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CLINICAL AND EXPERIMENTAL HYPNOSIS**

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EDITORIAL

As I write this editorial, the 28th ASH Congress and Workshops, held in Alice Springs and at Ayers Rock Resort, 9–16 September, is now becoming a memory. Reports from those in attendance were consistently to the effect that the Congress ran smoothly, was an educational success, and facilitated touring and social activities in the Red Centre. When planning for the Congress began in late 1996, I was aware that the Society was taking a risk in holding its annual conference away from a capital city (from where it could draw upon a resident population of members for registrations) and in a remote location which required all registrants to travel, pay accommodation and other costs, in order to attend and participate. I believe the risk was well worth taking, both in financial and societal terms

While audited accounts of income and expenditure for the Congress have not been completed at the time of writing, as Congress Chairman I expect that the 28th Congress will have covered all expenses. More importantly, I believe the Congress and its success have done much to promote the Society and to further the aims of the federal body.

Each branch of the Society was represented at the Congress. Bringing registrants together in the heart of Australia was always my intention and, in so doing, the Congress fostered the view that the Society is a *national* hypnosis organisation with branches in every state. Such a national view runs counter to the view that ASH is a body centred in Victoria, or even worse, nothing more than a constituent part of the ISH that happens to be located in Australia. The Society is an *Australian* professional organisation which exists to promote the safe professional use of hypnosis by appropriately trained professionals. The Society exists to serve the needs of its members and to ensure the community receives only the best when hypnotically based therapies are used by health professionals and I will continue to do what I can to see that the Society serves its membership and the community first and foremost.

Links with other national hypnosis organisations and with the international society are important — they contribute to the credibility of the Society, and expand and develop the knowledge and skills of members of ASH through national and international contacts. However, the professional needs and interests of members of the ASH must remain the primary focus of our federal and branch committees if the Society is to succeed and advance nationally and retain its national pre-eminence in hypnosis training and education

Changes to Editorial Staff

In June, Ms June Simmons, my Editorial Assistant since 1993, resigned due to work pressures. I thank June for the time and effort she gave to the journal and her contribution to the editorial process. She possessed the ability to take manuscripts and turn them into literary works which made sense! June is sorely missed.

Our new Editorial Assistant is Ms Brenda Burr, who comes to the position from Melbourne University of Technology. Part of Brenda's duties in that position was that of editorial assistant for a music journal. She has already demonstrated her capacity to fulfil the duties of her new position and I look forward to working with her.

The current Associate Editors for the journal took up their three-year term in 1995 and, with the end of that term, I have made some changes to staffing. To promote as widely as possible the view of ASH as a *national* society, I have invited Kathryn Gow, PhD, from the Queensland University of Technology to join the Associate Editorial team. Kathryn comes to the position with an extensive background in psychology, research, and editorship.

Also joining the editorial board is Graham Wicks, MBBS, DObstRCOG, FRACGP, from the Women's and Children's Hospital, Adelaide. Graham is a medical practitioner renowned nationally and internationally for his work with hypnosis and he will make an excellent contributor to the work of the journal.

Another addition to the editorial staff of the journal is the appointment of Alistair Campbell, MCLinPsych to the position of Abstracts Editor. Alistair will be responsible for collating and preparing abstracts of the current literature, which will be published as a service to members of the Society in the bi-annual *Federal Newsletter* of the Australian Society of Hypnosis.

Reflecting the increasing cooperation and collaboration between the journal and the Board of Education of the Society, I am pleased to advise that the Board Chairman, Professor Graham Burrows, AO, KSJ, MD, has agreed to take up the role of Chief Editorial Consultant for the journal. Graham has been a valuable member of the Editorial Consultancy team for some time, together with some notable international practitioners and researchers, and I look forward to input from him and greater collaboration with the Board of Education in advancing the educational goals of the Society. The most recent publication of the journal, described below, attests to the productivity of our collaboration to date.

Hypnosis in Australia

I am proud to have conceptualised, realised, and published *Hypnosis in Australia*, the most recent clinical handbook published by the journal. Originally conceived as the proceedings of the 28th Congress, *Hypnosis in Australia* became much more — an up-to-date review of theory and clinical practice in many applications of hypnosis in therapy. You will find the complete contents detailed at the end of this issue of the journal and members of the Society will have recently received a brochure describing the book. I recommend it to you and hope that you will support your Society by purchasing a copy.

New Subscribers from New Zealand

I am delighted to advise readers that, commencing with the May 1998 edition, the journal is now read by over 50 members of the New Zealand Society of Hypnosis. The journal entered into an arrangement with the NZSH to provide a bulk mailing of each issue of the journal to a New Zealand address and to then have the individual subscriptions mailed out locally. I welcome readers from New Zealand and invite each to consider submitting manuscripts for inclusion in the journal.

Collaborative Arrangement with *Contemporary Hypnosis*

I also wish to invite subscribers to consider a subscription to *Contemporary Hypnosis* (formerly the *British Journal of Experimental and Clinical Hypnosis*). By special arrangement with the Editor, Dr David Oakley, and the publishers, subscribers to *AJCEH* can subscribe to *Contemporary Hypnosis* at a special discounted rate (see details later in this issue). