hypnotic): (Did anyone come into the room a while back?)							
	1	2	3	4	5+	Split rating/ confused rescuer?	Total
High	12	6	1	3	0	3	25
Low	24	0	0	0	0	0	24
Total	36	6	1	3	0	3	49

Note: For each of these four questions, a 5-point confidence scale was used where “1” meant no confidence that a person had entered the room, and “5” meant perfectly confident that a person had entered the room.

There are some important practical implications from the data presented here. The development of tools which can differentiate between real and constructed memory may not be possible if it is proven that original memories are overlaid by recent imaginings and remembering. If, however, original memory is still intact after being recalled as suggested in some research (McCann & Sheehan, 1987), there may be a way in some cases (e.g., Johnson, Foley, Suengas, & Raye, 1988; Spence, 1994; Steller & Koehnken, 1989) of making the important distinction between fact and fantasy or differentiating “the signal of true repressed memories from the noise of false ones” (Loftus, 1993, p. 534). Research into memory systems and how they function is of crucial importance in establishing how best to investigate the extremely controversial and emotive area of truth in recovered memory.

Clinical researchers emphasise that the historical truth is not always the issue in therapy. Information may be clinically useful though not necessarily accurate (Bowers & Farvolden, 1996; Spence, 1982). However, in the legal setting it has been said there is another reality (Loftus, 1993) echoing also others' claims that the nature of recovered memories has profoundly different meanings for legal as opposed to therapeutic settings (Pennebaker & Memon, 1996).

The limitations imposed by the reported content of memories mean that the conclusions of pseudomemory studies can only be extrapolated with difficulty into the clinic or courtroom setting (Greene, Wilson, & Loftus, 1989). Laboratory experiments do not relate well to situations such as cases of suspected child abuse, or criminal events where the memories may have strongly emotional overtones. As Yuille and Cutshall (1986) comment in relation to eyewitness reports of real-life traumatic events, subjects can behave and remember very differently when they are true participants, and not passive observers. The issues are complex and both the clinical and experimental settings can help unravel the dilemmas.

CONCLUSION

The data just presented returns me to the relevance of what I signalled earlier.

Experimental and Applied Hypnosis: A Symbiotic Relationship

Drawing on my earlier comparative analysis and my discussion of recovered memories, in the last decade there is emerging something of what I would call a symbiotic relationship between experimental and applied concerns. The fusion is fuelled not only by the applied concerns of "forensic and clinical hypnosis," but by the special stimulation of the particular controversies currently captured by the ongoing debate on recovered memories.

It is clear that the applied issue which is most likely to occupy our attention in the future is that of recovered memories. Are such memories real and/or fabricated? What is the therapeutic meaning of memories retrieved in hypnosis? There are also questions, in particular, of what injustices can be caused to individuals, what law courts are able to do with uncorroborated information, and whether research can, for instance, isolate when hypnosis is being faked. The implications that this whole issue has for the legal status of hypnotically produced testimony are major. The relevance of the issue is already emerging in the recent experimental literature of Kinnunen, Zamansky, and Block's work (1994) on "is the hypnotised subject lying?" Analyses of recovered memories I predict will be the test case for the rapprochement of clinical and laboratory hypnosis. Much is needed to bring laboratory and clinical concerns together and I suspect that this single issue will provide us with some unexpected solutions. In the common search to differentiate actual abuse from its reporting, theory and practice will immeasurably advance from knowing whether repression or dissociation is at issue or subjects/clients are simply failing to report.

In final comment, I want to return to views I expressed in my article entitled

“Clinical and Research Hypnosis: Toward Rapprochement” (Sheehan, 1979). They are views I would wish to re-echo now.

The association between clinical and research hypnosis may be viewed in a number of ways, but one of the most useful modes of conceptualisation is to regard the two activities as analogous endeavours involving a stepwise sequence of operations anchored to solving a particular problem or issue. Difficulties exist, however, for assessment procedures to really detect the cognitive resources at work among hypnotised persons, procedures being needed which are attuned to the isolation of clinical events that will reflect the true interaction between motives, cognitions, and expectancies.

Let me conclude by pointing to the plethora of clinical, experimental, and conceptual issues requiring the interaction I am advocating. In the listing I am borrowing from Yapko (in press). There are major unknowns about trauma and childhood repression.

The associated assumption is that traumatic memories can be preserved at a higher level of integrity than normal memories for later recall. However, some basic questions about this phenomenon remain unanswered: how many buried traumatic memories remain intact, and how many deteriorate? If buried memories of trauma decay over time, is it because of natural deterioration of some sort, or is it due to a defensive self-protection?

Why do some memories of known trauma never return in some people while other people do recover such memories? . . . This raises several key questions yet to be satisfactorily answered: do children repress memories after each specific incident of abuse, or as a whole set of experiences at some later point in time? If children forget each traumatic episode instantly, as it happens, how exactly do they do this? How does the child lose continuity such that the event loses both its antecedents and immediate aftermath? If children store many memories of abuse and then later develop amnesia for them all, then what generates the amnesia if not the abusive episodes themselves? And, finally, why do some people repress a particular type of trauma and others do not? (Yapko, in press, pp. 28–29)

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¹ Material in Tables 1, 2, and 3 is drawn from the historical introduction used in the author's state-of-the-art address (Sheehan, 1996).

HYPNOSIS IN THE TREATMENT OF CANCER PAIN

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This article reviews a number of issues relating to the pain of cancer and its treatment, and the role of hypnosis in pain management. The author concludes with a number of case vignettes which illustrate the efficacy of hypnotic techniques for these patients.

Cancer still remains one of the most feared diseases, despite significant advances in diagnosis and treatment in recent years. One of the reasons is the associated pain. That this fear is not unwarranted has been demonstrated by epidemiological studies which have shown that 60% to 90% of adult tumour patients develop pain during the later stages of cancer (Bonica, 1980; Cleeland, 1984).

Cancer pain is defined here as acute and chronic pain which occurs directly or indirectly from tumour lesions and/or the accompanying medical treatment. For example, skeletal and neuropathic pain is caused by tumour infiltration. Classical medical treatment (surgery, radiotherapy, and chemotherapy) can curtail pain symptomatology in many cases by reducing the malignant tissues, but quite often patients experience painful side effects (secondary pain) like phantom pain after amputation, polyneuropathies after chemotherapy, or myelopathies after radiotherapy. Moreover, some medical interventions are quite painful themselves, such as bone marrow aspirations or lumbar punctures. These again can lead to conditioned pain, fears, and other unpleasant and anticipatory reactions, for example, conditioned vomiting (Noeker & Petermann, 1990; Rosen, 1984).

Studies have shown that the variance of the experience of cancer pain is only explained in part by such organic factors as type of cancer, illness stage, number and location of metastasis, or terminal phase. Therefore, part of the pain experience of cancer patients should also be attributed to psychological factors (Bond & Pilowsky, 1966; Bond & Pearson, 1969; Spiegel & Bloom, 1983a, Reprinted with permission from *Hypnos: Swedish Journal of Hypnosis in Psychotherapy and Psychosomatic Medicine* (1996, XXIII, 99–108)

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1983b; Turk & Fernandez, 1990). Today it is no longer necessary to emphasise that pain experience always comprises the interaction of sensory, affective, cognitive, and behavioural components, with these considerations incorporated in Melzack and Wall's (1965) Gate-Control Theory.

The problem with each and every pain therapy is its controllability and efficacy. Many patients report they are completely helpless and anxious if they depend on physicians and their staff for pain control and/or if their treatment does not offer the desired pain relief. Any assistance that helps the patient regain and control pain facilitates an essential improvement in the quality of life of cancer patients. Hypnosis is one, but not the only psychological method, by which a patient can gain control over his/her cancer pain.

Hypnosis and Pain Control

Hypnosis was one of the few effective analgesics until the introduction of ether in 1846 and chloroform in 1847. According to Gravitz (1988), the first documented anaesthesia with hypnosis was performed 1829 by a Parisian surgeon during a mastectomy. The British surgeon John Elliotson (1843) reported several pain-free operations with hypnosis (mesmerism). The Scottish surgeon James Esdaile (1846) performed several hundred minor operations as well as over 300 major surgeries in India with hypnosis (mesmerism) during which 80% of the patients felt no pain. Numerous experimental and clinical studies have since demonstrated that hypnosis is a very effective method in pain control (Crasilneck & Hall, 1973; Elton, Stanley, & Burrows, 1983; Evans, 1987; Hilgard & Hilgard, 1975; Peter, 1986, 1990).

Theoretical controversies concerning hypnosis traditionally revolved around two competing paradigms, the so-called special process and the sociocognitive perspective. Special process theorists (cf. Hilgard, 1989, 1991) hypothesise non-ordinary states of consciousness (e.g., trance), and special psychological or psychophysiological mechanisms (e.g., dissociation), and maintain that hypnotic behaviour, like hypnotic pain control, differs fundamentally from ordinary behaviour. Sociocognitive proponents, such as Spanos (1991), on the contrary, insist there is nothing special about the hypnotic situation because it simply represents a salient example of social interaction variables which social and cognitive psychologists regularly employ to explain other forms of social behaviour (like demand characteristics of the situation, attitudes, expectation, role enactment, etc.). According to sociocognitive theorists, the subjects in pain studies simply follow instructions and show the desired behaviour (Spanos, Carmanico & Ellis, 1994).

In a recent study, Kiernan, Dane, Phillips, and Price (1995) have shown, however, that hypnosis significantly attenuates even a physiological variable, the R-III, a nociceptive spinal reflex. This demonstrates that hypnotic pain control can be beyond the mere reduction of unpleasantness. The reports of reduced pain may truly represent not only the attenuation of sensory pain but

also that of a spinally mediated, that is, peripheral, process. Even though this kind of research was pioneered by Hagbarth and Finer, who already showed an altered spinal nociceptive withdrawal reflex by hypnotic analgesia, it calls for replication for it seems to show a truly descendent (“top down”) inhibition. This would add a third component to the already known two factors of pain reduction, the sensory and the affective.

Hypnosis and Pain Management in Adult Cancer Patients

Erickson (1959, 1966, 1967) and Sacerdote (1970, 1982) provided some of the best known clinical contributions to hypnosis in the control of cancer pain. Less well known are the early reports by Butler (1954), Lea, Ware, and Monroe (1960), and Cangello (1961). Butler’s hypnotic analgesia was successful in 5 out of 12 cancer patients. However, successful hypnotic analgesia correlated with the ability of the patient to be hypnotised, that is, suggestibility. Spiegel and Bloom (1983a, 1983b) reported significant differences in control of cancer pain (and other symptoms like depression and anxiety) with hypnotic analgesia in 34 patients with metastasised breast cancer in comparison to a control group which only received medication. Reeves, Redd, Storm, and Minagawa (1983) compared a group of cancer patients receiving two sessions of hypnotic training for the reduction of pain induced by hyperthermia with an untreated control group. The treated patients reported significantly less pain than the patients in the control group. More recent studies have also demonstrated the efficacy of hypnotic analgesia. For example, Kaye (1987) was successful with 8 out of 12, Kraft (1992) with 5, and Campanella (1993) with 8 cancer patients. In a controlled clinical trial, Syriala, Cummings and Donaldson (1992) were able to show that hypnosis was effective in reducing reported oral pain in 45 haematological cancer patients undergoing bone marrow transplantations. These studies, as well as my own clinical experiences (Peter & Gerl, 1985), demonstrate the efficacy of hypnosis in pain control in adult patients.

Hypnosis and Pain Management in Children and Juveniles

Hilgard and LeBaron (1982, 1984) treated leukaemic children and juveniles who had to continuously undergo bone marrow aspirations. The pain baseline was assessed on 63 patients and they were then offered an hypnotic analgesia pain management programme. Of the 24 patients who participated, 19 were highly suggestible and 10 out of 19 were able to reduce their pain during the bone marrow aspiration after only one hypnotic session and 5 after two sessions. The five patients who were less suggestible were unable to reduce their pain with hypnosis, but were able to reduce their anxiety before and during the bone marrow aspiration. Zeltzer and LeBaron (1982) compared the efficacy of hypnotic (guided imagery) and non-hypnotic behavioural intervention (deep breathing exercises and distraction procedures) in children and juveniles during

bone marrow aspirations and lumbar punctures. The pain and anxiety baseline was obtained from the patients themselves as well as independent observers during one to three medical diagnostic treatments without any psychological interventions. The baseline data showed that experienced pain during the bone marrow aspiration was greater than during the lumbar puncture. Results indicated that the two psychological interventions reduced the experienced pain during bone marrow aspiration significantly, with hypnosis being more effective than the behavioural intervention.

Hypnosis was also effective during lumbar puncture. Anxiety was reduced by the behavioural intervention, but significantly less so than with the hypnotic intervention. Kuttner, Bowman, and Teasdale (1988) compared imaginative involvement, behavioural distraction, and standard medical procedures on a sample of 59 children with leukaemia. After two intervention sessions the authors were able to show that the hypnotic method had an all-or-none effect during bone marrow aspiration, while distraction appeared to require coping skills which had to be learned over more than one session.

Does Outcome Correlate with Suggestibility?

In most of the aforementioned studies, the suggestibility of patients correlated with the success of the hypnotic measures. Spiegel (1986) clearly recommends that “There is no point in trying to use hypnosis with the one-third of patients who are not hypnotisable” (p. 87). This kind of statement requires that the patients take a suggestibility test (e.g., the Stanford Hypnotic Clinical Scale [Hilgard & Hilgard, 1975]) before intervention and the therapist is convinced that suggestibility is a valid stable trait (Hilgard, 1965). However, a number of sociopsychological studies have demonstrated that low-hypnotisable subjects can increase their hypnotisability if they practise enough (Gorassini & Spanos, 1986; Spanos, 1991; Spanos & Coe, 1992).

As does Bányai (1991), I believe that suggestibility/hypnotisability is both a stable trait within certain limits but also a teachable, and therefore modifiable, skill. Furthermore, the discussion on the superiority of indirect versus direct induction and utilisation of hypnosis (Lynn, Neufeld, & Mare, 1993) cannot be settled with an either/or argument. Especially with cancer patients, it is paramount to establish rapport (Peter, 1994c, 1996), in which case the question of suggestibility or the use of direct or indirect hypnotic approaches seems less important. Katz, Kellermann, and Ellenberg (1987), for example, found that therapist–patient rapport predicted the treatment outcome in children with cancer, but not their hypnotisability.

CANCER PATIENTS AND RAPPORT

I would like to discuss rapport with cancer patients in more detail, since I am frequently painfully aware of the problem of therapeutic relationship and successful outcome. With some of my patients I have been unable to establish a good therapeutic relationship. In such cases hypnotisability is relatively unimportant, since I cannot use it. Therefore it would be helpful for me if I could assume that suggestibility is considered a stable trait and that I could attribute my failure to the low or missing suggestibility of the patient. On the other hand I also know AIDS and cancer patients whose established low suggestibility could be improved due to our good rapport (Peter, 1994a). Sometimes I reach my limits with cancer patients, in comparison to neurotic and psychosomatic patients, because I tend to get too involved; that is, I lose the balance of distance and closeness. Too much closeness and empathy results in my suffering along with the patient and I become helpless. Maintaining too much distance, based on the need to protect myself from this kind of suffering, also inhibits rapport and prevents effective hypnotherapeutic therapy. Sometimes supervision is helpful, but not always.

Unrealistic and very high expectations on the part of the patient can also prevent therapeutic cooperation because any correction of these expectations might be taken as a rejection by the patient. Such expectations might be the convictions that even hopeless cases can be cured and that pain is completely eliminated with hypnosis. Such expectations and similar ones suggested by some dubious publications make it impossible to offer some patients that measure of hypnotic analgesia which might still be possible under the given circumstances, or even to talk to them about death or dying (Peter, 1994b).

Limitations of Hypnotic Pain Control for Cancer Patients

A number of additional problems can aggravate or even prevent the effective pain management of cancer patients. Hypnotic pain management needs the cooperation and concentration of the patient and some patients are not able to provide this because of their illness. Some pain states are so overwhelming that patients are unable to cooperate mentally; some brain tumours or extreme fatigue make psychological interventions impossible. However, the adequate provision of opioid analgesia has made it possible to control even severe pain.

In some cases, even the pain cancer patients experience can result in secondary gain. For example, the pain can be used as a vehicle to communicate with other people, family members, physicians, and hospital staff, or the patient receives financial compensation from health insurance or other organisations.

As long as these problems have not been worked through with the patient, hypnotic pain control will be impossible or only of short-term efficacy. However, I don't want to give the impression that hypnotic pain control for cancer patients is any more difficult than, for example, that for other pain populations. On the

contrary, during 15 years of therapeutic practice with these patients I have learned that the suggestibility and compliance of these patients is better than that of other pain patients (Peter & Gerl, 1984, 1985). For this reason cancer patients can profit considerably from hypnotic pain control.

Techniques of Hypnotic Pain Control

We need to differentiate between dissociative, associative, and symbolic techniques used in hypnotic pain control, although some overlap generally does occur in practice.

The objective of the dissociative techniques is to separate the pain, that is, to isolate it from the rest of the healthy body; or to separate that part of consciousness which suffers and is aware of the pain. The simplest way is diversion of awareness, for example, by involving the patient in conversation, that is, focused listening; by concentrating on parts of the body not experiencing any pain; or by suggesting feelings of warmth or coolness. Sometimes some simple relaxation techniques are sufficient to reinforce such pleasant feelings as warmth or heaviness in those parts of the body not experiencing pain and this forces the pain awareness into the background.

Symptom substitution also belongs to the category of dissociative techniques. Instead of pleasant sensations, disturbing sensations should be produced in other parts of the body until the patient is able to completely focus her/his attention on that spot. Such substitute paraesthesias can be an intensive itching, severe tingling, or numbness. For example, the patient can recall numbness felt after receiving analgesia from the dentist, or the falling asleep of an arm, and can then place these pain-antagonistic sensations to the painful area.

Real hypnotic dissociation begins when the pain sensation becomes reduced or changed hallucinatorily in such a manner that the pain is separated and completely isolated from the body schema. This works best for pain in the extremities. For example, each arm levitation, and each catatonic state of parts of the body represents almost automatically a clearly perceivable dissociation of the arm or the respective catatonic part from the rest of the body. Depending on hypnotic ability and existing rapport, larger parts of the body can be dissociated. Thus, some patients can, for example, leave their bodies from the abdomen or from the neck downward and concentrate on the other painless body parts. This can continue until the patient imagines they completely leave their painful body in the bed and moves with an imagined healthy body to another room where they watch TV or do other pleasant things (Erickson, 1959). The temporal variation of complete body dissociation, that is, out-of-body experience, is age regression to a time when there was no pain and the patient remembers pleasant experiences. This temporal orientation can be based on vacation experiences which are generally associated with pain antagonistic sensations (warmth and coolness, relaxation, or other pleasant sensations) and/or significant life occurrences, like engagement, marriage, or birth of a child (Campanella,

1993).

Associative techniques require that the patient pay attention to the pain, which at first most probably will have a pain reinforcing effect and, for this reason, should not be used with all patients, since it requires high motivation and a great deal of trust in the therapist. It is especially helpful in cases of radiating pain to determine the exact pain boundaries, that is, to find out where the pain-free areas start. Just the determination of pain boundaries can facilitate pain relief, in that the patient is told indirectly they can control pain. Once the boundaries have been established they can be traced with an imaginary pencil or pen suggesting to the patient that these boundaries can be changed, meaning they can be shifted more to one side or the other. It is better, however, to ask the patient to first perform such a shift by enlarging the pain area since this is easier than reducing the boundaries right from the beginning, or to simply ask her/him to change the location in terms of symptom shifting. Both instructions contain the message that pain is not something permanent or unmovable, but changeable and therefore reducible and relievable.

As soon as the pain boundaries have become variable, other pain modalities can be changed too. At this point it is important to know how the patient represents her/his pain in order to get to the so-called submodalities of perception. For example, if the pain sensation is experienced as sharp and stabbing, then the attempt is to dull it; if the pain is rather a pulling sensation, reduce the muscle tension or, for a burning pain, suggest a cooling sensation.

Most important, however, is to determine which submodality is responsible for most of the suffering. If it becomes possible to completely separate the suffering from the total pain experience then the rest pain, maybe in form of a so-called "white pain," may become much easier to bear. The most extreme form of such pain awareness would be to imagine the pain process as a purely physical process occurring within nerve cells and certain areas of the brain.

The step towards symbolic information processing is no longer difficult, once certain pain aspects have been changed. By symbolic processing I mean that the patient changes the total pain or certain aspects of it into symbolic or synesthetic representation, that is, into an adequate acoustic and/or visual hallucination. Within this new synaesthetic frame, changes can be executed much more easily than at the originally kinaesthetically experienced pain site, by imaging, for example, extinguishing a glowing fire, letting a storm die down, or calming down a stormy ocean.

The utilisation of associative or symbolic techniques by the therapist, however, should not imply to the patient they should view pain as a partner with whom one can converse or argue. Most cancer patients with unbearable pain would consider this an impertinence, if not a ridicule of their suffering (whereas pain as a partner would be appropriate for patients who are suffering from psychosomatic pain). Cancer pain is one of the most unnecessary pain experiences which really does not make any sense and which should be relieved with anything that has proved to be effective.

Which kind of hypnotic strategy or combination thereof should be used can only be determined by the kind and severity of pain, the hypnotisability of the individual, the patient's and therapist's attributes, and other factors. One of these is the issue as to what the pain signifies to the patient (does she/he interpret pain as a sign of being alive or as a sign of decay and impending death?). In the latter case, one should probably use dissociative strategies, whereas associative and symbolic strategies would be indicated for the former. In any case the therapist should select that approach which most easily brings about the desired objective.

CASE VIGNETTES

The following case illustrates the use of *dissociative techniques*. This patient had cancer of the mouth and came to me about one year after being diagnosed.

The first pain episodes could easily be controlled with relaxation, based on progressive muscle relaxation. At that stage it was difficult to determine whether pain control was achieved by the relaxed body state, or because of the patient's mental concentration while doing these exercises, or because of the mind-body interaction.

His pain became a lot worse when he had to have all his teeth pulled, two or three at a time, because the medical analgesia no longer seemed to work. At the beginning I taught him to remember how it used to be when he visited his dentist and when the injections brought about feelings of numbness. During this age regression, I suggested that the patient could leave the treatment room in his mind and travel to his favourite vacation place. This was a picturesque island located in the middle of the Mediterranean Sea, warm, sunny, and surrounded by cool waters. When the patient arrived there, he told me exactly what he saw, heard, felt, smelt, and did. By asking detailed questions about all the different sensory experiences, I tried to create experiential hallucinations in order to divert his attention from the actual experience in the dentist's office. At the next tooth extractions the patient was able to apply these dissociative techniques and he hardly felt any pain, except for some itching and pressure.

After this incident he did not discuss pain control for a long time, although tumour progression was evident. When I asked him he said that his "vacation technique" was still working very well.

Only a few months before his death, when the skin of the upper and lower jaw had already become necrotic, did he begin to complain once again about pain which no longer could be controlled by hypnosis alone, but only in conjunction with time-contingent opioid analgesia. At this stage he was only able to communicate by moving his head since he was unable to talk. Every time I visited him I told him stories about his special vacation place and kept reiterating that in one's mind one could leave the body behind and go to a place where one could think and feel differently. From his breathing and from the expression in his eyes it seemed as if my stories helped him, although it was

impossible to ascertain this from his facial gestures as his face was almost entirely destroyed by the cancer. Shortly thereafter, the patient went into a coma and died.

The next case illustrates the use of *associative techniques*. The patient had breast cancer and the cancer had already metastasised throughout her body, with the metastasis in the spine, in particular, being extremely painful. My idea was to increase the muscle tonus of her back muscles in order that those muscles would form a so-called corset around her spine. At first I used arm levitation with the right, then with the left arm, and then with both arms simultaneously. Then I instructed her “unconscious mind” to transfer the exact feeling of “light tension,” that is the “tight lightness” of the arms, across her shoulders down to her back and to continue doing this until this tightness formed a complete enclosure around the painful areas in her back, so that the pain would be locked in. At first the radiating pain was reduced considerably and with more and more practice the patient was able to change her pain experience. The hot and stabbing pain changed into a dull and cool sensation which felt uncomfortable but not painful. She was able to go without pain medication for about two months. After that she was admitted to the hospital because of pathological fractures of the spinal vertebrae and had to wear a real corset. During the last two weeks of her life, only very high doses of opioid analgesia were able to keep the pain under some control.

Symbolic change of pain experience can be illustrated with the following case. A patient with small-cell lung cancer came to me with extreme pain in the chest area following radiotherapy. I asked this patient if she would like to learn something about imagery. For example, she could imagine that she was standing in the middle of a meadow and in addition to seeing and feeling the different grasses and flowers she could also taste and smell them if she only got close enough. Furthermore, she would be able to hear the singing of the birds and the humming of the insects and their music filled the air. Just before she had seen and heard enough, and just before she would become bored, she could remember her chest pains out there in the normal world. She could then put this pain into the container which was lying at her feet but at the same time she could take great care that each and every corner of the pain would be in the box so that none would be sticking out when she closed it and picked it up.

After she had done this she was to take a walk into the nearby forest carrying her box under her arm or on her shoulders until she found a bubbling spring. At that spring she should take a rest, have a drink of water, and continue to go deeper and deeper into the forest until she came to a cave. She enters the cave still carrying her pain box. As she explores the cave it gets larger and larger until she comes to a very big and light room. In this room she finds a very old and wise woman. She goes to the woman, holds up her box, and asks her what she is supposed to do with it. The old woman first looks at her and then at the box for a long time and finally asks how much this box weighs. The patient is very surprised when she realises that the box has become much lighter than before.

Actually it had become so light and small that she was able to carry it in her hand, whereas before she had to frequently carry it on her back or change sides because it had been so heavy. Now she was happy. She thanks the old woman, leaves the cave and goes back to the meadow, with the box remaining small and light.

When the patient came out of the trance, and after the discussion of various unimportant matters, the patient said, after being asked, that her chest pains were a lot less — about half as bad as before. I repeated this story every session — the old woman in the cave kept changing important pain aspects — until the patient no longer talked about chest pains. The pain-free period that followed might, however, also be attributed to the fact that the lungs were healing. This patient is really an unusual case. According to medical statistics she should be dead, since small-cell lung cancer has a very poor prognosis. However, she is still alive three years after diagnosis and doing well.

CONCLUSION

Hypnotic pain control can be learned and applied relatively easily. It provides the patient with an additional measure of controlling the illness and pain. This again gives the patient back their feeling of independence and leads to an improvement in quality of life experience. The expectations of the patient about its effectiveness should be realistic and should be realistically conveyed as such by the therapist. Hypnotic pain control should not be considered a substitute for effective opioid pain management. However, in many cases hypnotic analgesics can reduce the amount of otherwise necessary analgesia and in some cases even replace them for a longer period of time.

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HYPNOSIS IN THE TREATMENT OF HEADACHES

Patricia Burgess

General Practitioner

This case illustrates the use of hypnosis to alleviate chronic headaches in an 8-year-old girl. It underlines the importance of a child's need for mastery and how hypnosis can help a child regain that sense of mastery and so make the necessary responses for change. It also demonstrates how much therapeutic work can be achieved at an unconscious level without the therapist knowing the content.

HISTORY

Presenting Problem

Jane was referred by her general practitioner in March 1995 and came accompanied by her mother. She complained of increasing frequency and severity of frontal headaches over a four-month period.

The onset coincided with a febrile illness with accompanying headache and fatigue and was thought to have been viral in nature. The illness lasted about two weeks, the symptoms being relieved by the use of paracetamol.

However, the headaches continued to occur at a frequency of about three per week, until the last two months when they began to occur daily. Jane would often wake up in the morning with a headache or the headache could begin any time of the day, at school or on weekends. There had been no nausea, vomiting or aura, but Jane's mother reported that Jane would often appear very pale. Jane was experiencing difficulty going to sleep and would often lie awake for a couple of hours because of the headache. The symptoms were interfering with daily activities. She had begun to miss days of school and not infrequently needed to lie down in the sick room. Jane had previously been very active in basketball but there had been a reduction in performance and she often needed to leave the court during the match, because of fatigue or headache.

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There had been changes in mood and behaviour and her mother reported that she had become more “clingy” and seemed insecure. She appeared easily upset and at times very teary.

Jane’s own assessment was that she did not know why she had headaches. She told me sometimes she “felt sad” and even though she liked school, had lots of friends, was happy in her family and loved her sport, she sometimes felt she could not “cope.”

Management at the Time of Presentation

At the time of presentation Jane was needing regular four-hourly pain relief during the day. Her mother was making every effort to “stretch out” the medication (Paradex), but she was increasingly concerned about Jane’s dependence. She was also taking Inderal 30 mg twice daily prescribed by a paediatrician.

Jane had been assessed early in 1995 by a paediatrician, who had diagnosed probable migraine and early puberty. Full medical and neurological examinations were normal as were X-rays of the facial sinuses. Jane was commenced on Sandomigran 0.5 mg to 1.0 mg twice daily. When this failed to provide relief, she was commenced on Inderal 20 mg twice daily, this being later increased to 30 mg twice daily, in the hope of achieving control. Jane appeared to have failed to respond to the two frequently used drugs for migraine prophylaxis and there was concern that something more serious was present. A cerebral CT scan showed no pathological lesion.

Jane and her family were naturally a little more than anxious about her lack of response to the “normal” range of drugs. Coupled with this was increasing concern about the development of dependence on Paradex.

Past Medical History

Apart from a bout of abdominal pain in 1994, history of sore throats and tonsillectomy twelve months earlier, Jane’s physical health had been good. There had been nothing in the history to indicate psychological ill health.

Family History

Jane is the youngest of five children in a close and supportive family environment. She has two brothers and two sisters.

Jane’s mother suffered several migraine headaches when younger. There was no history in the family of depressive illness. Jane liked school and was a good achiever under her own efforts. She enjoyed reading, while her main sport was basketball, in which other members of the family were involved. Jane was a good player in a team which was achieving considerable success.

The family had a pool at home and Jane often spent time swimming, and just enjoying being in the pool. She loved birds and she had many budgies of her own, many different colours, but her favourites were the yellow ones.

SUITABILITY OF PATIENT FOR HYPNOTIC PROCEDURES

Since the days of Bernheim in the late nineteenth century, we have known that children are more hypnotisable than adults, as long as they understand the instructions and pay attention, the peak age being about 7 to 14 years (Gardner & Hinton, 1980). Trance-like states and daydreams are very common to everyday childhood experiences.

Other important factors contributing to suitability of this patient for hypnotic procedures were as follows:

1. There were no contra-indications.
2. The problem that Jane had was amenable to hypnotherapy.
3. Jane and I had established good rapport and Jane had witnessed the positive interaction between her mother and myself.
4. Jane wanted to get better.
5. Jane's parents readily accepted the concept of hypnosis, and understood it to be non-threatening to her.

RATIONALE FOR USE OF HYPNOSIS IN THIS PATIENT

Recurrent or chronic headaches are often psychogenic in origin, but it was difficult to put this sole label to Jane's headaches. By the time I saw her there had been extensive investigation into the nature of her headaches and I was satisfied that there was no pathology which would require other types of management. Recent Epstein-Barr (glandular fever) studies had indicated that Jane had been exposed to the virus sometime in the past. This was probably the virus which, four months ago, had triggered the headaches. What began originally as an organic headache, ultimately was composed of anxiety factors and possibly iatrogenic as well.

The ability to manage pain by hypnotic techniques is known to be related to hypnotisability and children are generally expected to do well. Jane did not appear to have any underlying emotional need for her headache and in such cases symptom-oriented methods can work very quickly.

Chronic pain is accompanied by anxiety ("I can't cope") and depression ("I feel sad") which in turn exacerbate the pain and so the cycle goes on. Anticipation of pain and subsequent anxiety can add to the pain experience. The use of hypnotic techniques can break this cycle and allow the child to move towards personal well-being and security.

My experience has been that, often, children in chronic pain are "out of control," need mastery over themselves and their environment. Hypnotic techniques can allow children to regain control and manage their own problem.

GOALS OF MANAGEMENT

1. To explain the nature and cause of the problem to Jane and her mother.
2. To actively increase Jane's motivation by my enthusiasm for success and so

foster continuing sense of hope.

3. To teach Jane strategies for gaining control of her problem and thus curing her headache.
4. To enable Jane to regain her former state of physical and psychological health.

In using hypnosis I planned to:

1. Use the relaxation response to reduce anxiety and muscle tension, and thus show Jane how she could “feel different.”
2. Increase response to suggestion for ego-strengthening and to use post-hypnotic suggestions for symptom control.
3. Create alterations in perception of the pain.
4. Encourage Jane to privately communicate with deeper levels of awareness.

SPECIFIC TECHNIQUES

1. I planned to use a blend of permissive and direct suggestions for involvement in visual and kinaesthetic imagery, utilising Jane’s particular areas of interest.
2. Therapy techniques were to be mainly metaphors to arouse curiosity and to encourage Jane to explore new frontiers.
3. Jane and her mother had begun monitoring the severity of the headache on a scale of 1 to 10, so I planned to continue this as a guide to progress.
4. I planned to incorporate post-hypnotic suggestions which would offer a series of challenges to allow Jane, in her own time, to move forward to success, and which would build in protection for any future headache.

SESSION ONE

With the knowledge of the positive Epstein-Barr study, I was able to give a name to the origin of Jane’s problem. I explained the nature of post-viral headaches and time needed for their cure. I also explained how tension and worry can make headaches worse. The use of medication was discussed, particularly possible dependence and side-effects.

I believe that therapy actually commenced when Jane first began to explain her problem to me, and together we were able to create favourable conditions for a positive outcome. When Jane and her mother first presented, the situation to me seemed rather urgent, as she had been in discomfort a long time, and she had this feeling of “sadness.” Her headache was usually about level 5 on the scale but with Paradex at times it was 3.

I told Jane that I could show her ways of curing her headache if she was willing to learn. She could do it where no-one else had been able to. My explanation of hypnosis was that it would involve imagining doing things that she liked and going on imaginary trips to find interesting and lovely places and

perhaps to meet new friends. I elaborated on these ideas, linking in to a child's natural curiosity for new experiences.

Jane needed no encouragement and, with permission and support from her mother, I proceeded with hypnosis at the first session. The induction was "movement imagery" asking Jane to imagine playing basketball with the suggestion to let her head nod when she felt tired or uncomfortable and needed to rest. At this signal I asked her to rest quietly. I then offered ego-strengthening suggestions, aiming to help Jane feel more self-worth. I explained once again the cause of her headache and how no-one had been able to fix it. I reaffirmed my belief in her ability to help herself because "you are a special person, part of a special family who love you and want to see you as your old self again."

I then asked Jane to imagine herself in her pool at home, floating, and with whom she liked. I asked her to feel light and floaty, and to imagine her headache becoming cool and floating into the water. This was followed by, "Now Jane I want you to make your headache just a little bit stronger, just up to 5, and nod your head when you have done that."

Upon the signal, this was quickly reversed with the suggestion for, "Now you can do that, so you can float the headache away in the cool water, and watch your number scale as you do that. Feel how better the headache is now." This was followed by a post-hypnotic suggestion for daily practice: "Little by little every day from now on you will find that you won't be bothered so much by your headache, and you will be pleased how much happier you feel. Soon you will be able to enjoy your basketball and all the other things that you like."

Jane had enjoyed the floating and had her budgies on her tummy. She had begun the session with a number 3 headache and increased it to number 5 on request. It was now less than 3. Jane told me she would practise every day and we discussed the possibility of her school teacher allowing Jane to use her hypnosis if the headache was a problem at school.

SESSION TWO

When I saw Jane one week later her headache was on number 2. She had been without Paradex for three days. She was feeling better and was back playing basketball although she had not played in a competition. Getting to sleep was no longer a problem. Jane had practised floating her headache away twice a day (always at bedtime) and at school when needed. She looked better, and was keen to learn more.

I planned at this session to:

1. Reinforce Jane's achievements so far.
2. Allow her to develop an increasing sense of control through imaginary involvement, and enhance her ability to solve her problem when no-one else could.
3. To build on previous post-hypnotic suggestion for achieving success.

I used the basic framework of Marlene Hunter's trip on a cloud through a rainbow and "a child like you." When we (Jane and her friends and myself) reached the rainbow on our cloud, Jane was allowed to direct the cloud to fly through any colour she wished. We then proceeded as follows:

and now that we are on the other side of the rainbow we see a beautiful land, green grass, beautiful flowers, buildings and lots of happy people. Our cloud settles down on a soft green lawn so we can all climb out. When you look around, you can see all sorts of interesting things, Jane, but you begin to notice that there is a little girl who seems to be standing on her own. There are lots of happy people around but she does not seem to be happy. She has had a headache just like yours, she has had a rotten old headache for a long time and nobody seems to have known what to do to help her. She is very miserable and her family is miserable too. But she knows that you have had just the same problem and somehow she looks a little like you. She has beautiful blond hair, she has a green T-shirt on and blue shorts and she does look a little like you. So she understands that you know what your headache was like, and she also knows that you have done something to help your headache go away, something that other people could not do. She wants to ask you to help her. Jane just nod your head if you would like to help this little girl. That's good, very good. Now you can talk together and I need not know about this. She is relying on you to help her, so spend time talking to her. And she wants to ask you some questions and you can answer them. I need not know any of this . . . it is your own very special secret between the two of you. She seems to live in such a happy place and it is not nice that she has been so unhappy. When you think you have answered her questions and told her what she needs to know, just nod your head. . . That's good, well done. And you will be able to visit this little girl any time you wish . . . in fact she would probably look forward to seeing you again.

The return journey involved passing twinkling stars and a smiling moon, with Jane checking that everyone was safely back home in our land.

Then followed ego-strengthening suggestions and reinforcement of previous post-hypnotic suggestions:

I think that it won't be long before your headache will be down to a number 1, and very soon after that I think it will be at a zero. But, in the future if you do have a headache, then you will tell someone about it. But I think it won't be long before this headache is down to zero. And you can feel very pleased with yourself. You'll find that you will be so interested in what you are doing, now that you can play basketball and enjoy all those things that you like, that the old headache won't bother you.

Jane had been part of the whole experience and had taken her birds and a school friend with us. She told me that the land was very bright and pretty and that she would like to go back to see her new friend.

SESSION THREE

One week later Jane's headache was at a number 1 and there had been no need for Paradex. She continued to practise every night, going through the rainbow to speak to her new friend. Jane's mother noticed that Jane rarely mentioned her headache, she was enjoying life again, basketball was in full swing and Jane did not need to practise at school any more. Jane's mother commented that she "had her child back again."

The family had kept an appointment previously arranged by their general practitioner with a second paediatrician. He had concurred with the diagnosis and was supportive of hypnosis. Inderal was to be withdrawn on a sliding scale.

Despite good progress, I felt that Jane still needed to experience one further dimension important for childhood growth, that of rewards. At this session I planned to extend the metaphor used previously. This time the "child like you" was better and wanted to thank Jane for her help. She shared a special secret with Jane, taking her to an old palace that she had discovered. The two girls spent time dressing up in princesses' clothes, with lots of jewellery and crowns, all the while feeling how good it was to be happy and free.

OUTCOME

Just over a week later Jane was headache free. She continued to practise and had been floating the headache away in cool sand at the beach, telling me that she had made this up herself.

Later, Jane's mother told me that Jane had helped her older brother deal with an itchy rash, telling him how easy it was to "imagine it away."

Up to this time Jane remains well. She chose to use her hypnotic talents, instead of taking a Panadol recently, after she had had sutures to a chin laceration.

DISCUSSION

The goals of management were achieved in three sessions of hypnosis. Once Jane had a taste of success, her mastery increased. The final step was to use her natural childhood tendency for sympathy and the innate impulse to help "a child like you" who was really herself. She allowed nothing to be final or fixed about what she had learnt, being able to use her skills with her family.

Very often hypnosis is thought of as a last resort, and I must say that I found this to be a huge advantage. I had the benefit of information about failed treatments: I had a child who felt oppressed and a failure because she had not met medical expectations: I had supportive parents who needed answers and help: but best of all I had a child who wanted to get better.

It makes sense to postulate that Jane's headache had many facets to its chronicity. Her lack of understanding and information about its cause created anxiety, which probably decreased pain tolerance, and side-effects from one or

more drugs or a combination of drugs.

Children are so much influenced positively or negatively by adults and so often perceptions of symptoms can be temporarily or permanently affected. This case has been a reminder to me to be ever-vigilant in my response to children in pain. All who are involved in the care of children should be aware of the need for sensitivity in responding to a child in pain.

Gardner (1976) points out in one of her surveys of health professionals' attitudes to hypnosis that most felt comfortable with other treatment modalities (pharmacological) and would continue with those before exploring anything unfamiliar to them, even if the familiar approach was apparently inefficient. Although this survey was done in America and in 1976, I suspect that in Australia the situation may well be the same today.

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POST-TRAUMATIC STRESS DISORDER

Malcolm Desland

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A 40-year-old woman presented with a complex chronic PTSD, including a rape (18 months before admission), a rape at age 15, and a childhood sexual abuse history. Coupled with this was a previous negative therapy experience. At presentation she was severely symptomatic, excessively anxious and avoidant. This case study discusses her history and presentation information, assessment of hypnotisability, case formulation in light of a previous negative therapy experience, counter-transferential issues, and initial interventions utilising hypnosis and cognitive behaviour therapy. Therapy is still continuing, so follow-up and outcome data are not available.

The available clinical and research literature indicates a relationship between Post-Traumatic Stress Disorder (PTSD) (DSM-IV; American Psychiatric Association [APA], 1994) and hypnotic phenomena (Evans, 1991, 1994; Spiegel, 1994; Spiegel, Hunt, & Dondershine, 1988). PTSD symptoms fall into three clusters: (a) intrusive symptoms such as nightmares and flashbacks; (b) avoidant behaviours, such as emotional numbing/detachment and avoidance of anxiety evoking stimuli; and (c) arousal symptoms, including hypervigilance, exaggerated startle response and anger outbursts (APA, 1994; Turner, 1991). Spiegel (1994) and Evans (1994) state symptom clusters parallel hypnotic phenomena. Intrusive symptoms parallel absorption; avoidant symptoms parallel dissociation; and arousal symptoms parallel the heightened suggestibility of hypnosis.

PTSD sufferers demonstrate higher hypnotisability levels than other psychiatric disorders and the general population (Spiegel et al., 1988). High dissociation and absorption levels are also reported (Bernstein & Putnam, 1986; Branscomb, 1991; Bremner, Southwick, Brett, Fontana, Rosenheck, et al., 1992; Coons, Bowman, Pellow, & Schneider, 1989; Mackay, 1994).

Evans (1991, 1994) argued that hypnosis is the optimal choice in helping this population. Hypnosis actively accesses dissociative and absorption phenomena, increasing therapeutic effect and reducing therapy duration (Brown & Fromm,

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1987; Spiegel, 1994; Stanley, Burrows, & Judd, 1988).

This case study examines hypnosis and cognitive behaviour therapy (CBT) in treating chronic complex PTSD in a 40-year-old woman named Ms V who was admitted for in-patient treatment. The assessment spanned four interviews, including psychometric tests during the first 10 days in hospital.

ASSESSMENT INFORMATION

Presenting Problem

Eighteen months previously, Ms V was raped by a masked intruder while working night shift in a developmental disability home. She was attacked from behind and forced to the ground. During the attack she sustained knife wounds to her left shoulder. She managed to convince her assailant to stop and talk for two hours as she attempted to dissuade him from raping her, but she was ultimately unsuccessful. The police arrived shortly after she called them and the next day was spent at the police station. She was then referred to the local sexual assault centre where she attended weekly for six months. She was then referred to a consultant psychiatrist whom she saw weekly for 12 months. The psychiatrist then recommended in-patient treatment.

Four days prior to the rape she had returned to work after time off for a hysterectomy operation. The rape caused internal bleeding, which necessitated surgery in the week after the rape to cauterise the injuries.

Background Information

Ms V was the second youngest of six children (five boys, one girl). Her early family childhood was described as “idyllic.” She was closest to her father, but, at about age eight years, this changed when her father developed a drinking problem. The closeness turned to sexual abuse. This lasted from age 8 to age 16, when she left the family to marry her present husband. This still exerted effects upon Ms V. In a flat detached manner she spoke of her anger and disappointment at him “ruining” the relationship. The sexual abuse has remained a secret to other family members. Her father died from cancer when Ms V was 21. She reported nightmares of her father and stated her sexual relationship was negatively affected by what had happened to her. At age 15, Ms V was raped by a masked man while dating her present husband. The couple were parked at a secluded spot when a torch light shone in their faces. A man claiming to be a police officer told her husband to leave the car. He was tied up and Ms V was raped.

In the late 1980s, she was contacted to give evidence in a legal case where a police officer was charged with multiple rapes. Ms V gave evidence about her own rape. This was disturbing, as the accused was the chief investigating officer on her case. The investigation against the accused was inconclusive, he was

acquitted and awarded compensation, which Ms V found very distressing. With his compensation, the accused retired to live in Queensland, the state in which Ms V lived. This resulted in relapse of PTSD symptoms in Ms V and alcoholism in her husband, prompting a rapid sale of their home (at a substantial loss) and a return to New South Wales.

Ms V is married with three children. Her early married years were troubled by her husband's drinking. He was not violent, though verbally abusive and unreliable. He sought help through Alcoholics Anonymous and had remained abstinent, apart from the lapse mentioned. Her family is supportive and tolerant. She sees herself as not deserving this. Since the last rape, the family have purchased two large dogs to help Ms V feel safe. She considered herself "a burden to all."

Ms V did not complete Year 10 and has had a range of jobs. In recent times she had worked for the Department of Community Services in a developmental disability home. She spoke highly of this job, believing she "was made for it." Since the rape, she has not returned to work. She fears being forced to return to work as part of her occupational rehabilitation.

Ms V has a supportive social circle of friends, although most were unaware of her PTSD. She reported no alcohol or social drug use, stating she did not want to "lose any more control."

Medical Status

Ms V had hypotension through a congenital kidney condition. This was managed by Aprinox (bendrofluzide). At presentation she was taking Xanax (alprazolam) and Prozac (fluoxetine).

Previous Treatment

Ms V's first counselling was with the sexual assault centre. She viewed this counselling as negative, "going around and around in circles. I couldn't see the point of going over and over it again." She perceived the counselling as bewildering and focused unnecessarily on her husband's former drinking. She was encouraged to attend AA, even though she did not feel alcohol was relevant.

The "final straw" came when the therapist conducted an eye movement desensitisation and reprocessing (EMDR) technique (Shapiro, 1989a, 1989b). Prior to the EMDR usage, a progressive muscle relaxation was conducted which resulted in a dissociative experience for Ms V. She visualised Freddie Kruegger (the main character in the *Nightmare on Elm Street* films) at her feet. She reported the session was conducted as the therapist read a journal article on EMDR. The session ended with Ms V leaving extremely traumatised, and she had a car accident while driving home. Contact with the therapist was terminated.

The psychiatrist's sessions were supportive but had not decreased her distress greatly. Commenting she could "often see the point of the advice, but [I] can't do it."

Current Symptomatology

Ms V presented in a very distressed state. She reported dissociative episodes, including flashbacks, intrusive thoughts, and emotional lability. Her rape memories were "fuzzy" and she commented that, for a long time after the event, she was "only half there." She reported her traumatic experiences without affect or expression. Her sleep was erratic, punctuated by nightmares of both rapes and the familial sexual abuse. Nightmares and flashbacks included movie characters from *Teenage Mutant Ninja Turtles* and Freddie Krueger. Ms V believed both were expressive of previous traumata: the *ninja* turtles are masked and stocky in build, similar to the recent rapist. Ms V's psychiatrist interpreted dreams of Freddie Krueger, with his long claws and gnarled hands, to be expressive of incestuous encounters with her father. During the assessment, Ms V was cooperative, reportedly saying she wanted to "get better."

Psychometric Testing

To augment assessment information, the following tests were administered: the Impact of Events Schedule (IES; Horowitz, Wilner, & Alvarez, 1979); the Tellegen Absorption Scale (TAS; Tellegen & Atkinson, 1974); and the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986).

The IES, on which Ms V scored in the high range, measures PTSD symptom severity. She was still highly symptomatic 18 months after the last trauma. Most severity arose on arousal and intrusive symptoms. The TAS measures capacity for absorption. Absorption phenomena occurs in hypnosis and PTSD. As expected, she scored higher than the normal range on the TAS (Mackay, 1994), indicating Ms V was absorbed in her internal processes (Walker, 1994). Given the traumatic nature of her internal processes, this conveys the distress experienced. The DES measures dissociative capacity. It was reasoned the extent of Ms V's dissociation was important in planning treatment. On the DES, her scores were consistent with chronic PTSD sufferers (combat veterans and childhood sexual abuse victims) (Branscomb, 1991; Coons et al., 1989). This paralleled her reports and presentation.

DIAGNOSIS

Following hospital policy, DSM-IV (APA, 1994) criteria were used. The following diagnosis and classifications were applied:

Axis 1: Post-traumatic Stress Disorder (Immediate Onset/Chronic type).

Axis 2: No evidence of personality disorder.

- Axis 3: Hypotension and a current congenital kidney condition.
- Axis 4: There was evidence of economic problems and problems with the legal system. Each was due to the rape and subsequent loss of employment.
- Axis 5: Current Global Assessment of Functioning (GAF); 35. Highest GAF level in last year; 50.

CASE FORMULATION

The following issues were considered:

1. Negative EMDR experience: EMDR is considered a dissociative treatment (Evans, 1994) evoking abreaction. It was imperative for hypnosis procedures not to fall into the same “abreactive trap.”
2. Dissociation and DES scores: it was hypothesised similar high levels of abreaction could be induced in hypnosis. This should occur within the contained context of a strong trusting and structured therapeutic relationship.
3. Reactions to nursing staff: regular monitoring was required.
4. Therapy would focus on empowerment over symptoms and symptom removal, using Ms V’s decision making and choice. Therapy including hypnosis would be collaborative (Golden, 1989). Ms V would be active in therapy, as opposed to a therapist ministering treatments to “get her better.”
5. Hypnosis as an intervention would be applied using caution and structure, to minimise any noxious images or effects.

ASSESSMENT OF HYPNOTISABILITY

Hypnotisability was determined considering three factors:

1. Her attitude and perception of hypnosis.
2. Hypnotisability as measured by the Stanford Hypnotic Clinical Scale for Adults (SHCS:A; Morgan & Hilgard, 1979).
3. Assessment of contraindications.

Ms V reported no prior hypnotic experience. It had been recommended by an insurance medical officer. After an explanation was given, she was positive about hypnosis. Though the literature documents higher hypnotisability in PTSD victims (Spiegel et al., 1988), assessing an individual client’s hypnotisability is required. Ms V scored in the high range on the SHCS:A (5/5). No contraindications were evident.

THERAPY

This description begins with session 5, in which the hypnotic procedures were commenced.

Session 5

I explained that hypnosis was an altered state of consciousness which paralleled other normal spontaneous changes in consciousness (becoming lost in a daydream, or becoming immersed in reading a good novel). We talked about attentional shift occurring, enabling the person to suspend the usual functions of consciousness, permitting a focus on internal processes. I also informed Ms V of other changes to consciousness which might occur, promoting a relaxation response, suspending critical self-awareness, and reducing vigilant monitoring. She consented to hypnosis.

Ms V was educated about PTSD symptoms and their relationship with hypnotic processes (Evans, 1991, 1994). Dissociation was used to help her “reframe” her current way of coping with intense feelings. Intrusive symptoms were explained as the central symptoms of PTSD. The inherent imagery was “painful, distressing and very absorbing.” Absorption was explained as an involuntary capacity to become lost in internal experiences (Mackay, 1994; Walker, 1994). Ms V was relieved with this, as it removed part of the personal blame and weakness she felt for having nightmares and other symptoms. Relief was promoted further by the information that therapies utilising hypnosis could change this. Hypnosis would be used to promote relaxation, alter intrusive imagery, and promote helpful imagery aimed at change. Ms V was told that therapy was collaborative (Golden, 1989), utilising her ideas as much as the therapist’s.

Ms V’s arousal was caused by cognitive, dissociative, and physiological factors. Cognitions identified were: “I will never be safe again,” “It [rape] will happen again,” “I cannot stop it happening because I am stupid,” “I should have died that night,” and “I deserved it.”

Dissociative symptoms included experience of, and attempts to avoid, flashbacks. The Freddie Kruegger image occurred intermittently. Other dissociative phenomena included seeing or feeling a “shadow” behind her or someone watching her.

Physiological symptoms included heart palpitations, muscle tension, rapid breathing, hypervigilance, and rigidity.

The initial intervention was to develop a “safe place.” Ms V said she felt safest or relaxed when taking a bath in the late afternoons at home, but that she experienced this feeling very infrequently. Reducing arousal symptoms would not be merely remedied by “safe place” imagery. This was conveyed to Ms V to orient her expectations.

Session 6

Ms V felt better since the last discussion and hypnosis was commenced with a modified eye fixation induction with suggested eye-closure. Suggestions to relax with each exhalation occurred. Deepening constituted a 1–20 count. The

induction and deepening were selected for their straightforward simplicity. In trance, Ms V was asked to “spend a few moments getting used to this,” and then feedback was elicited. Slowly, she responded, saying she felt “fine.”

The session was devoted to safe-place images. Given her high hypnotisability, regular feedback was gained. The intention was to monitor and, if necessary, alter any noxious effects. Images were developed through imaginative involvement, with each image coupled with soothing suggestions (knowing the place, feeling OK, letting herself relax). Feedback was received before proceeding to the next image. The initial images were her home, the yard, surrounding bushland, seeing both dogs, husband and sons around the house. Ms V was asked to visualise herself “floating” in the bath (Spiegel, 1994). Positive suggestions were made of feeling warmed by the water, reassured when seeing her bathroom nicknacks, burning incense, flickering candles, and the sunset through the window. Ms V was urged to comfortably lose herself in this reassurance. Her feedback: “I’m feeling wonderful.”

Suggestions were made to relax different parts of her body. This comfortably flowed until her hands were reached. With this, the Freddie Kruegger image appeared at the window. Ms V reacted with tension and fear. She was asked to relate her experience, and she uttered “frightened.” Questioning and therapeutic interventions assisted Ms V, identifying the intensity of the fear, tolerating this, and investigating it. This exposure lasted briefly, with Ms V requesting it to end. She was asked to visualise steam clouding the window and the image growing smaller. Anxiety reduced and the body relaxation recommenced. De-hypnotising used a 20–1 count, with suggestions of bringing the relaxed feelings into the waking state. In debriefing, Ms V expressed ambivalence; feeling positive about the relaxation and pleasant imagery, combined with anger and annoyance with the intrusive stimuli. She experienced visual (flickering candle), kinaesthetic (floating and warmth of bath), and olfactory (incense fragrance) stimuli during trance. The same induction, deepening and de-hypnotising procedure was used throughout therapy.

Session 7

Hypnosis was not conducted in this session. Ms V reported she had experienced intrusive stimuli during the day and nightmares at night since her last session. Despite this, she felt more relaxed, but “hassled” and intrigued by Freddie Kruegger’s image, and expressed the desire to explore methods of alleviating these images. Explanations regarding CBT interventions were given including exposure, desensitisation, or modifying the image (Spiegel, 1994). Ms V became eager to “get” Freddie Kruegger. This idea evoked embarrassment, glee and anxiety in her, and she was cautioned to maintain realistic expectations. She was encouraged to use her absorption capacity by attending to positive stimuli. Absorption as a concept was elaborated, indicating it would work both positively and negatively. Ms V was asked to experiment by focusing on flowers and a

fountain in the hospital grounds. She often found herself “looking at things and not knowing where the time went.” This was exemplified as positive absorption and she was encouraged to consciously use this to lift her moods, rather than using it as an avoidance strategy. The next session was scheduled in two days.

Session 8

Ms V reported enjoying moments of positive absorption. Nursing staff had reacted differently to this, with some viewing her as becoming more isolated.

An hypnotic trance was induced in this session and safe place imagery evoked. The intention was to expose negative images, then alter these according to Ms V’s input. Monitoring through feedback would continue. When asked if she wanted to alter the image, that is, introduce noxious stimuli, she hesitated, then visualised Freddie Kruegger behind the closed window. I suggested she exhale tension by slow breathing and she indicated she was “going up and down.” As Ms V became more anxious, suggestions to tolerate her emotions were given and she was invited to change the image. Slowly, she indicated that Freddie was “now chained to a tree, secure but struggling.” The final suggestion was to feel her achievement. Debriefing included review and reinforcement of her gains.

Session 9

This session took place three days later. No hypnosis was used. Ms V reported feeling good about the last session. Since then, she supported herself by positive visualisation. Although Ms V felt positive and motivated, her symptoms remained unchanged. She introduced new therapeutic material in this session by speaking of her relationship with her father, specifically his tacit coercion. The striking difference was the increase in expressed affect. She shared with me her use of dissociative coping strategies as a child. I highlighted the parallel process with the previous hypnosis session, specifically how her strategies promoted safety as a child, but, being safer now, she was able to express her emotions. These different coping behaviours empowered her to face her perpetrators in different ways as a child and as an adult. She became animated on awareness of the connection. The next session was scheduled for three days later.

Session 10

Since the last session, Ms V had thought things over, perceived pressure from nursing staff, and felt more uncomfortable with Freddie Kruegger. She said it was new for her to feel sad about things in the way she now was. Her sleep was less disturbed. We talked about feeling emotions and grieving losses and she lamented the nurses felt she was doing nothing. The vague and derogatory

weekend nursing notes validated this, indicating a lapse in clinical staff communication. To remedy this, clinical meetings were arranged

Her increase in expressed emotion coincided with more discomfort about the negative image and its recurrence. This was dealt with by two interventions: (a) comments on her beliefs about how much she could emotionally handle and her fear of losing control; (b) agreement to address this using hypnosis.

Session 11

Ms V initially expressed ambivalence regarding this session as she feared recalling experiences, despite needing to come to terms with the issue. Her fears were empathically supported and hypnosis indicated as a method of containing and managing her fear. The session rationale, to enhance control and understanding of the negative image, was explained to her. More information would be accessed by an affect bridge (Gibson & Heap, 1991), enabling abreaction, exploring aetiology, and identifying associated cognitions.

Safe-place imagery was used with a split-screen technique. The safe place was visualised on one screen and the disturbing image on the other. Suggestions of toleration and management of the image and associated affect were made. Through feedback, Ms V guided alternations between the two screens for further control and management. When comfortable control was gained, Ms V was asked to focus on feelings and body sensations generated. She reported fear, revulsion, disgust, and tightness in the neck. This was intensified slightly by counting . . . 2, . . . 3, . . . 4. She was instructed to go to earlier experiences of these feelings. She spoke of the occupational health and safety officer allocated to her case management. She described him as “a sleazy bastard who couldn’t be trusted,” detailing how he regularly asked her out for a date. This information was not given during assessment. She conveyed guilt and anger when stating that she “must have deserved being raped because” of his actions. Her own actions in refusing, then telling her supportive supervisor, and reducing contact were reframed from “defenceless” to self-protective. I tried to help her to re-contextualise the experience, placing emphasis on the OH&S officer’s sexual harassment as his own manipulative behaviour and his responsibility, altering her self-blame to viewing the unfortunate randomness of his selection (Spiegel, 1994).

In trance, Ms V integrated this information and was able to re-attribute responsibility to the other person. The session ended with suggestions of using the new information to help herself. Once out of trance, Ms V elaborated on this experience she had forgotten to tell me. The debriefing facilitated further integration, altering beliefs about blame for the rape. It was agreed to explore this in the next session, three days later.

Session 12

Since the last session, Ms V's use of absorption was continuing well. Intrusive stimuli during the day were fewer, and more manageable. Her sleep remained erratic and only slightly improved. Ms V requested the same trance procedure with the split screen, evoking the affect with improved management, then the affect bridge. The experiences generated — in particular, the rapist's actions which were unpredictable, at times conversant and apologetic, silent, highly agitated or impulsive — still distressed her.

Material from the earlier, more threatening rape also emerged. He had threatened to kill her or her boyfriend if anything was said and stated she “had it coming” to her. I explored the effects of this on her, at physiological, emotional, and cognitive levels. I tried to subtly dispute her beliefs about blame and responsibility. Her concern about the possibility of the rape happening again were reframed as self-protective.

Ms V was asked to consider new thoughts about safety and the possibility of another rape. This prompted silent vexation. Encouragement was given to consider the belief that rape would not happen again as she was safe, but she felt dissonant about this. This was resolved by helping her adopt the belief that she was safe at this time. She repeated this to herself several times, paired with concentration on breathing to promote comfort. The session ended with the safe place screen to stabilise affect.

In debriefing, Ms V spoke about how clear her memories were now, compared with the “fuzzy” ones she had before. She was exhausted but enthused by the session. Next session was in two days.

Session 13

In the time since the last session Ms V felt less agitated. Daytime intrusive symptoms had decreased, but her sleep pattern had worsened. She was aware of nightmares, but had no memory of them. She requested the same hypnotic procedure with the intention of getting in touch with the past and “getting on with it.”

The same procedure swiftly moved from split screens to affect bridge. Ms V detailed family experiences, with affect ventilated towards her father for his behaviour. She expressed anger and sadness at the mixed messages from her father: How she was labelled as “special” and how her father “couldn't help it.”

She then expressed anger and bewilderment to her mother for not knowing the obvious. Ms V was asked to express her new awareness and views to each parent, and she demonstrated tentative changes in her beliefs. The new beliefs were coupled with breathing to reinforce the changes and empower her.

The safe-place screen diverted Ms V from this material and she was asked to recall positive experiences with her parents. This was to promote a complete

perspective (Spiegel, 1994). She initially struggled, but recalled pleasant moments with each parent, which were then projected to the safe-place screen. De-hypnotising and debriefing followed. She expressed mixed reactions to the session, vacillating between feeling freer and more guilty. I empathically supported her, by indicating her awareness of a broader perspective and time restraints which prevented resolution at this session.

Session 14

In the two days since the last session, Ms V's interrupted sleep continued. Although accepting this, she sought support from the night nursing staff. She was fatigued and confused, but okay about the last session. The split-screen technique was again used. Suggestions were made to investigate and tolerate the feelings evoked by the positive and negative images. When comfortable toleration was gained, the images were modified to later events. Using feedback, this shift occurred twice. Images alternated between each rape and the positive images of support from others and herself were intensified by counting 1–5 and coupling breathing.

Sessions 15–18

Ms V wanted to talk things over without hypnosis. Sessions since have constituted typical therapy sessions devoted to further integration of material accessed in hypnosis sessions. As such, therapy could be considered a continuation of the debriefing phase in hypnosis.

Sleep disturbance continued, so her psychiatrist prescribed Tryptanol (amitriptyline), which helped achieve regular sleep. Although she continued to have vivid dreams, the content was no long distressing or traumatic.

Ms V disclosed the abuse to her closest brother. She received another point of view and felt there was understanding. Ms V and her husband have planned a reaffirmation of wedding vows and a second honeymoon. Overall observations and self-reports indicate improvement continuing.

This case study details six weeks of in-patient treatment using hypnosis. In-patient treatment is still continuing and out-patient contact will be negotiated to continue therapy. The IES was readministered at the end of session 18. Her scores had reduced marginally to be in the moderate range. This appeared inconsistent with her self-reports.

In conclusion, hypnosis and CBT were utilised in an in-patient treatment of a chronic complex post-traumatic stress disorder. Treatment response thus far has been positive. Clearly prolonged contact is indicated. The efficacy of this intervention is still unclear as the resilience of change is yet to be determined in a community context.

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OBSTETRIC HYPNOSIS: TWO CASE STUDIES

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This article examines the use of hypnosis in preparation for childbirth. Two cases are described in which a model of obstetric hypnosis was used in psychological preparation for labour, delivery, and postpartum issues. The techniques were utilised over a relatively short period of time and offered significant benefits to the mothers. One benefit was flexibility in terms of helping mothers achieve their individual goals. Other benefits included an increased sense of self-confidence, ability to remain calm during labour, and ease of transition into breast feeding. The role of practice on treatment outcome is also addressed.

There is a substantial body of literature to suggest that the use of obstetric hypnosis combined with childbirth education produces greater benefits to mother and child than either treatment alone. Some of the benefits of hypnosis include reduced medication, decreased perception of pain, higher Apgar scores, and reduced bleeding (Craker, 1992; Harmon, Hynan, & Tyre, 1990; Oster, 1994). Despite the introduction of chemical agents, hypnosis is re-emerging as a viable adjunct to current medical procedures in terms of the physiological and psychological benefits afforded to mother and child.

THE APPROACH

Most models of obstetric hypnosis use a several-session approach over a several-week period (individual or group) to prepare the expectant mother for the labour and delivery process (Harmon et al., 1990; Hilgard & Hilgard, 1994; Longacre, 1995; Oster, 1994). The two cases presented differed from the aforementioned models in that the patients received two individual hypnosis

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sessions on two consecutive days.

The amount of time between treatment and the onset of labour varied. In the first case, the patient received hypnotic sessions two days prior to delivery. In the second case, the patient received hypnosis five weeks prior to delivery. During these sessions both patients were prepared for labour, delivery, and post-delivery experiences. The patients were also given instruction on the use of self-hypnosis (Preston, 1995).

SESSION 1

History was obtained regarding the expectant mothers' previous birth experiences and their attitudes to childbirth. In both cases this was a second pregnancy and delivery. Information regarding their current expectations about labour, delivery, and postpartum experience was also obtained. The patients were then introduced to hypnosis.

Initially a technique was used to help relieve the patients of previous negative experiences associated with childbirth and give them some positive expectations and affirmations (Preston, 1995). This technique involved guided imagery, in which the patients were asked to picture themselves at a blackboard in a classroom writing the sentence, "I can manage my discomfort during labour and delivery." It was then suggested to the patients they picture themselves in a library throwing out all books containing negative thoughts and experiences related to pregnancies and deliveries. They were also given the suggestion to unwrap three books titled: *Success*, *Desires*, and *Health and Happiness*. These books were placed in a prominent spot on the shelf. The patients were then asked to find a comfortable spot in the library and go there for the treatment phase of the session. Hilgard and Hilgard (1994) have suggested testing for depth in hypnosis research. These patients were tested for depth of hypnosis at various times during the treatment using the heavy hand and hand levitation tests. The results of the tests were consistently positive. Both patients appeared to achieve a very deep state of hypnosis.

Once in a comfortable place in the library, the patients were given several techniques for pain management (Longacre, 1995). A direct suggestion was made that touching the forehead by either the patients or their husbands would cause numbness in the midsection and total relaxation, and that a touch by a gloved hand would cause numbing and relaxation to areas such as the vagina (Preston, 1995). The patients were also asked to picture a pressure gauge on the wall that measured discomfort related to pressure on the pelvic region. They could control their level of discomfort by decreasing the numbers on the gauge. Patients were then asked to picture themselves going through labour and delivery in great detail, starting with the onset of labour, the trip to the hospital, arriving on the hospital unit, stage I and II of labour, pushing, and finally ending with breast-feeding. Each was given additional suggestions related to diminished bleeding, numbness in the vagina, peritoneum and abdomen, and rapid postpartum recovery.

SESSION 2

The patients were instructed in the use of self-hypnosis which they practised in the office. They were also taken through the same guided imagery exercise from the previous session.

CASE PRESENTATIONS

Case One

The patient, aged 32 years, was self-referred for obstetric hypnosis. She reported this was her second pregnancy in three years. She had attended Lamaze class prior to her first childbirth. During our initial hypnosis session she recalled several negative experiences associated with her previous pregnancy. Her labour was long, approximately 20 hours, and she had complications during the final phase of her labour, the transition. She received an injection of fentanyl in the lumbar region of her spine (intrathecal) for pain when she was at approximately 5 cm dilation. She reported that the baby got stuck on her pelvic bone, causing extreme pain, affecting her ability to push successfully. After being faced with the possibility of a caesarean she was able to finally deliver vaginally. She indicated that her difficulty was concern about modesty. Several friends were present at this birth watching her cope with labour and transition. She was worried about their impressions of her. The patient reported she had difficulty recovering from this pregnancy and difficulty nursing. The baby would not latch on to the breast, reportedly due to inadequate milk production. The patient's concerns regarding this pregnancy were: being able to push successfully during transition, being able to breastfeed comfortably, and whether or not her 2-year-old daughter would adjust to the new baby. She was also concerned about embarrassing herself in front of her friends by appearing unable to control her behaviour during labour and transition. She exhibited some apprehension which she described as performance anxiety.

Result of Hypnotic Intervention

The patient reported her labour began at home the day following her second hypnosis session. She reported she used the hypnosis successfully to control her discomfort at home. She was unaware of using hypnosis after she arrived in the hospital at 2 a.m., despite her report of being in a trance-like state for the next two hours while her husband touched her forehead. She received her first intrathecal when she was dilated to 4 cm. She described her contractions as very intense compared to her previous labour. She received a second intrathecal at 6.30 a.m. when she was dilated to 8 cm. Subsequently the obstetrician told her to push. Her initial response was to cry and request a caesarean. However, she found a comfortable position and began to push effectively, despite the fact that

the baby became caught on her pelvic bone. In spite of the baby being caught, the patient reported her efforts at pushing were more efficient compared to her previous delivery experience.

The patient reported several experiences that gave her comfort. She said that, while pushing, she felt an increased sense of comfort when the obstetrician put his hand in her vagina and applied pressure posteriorly. She reported achieving comfort when her husband, watching the foetal monitor, made the comment, "The numbers are going down." The patient also reported that the affirmation, "I can manage my discomfort," was helpful in coping with the difficulty of transition.

The patient's husband was present for the labour and delivery. He reported this delivery was markedly smoother than the first and he indicated his wife was calmer and more focused during labour and was more effective when required to push. According to him, the patient seemed more confident throughout the entire process and he was impressed with the results.

The patient reported she had heavy bleeding for one day following delivery and then noticed the bleeding had greatly diminished. Her nipples were very comfortable despite 24 hours of nursing. She received one dose of Tylenol with codeine for the afterpains and used hypnosis to control subsequent cramping. She was surprised to find that she was up and about sooner after this delivery, compared to her previous experience. Her baby boy, she reported, was easy to manage and seemed very calm. The Apgar scores were 7 and 9.

At two week follow-up, the patient reported her baby continued to be very calm and easy to manage. Her milk supply was abundant and her nursing was going exceptionally well. Her 2-year-old daughter was adjusting nicely to the presence of a new sibling.

Case Two

The second patient, a 29-year-old, was also self-referred for obstetric hypnosis. She reported this was her second pregnancy in four years. She attended childbirth education classes and learned the Lamaze technique with her first pregnancy, but reported limited success using this technique. She indicated that once her water broke the contractions began slowly, with low intensity. After six to seven hours of labour she felt intense discomfort and received an injection of Nubain. She pushed for one and a half hours.

Her reason for using obstetric hypnosis with this pregnancy was to avoid the use of medication during and after labour. Her other goal was to have the baby one hour after she checked into the hospital. She used the Bradley method for childbirth preparation (Eisenberg, Murkoff, & Hathaway, 1984). The patient had one complicating factor, which was some abnormal cells on her pap smear. She was given a suggestion to remove the abnormal cells from her cervix. Two weeks later a coloscopy showed no abnormal cells.

Results of Hypnotic Intervention

During hypnosis the patient accurately predicted the date her son would be born. Labour began at home where her water broke. She checked into the hospital at 11.30 p.m. and the baby was born at 1 a.m. The patient reported she was very comfortable until transition, when the pressure became more intense. She felt calm and in control during the entire process and received no medication despite the hospital staff suggesting she might want some. She was pleased that she felt very alert and reported the birth was very easy. During the pregnancy, the patient had expressed concerns that the baby might be resistive to coming out as she had this sense with her first child during transition. This baby seemed to come out on his own as the obstetrician told her to stop pushing toward the end of the delivery. She indicated that two friends who were present during the delivery commented on how she made the labour and delivery look easy. The patient's husband commented on how he had never seen anything like this. He said, "I don't know what you did, but it was incredible."

According to the patient, the baby was calm and relaxed at birth. The Apgar score was 9. She reported that she had very little discomfort postpartum. There were no reported complications associated with breast-feeding. At one-week follow-up, the baby was still calm and easy to manage. The mother's bleeding had stopped and she was feeling comfortable. She felt the hypnosis was useful for both herself and the baby. She had practised self-hypnosis once a day for four weeks prior to her delivery.

DISCUSSION

These cases illustrate the benefit of individualising or tailoring the intervention (Flatt, 1984). In each case the patients used hypnosis in a slightly different manner, according to their goals relative to the childbirth process. In the second case, the goal was pain control without pain medication and a shorter labour. In the first case, the goal was being able to push effectively, control of behaviour during labour, to breastfeed comfortably, and to help her daughter successfully adjust to a new sibling.

Another point raised by these two cases is the role of practice with regard to self-hypnosis and outcome. In the first case, the patient was unable to practise the self-hypnosis to any degree prior to her labour. Despite this, the patient appeared to achieve benefit from the hypnosis on a subconscious level as opposed to a conscious level. In the second case, the patient practised self-hypnosis on a regular basis and appeared to achieve benefit on a conscious level.

The outcomes of both cases illustrate various types of possible benefits afforded to mother and child. Both mothers reportedly had calmer infants. Both experienced a smooth transition to breast-feeding and an increased ability to manage afterpains. Both also reported a rapid and comfortable postpartum recovery.

While medication appears to provide benefits in terms of pain management during labour, it appears to offer little with regard to increasing the patients' self-confidence and ability to focus. Hypnosis appears to offer benefits to the mothers in terms of increasing their ability to remain calm during labour, and increasing their ability to cope with postpartum issues such as breast-feeding, blood loss, and afterpains.

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CONCEPTUAL THEORY OF SELF-HYPNOSIS

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In 1976 I asked Dr Milton Erickson if he could give me some guidance with a most important project — writing my book on self-hypnosis. He thought it was an unusual request from me because we had just finished a day of learning that focused on the value of face-to-face consultations. In order for a client to learn self-hypnosis, which was individualised, the therapist and the client would have to work together. I suggested there could be a book that helped people learn self-hypnosis and individualise it to themselves. Plus, Dr Erickson and I agreed that if a person were interested they could always have a meeting with a professional afterwards or the professional could give them this book for further training.

Since then, I have continued to try to explain how self-hypnosis works to physicians, psychologists, dentists, counsellors, medical students, graduate students, and many thousands of clients. It was during my recent trip to India that I discovered the conceptual theory that I'm introducing to you now. I was instructing meditation teachers about self-hypnosis. Few of them knew about self-hypnosis or hypnosis. I had to describe and demonstrate something of which they had no previous understanding. This was a first for me since most of my teaching is with people who often come in with negative or magical expectations about hypnosis. While I explained to this group that meditation and self-hypnosis are very similar physically, psychologically and emotionally, they differ significantly in their focus. Meditation intends to help a person develop a state of joy, presence, peacefulness, openness, and awareness. Self-hypnosis taps into the same state, but there is also a focusing on a specific goal, challenge, or intention. It is a body–mind experience like meditation. Self-hypnosis is used more as a tool to reorganise thoughts, feelings, patterns, expectations and outcomes. Naturally, in meditation, self-hypnosis and all of life, each person is responsible for their own evolution. We cannot make anybody else responsible and to accept this gives us strength. Self-hypnosis can help create one's own

inner evolution.

The meditation teachers in India were open to learning self-hypnosis but wanted a better definition. I told them what I knew, based on my years of experience.

THEORETICAL IDEAS

The conscious mind wants to stay in control. It knows what it's doing and wants to keep things as they are, very familiar. The conscious mind wants to keep the unconscious mind from taking over (which it thinks of as the unknown). The conscious mind will frequently try to dominate the unconscious mind when it thinks it is in danger of the unconscious mind manifesting itself in an uncontrolled way. The conscious mind represents the known and is usually under control. When we utilise self-hypnosis we are tapping into our unconscious mind, too. Most people believe that they can manage the conscious mind, but opening of the unconscious mind could lead to insecurity and this perpetuates the fear of the unconscious.

This is the conflict: the conflict between the conscious and the unconscious; between the energy that has become manifest and the energy that wants to manifest.

Each individual is unique and has the choice whether or not to evolve. Self-hypnosis is a risk, with the possibility of disappointments, and there are no guarantees on this journey. One person's understanding cannot be given to another. Individuals need to find their own sense of understanding. There are trials, errors, failures, frustrations, and real living that occurs. With self-hypnosis there is growth. Clearly, an individual may simply continue their biological/mechanistic existence and never pursue any kind of individual evolving process. That is one's choice.

Every person develops their own unique wall between their conscious mind and their unconscious mind. As a child, this may have been protective, self-sustaining, and intelligent at the time. But as the person becomes an adolescent (medium-sized kid) or an adult (grown-up-sized kid), the protective wall becomes a barrier and very likely keeps positive potential away more than it keeps problems at bay. The conscious mind, in trying to protect itself and keep itself in control, actually ends up keeping the creative potential of the unconscious mind at a distance. Unfortunately, this means that people try to resolve problems either with their conscious mind (most waking hours) or with their unconscious mind (much of sleeping time in dreams which are often forgotten or discounted). Perhaps, you're beginning to see where I'm going with this self-hypnosis theory: self-hypnosis helps remove the wall/barrier and builds a bridge connecting the conscious mind with the unconscious mind. For the first time in a long time, an individual can benefit from all of their inner resources and their conscious and unconscious, simultaneously and together again.

A harmonious relationship between the conscious and the unconscious can

begin with self-hypnosis. For example, imagine a river that has a wall in the middle of it that is intended to keep two communities apart (which represent the conscious and unconscious). In order to build a bridge that connects these two sides of the river, the wall is gradually removed. Once a longstanding wall is removed, including the Berlin Wall, which surprised the whole world when it came down, a bridge for new communication develops automatically.

As a demonstration of this, I had each of the meditation practitioners go through a six step-process:

1. With eyes open, write down a challenge that you are facing in your life at the present time
2. With your dominant hand, write down everything you can think about while focusing on this problem . . . thoughts, ideas, doubts, etc.
3. With your eyes closed and with your non-dominant hand, communicate everything you feel, and imagine while focusing on this challenge . . . and this may be with shapes, designs, doodling or words.
4. Still with your eyes closed, imagine that you are up on a hill looking down on a bridge that is connecting two sides of a river (like East and West) and it's replacing a wall that has blocked the two sides of the river for years. Now, from this observer perspective without judgment or criticism, and with your non-dominant hand (or with your dominant hand or both hands together), allow your writing utensil to move across the paper as you allow for a dialogue between the conscious mind and the unconscious mind . . . the East side of the river and the West side of the river . . . and everything else that you are able to observe about this transformation from this detached and yet absorbing point of view. Be aware that at any time you need to feel safe, secure, with just enough detachment and perspective, you can always feel free in the observer perspective . . . during this experience and during any experience, as need be. Simply, remember the bridge that you are creating and allow your breathing to re-connect you with this any time. Naturally, your breathing is a bridge between your outermost self, your body, and your innermost self, your awareness. Perhaps, you can notice that your conscious mind and your unconscious mind are thanking one another for their concern and even saying, "I'm sorry for ignoring you in the past." It's possible now for them to tell each other what they believe is important for the other to know. Let them connect closer on the bridge and in your own worlds, saying something like, "I want to come closer and be a friend . . . I never thought about you working for me all those years and I have never thanked you and is there anything that I can do better for you in our future?" Just allow the writing utensil to move across the paper as they dialogue.
5. Next, with your eyes closed, imagine that you are up on what may be the highest hill around and you're looking down at the observer on the hill below that has been observing the bridge that's connecting the two sides of the river. So, you're observing the observer and you're observing the bridge that's

connecting your conscious side with your unconscious side. Now, with both hands together or your non-dominant hand or dominant hand . . . it really doesn't matter . . . your choice . . . and without any judgment, criticism or filtering . . . allow your writing utensil to move across the paper as you describe what you're observing about the observer who is observing the bridge and both sides of the river. Allow the writing utensil to move across the paper as you, from the highest hill point of view, observe what you can about what's going on down there on the bridge as the two sides of the river, (the conscious mind's ideas and the unconscious mind's creativity), connect with one another harmoniously.

6. Finally, as you are getting ready to finish with all this in the next few minutes (and you know you can come back to this experience any time you choose to), re-focus on the rise and fall of your breath. Also be aware that the bridge that connects your conscious mind with your unconscious mind is the key that opens up the wall, removes the barrier and develops the new internal structure for your whole self. You may want to acknowledge that from any observer perspective, this is the master key that can open up all the doors. While you're finishing up and relaxing inside about letting go and going with the flow, keep in mind that the pilgrimage itself is the goal.

The unconscious mind has almost always been in conflict with the conscious mind. The conscious mind has tried to dominate the unconscious mind because it believed it was in danger of the unconscious manifesting itself. The conscious mind is controlled and the unconscious is not. You can manage the conscious but with a burst from the unconscious an insecurity may develop which is the fear of the conscious mind. This is the conflict. The conflict between the conscious and the unconscious; between the energy that has become manifest and the energy that wants to.

Self-hypnosis and hetero-hypnosis open up the whole issue of vulnerability and what is possible. As you approach the bridging the conscious mind and the unconscious mind in a way that is respectful, maintains each individual's dignity and allows for a whole outcome, making friends with yourself like this expands the communicating, caring and relaxation better than perhaps ever before. The building of the bridge can take time and a commitment to the construction.

As an example, on the first day of my five-day workshop in India, a doctor asked me if self-hypnosis might be helpful in helping him manage his anger. He went on to tell me that his younger brother had just died of leukemia and how quickly it seemed that his brother, who was only 19, had gone from healthy to dying. This doctor had always benefited from his meditations when he was unhappy, going through a difficult time, or even been sick himself. This time he was really troubled because he was getting angry with his wife and co-workers, and felt like these feelings were underneath the surface at all times. When I demonstrated the approach described above, he was the volunteer subject. As

one might expect, his meditation experience allowed him to get into a calm, peaceful state very easily. Once he allowed his conscious mind to communicate what it was thinking about his present life situation, he expressed a lot of self-doubt, self-criticism regarding not being a good enough brother, and a variety of negative expectations about his future. His unconscious communication allowed for sadness, tears, anger, and longing for his brother. He also expressed a comfort as if his brother were with him, telling him not to worry, that he was okay now, and that he loved him for all that he had been. The bridge and observer perspective opened up a whole new way of looking at the whole thing. The doctor felt like his own inner therapist was reminding him that he could choose to be afraid of living now or he could be free and evolve with all that was happening to him and his family. He was able to realise that if he stayed stuck in the fear of living he would be a slave. He would not have to be responsible and this could even become comfortable. This could be less of a burden. Then, he made the choice to be responsible and it was time now to deal with the struggle. He could see that he alone was responsible and there was no escaping this. He did not want to postpone the problem or deny the responsibility. In all of this he felt courageous for the first time in a long time. He felt more comfortable being expressive and it was described as a “positive force.” He finished the process with a sentence about his choice as being totally his responsibility.

Self-hypnosis can open up the doors of inner evolution including: listening to your inner wisdom (both logical and poetic), learning to deal with all sides of oneself (female, male, aggressive, receiving, open and waiting), reorganising the way you experience yourself and situations (in friendship, work, love, or problems . . . when in doubt, go deeper), living in the present and stopping the past from controlling you now and in the future (with awareness and courage dealing with the predetermined and the undetermined ways of life), and accessing personal resources to overcome denial, boredom, imbalance, or any vicious cycle (each of us must grow like a tree – in all directions – if we grow in only one direction we are bound to be in deep difficulty). Naturally, there are unlimited applications for self-hypnosis, especially as we learn to accept ourselves as a whole human being. And we remember that the pilgrimage is the goal.

Thank you for your openness in accepting your conscious mind’s ideas and your unconscious mind’s creativity. Together, you are able to utilise all of your resources with any issue, any time you choose.

CASE NOTES

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

USING ERICKSONIAN HYPNOSIS AS A TRAINING TOOL

Kathryn Gow

Psychologist

The promotion of certain Ericksonian techniques through the NLP community has led to hypnosis being utilised, for the most part very successfully, in NLP training programmes. The following scripts are examples of unconscious reviews that trainers can utilise to pull together the learning of the day, for example, in an NLP trainers' programme.

In the following scripts, NLP trainers' terminology is embedded in the language. The scripts are delivered by trainers at the end of a session, day or programme, to summarise what has been learnt within a specified time frame. NLP terminology is packed into the body of the script.

Trainees report that such scripts, delivered while in a light to medium trance state, are powerful facilitators of their learning and increase their recall of the content and integration of the course material.

The underlined words indicate the main NLP techniques or messages that are incorporated within the general theme of positive thinking and ego-strengthening. These underlined words are commands to be emphasised. The names of the techniques are listed at the beginning of the scripts for readers' information. Those of you who are familiar with NLP terminology will recognise the subtlety of the suggestions.

You will note that two dots (..) are used to indicate the blurring of one message into the other.

Script 1 contains references to NLP and Ericksonian concepts and is the simpler of the scripts. The concepts, heavily embedded in Ericksonian language, covered in Script 1 are: the swish technique, transformational search, the self-edit, Bateson's logical types and general Ericksonian language.

Script 2 contains more NLP concepts to be reviewed: parts integration, Bateson's logical types, Bateson's distinctions, Rossi's and others' neurological connections, Dilt's belief changes, calibrations, physiological shifts, submodalities, drill, the swish technique, Bateson's ecology, the magic of Erickson, Tad James' time line therapy, secondary gains, Clare Graves values, identity change, metaphors, principles and rules, the circle of excellence and the Milton model.

USING THE MILTON LANGUAGE AS A FACILITATOR OF LEARNING

Script 1: Self-Esteem as a Trainer

Outcome: For trainees to review the day with insight and understanding as they build their self-esteem.

As you prepare to review your learnings today with insight and understanding, you may swish to close your eyes and relax or you may prefer to sit in your chair very comfortably with your eyes open and fixed on one spot and go into a trance whichever way you prefer to do it .. your way (that's right) and if you wish to transform your search, you can go in and out of trance during your edit, then you can allow your conscious and unconscious mind to come together to produce the most useful insights for you to feel good .. that you have now come a different way along the path that you have chosen to follow .. your inner voice which may have one special message about your learnings which is highly significant for you..r integration is occurring now at a deeper level than before you leave soon with the special gift that your unconscious mind is now giving you, because you are special, as there is only one of you, and if you are a logical type, then you know that it will depend on the quality of accessing which distinctions you can now make about how brilliant you really are.

And it's a good thing to value the possibilities of making the changes that you have, or have not, allowed to occur, at a neurological level, to a time

in the future when you are standing up in front of people who need to change beliefs about learning, and you can calibrate the shifts in submodalities because you have let go the blocks and refined your drill to such a special tune that you can almost hear the swish of your hands as those powerful parts of you come together to make changes so the ecology of your being is in time with the cosmic play that you can not not prevent yourself from finding joyful as you open your eyes now and anticipate with clarity new ways of bringing more magic into your life.

Script 2: The Milton Model, Learning and NLP Training

Outcome: For participants to confirm that they are more confident and comfortable in changing their identity to that of an NLP trainer.

As you now prepare to model Milton and conduct a self-edit on your insightful strategies employed today, notice that you can not resist making your chair feel comfortable by being totally entranced by what you have learned .. a lot and changed your identity to that of an NLP trainer and you already know what to do, didn't you.

A part of me is wondering if you are completely comfortable now because that means that you can make more and more new neurological connect .. your mind and body in such a way from old patterns that resisted you and violated your integrity is of value and I know that a part of you wants to ensure you preserve the learnings from all of these experiences and let go of the emotions, so that you block out the old picture and swish into your new identity with distinction.

As you turn up the volume on the voice of your inner wisdom, you can know just how logical it is to type the Clare Graves levels of value .. your own progress because that means that you can calibrate towards success and you may negotiate your gains with a secondary part of you that is critical to finer distinctions, didn't you.

As I spoke to Judy yesterday about this feeling of taking a flying leap, she said that apart from experiencing how to fly, you can enjoy landing safely on the other side and notice you have survived this metaphor of let .. ting go your old identity, didn't you. As you say "me too!!", you can observe the playful ecology of your principles as the creative design of the universe empowers you to process the content and structure your play in alignment with your circle of excellence and you can not not know your outcomes and when you are ready, open your eyes to the models surround you.

RECOMMENDED READING

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BOOK REVIEWS

From Mesmer to Freud: Magnetic Sleep and the Roots of Psychological Healing. Adam Crabtree. New Haven: Yale University Press. 1993. x + 413. US\$45.00 + postage and handling; hardcover.

The history of hypnosis, with its roots in the practice of Franz Anton Mesmer and the French Mesmerists, is a source of deep fascination for me. So, given the opportunity to review a book on the history of hypnosis has been a great opportunity to indulge.

The main theme of *From Mesmer to Freud* is obviously not a new one. Crabtree basically argues, along the lines of Ellenberger (1970), that psychiatry and psychology owe an unacknowledged debt to hypnosis and mesmerism as the fundamental sources of subsequent psychological theorising and research. However, Crabtree goes on to introduce masses of original source material that really seems to capture the concepts and questions that were current for the historical periods he covers. In many ways it would appear that Crabtree is trying to cover ground that has been left a bit bare by earlier historical references. In doing so he has taken on a massive task.

From Mesmer to Freud is organised in four parts that appear to loosely follow the historical development of hypnosis from magnetic healing to mesmerism to magnetic sleep. Crabtree intends to trace the basis of many modern psychological concepts in the earlier work of the magnetisers. Indeed, he seems to be deeply enamoured of mesmeric history and it is easy to become overwhelmed by the amount of detail he provides on the early mesmerists and their cases. Overall, Crabtree spends considerably less time on the practitioners of hypnosis than the mesmerists. This is not such a bad thing, insofar as the detailed history of Mesmer and his followers seems to have become increasingly marginalised and mythologised in the history of hypnosis. But some of the book becomes a repetitious presentation of case material as Crabtree minutely traces the contribution of mesmerism to psychological concepts, mind–body issues, spiritualism, and several other topics.

Crabtree explains that his approach to historical research is to avoid the “error” of presentism. Presentism is the practice of interpreting historical documents and events within the sociopolitical context of the present day. Crabtree sees this as an error in that it does not take into account the context within which events occur. To my mind, however, this suggests that Crabtree should endorse a position of analysing documentation within its historical

sociopolitical context. But the major weakness of his book is its almost total lack of analysis. There were very powerful societal and professional forces arraigned against the practitioners of mesmerism and hypnosis, yet Crabtree fails to analyse the factors and issues that led to the various twists and turns in the fortunes of hypnotic practice. Rather, he presents the material that tells the story without trying to set the scene. I found this very unsatisfying as I think Crabtree has taken an erroneous position in trying to be objective by presenting history as the source material by itself. I doubt that it is possible to be objective in relation to anything. Further, I feel that unless we analyse historical records from an understanding of the broader context of that period, it is not possible to tease out the whys and wherefores of the production of information. This is very important in the history of science, which is especially clouded by its mantle of scientific “objectivity,” “rationalism,” and “truth.”

In relation to this Crabtree highlights an interesting question that nobody appears to have properly explored. Whatever happened to the practice of mesmerism? From Crabtree’s presentation it would appear that it was transformed into spiritualism and largely disappeared in medical and psychological circles. This is a fascinating example of the political avoidance of a therapeutic practice due to its association with so-called “unscientific” superstition. Even today there are only two references to using mesmeric “technology” and I could only find one of these (Pulos, 1980). But Crabtree really fails to explore any of this in detail.

In general, *From Mesmer to Freud* is a well-written book with a fascinating tale to tell. There is probably too much detail and repetition to make it a really great book but it is stimulating in its own right. Crabtree could certainly have got away with producing several volumes of information. I would be inclined to read any subsequent volumes he produces because he is an apparently meticulous and careful historian, despite my disagreement about his philosophical approach to his task.

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ALISTAIR CAMPBELL, Clinical Psychologist, Launceston General Hospital

BOOKS AVAILABLE FOR REVIEW

Members of the Australian Society of Hypnosis interested in reviewing books should apply to the Editor. Reviews are subject to editorial review prior to publishing.

Robert G. Kunzendorf,
Nicholas P. Spanos,
& Benjamin Wallace (Eds.)

Hypnosis and Imagination. Amityville, NY:
Baywood Publishing, 1996.

Larry K. Michelson, &
William J. Ray

*Handbook of Dissociation: Theoretical,
Empirical, and Clinical Perspectives.* New York:
Plenum Press, 1996.

Karen Olness, &
Daniel P. Kohen

Hypnosis and Hypnotherapy with Children.
(3rd ed.). New York: Guilford Press.

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Experimental Hypnosis**

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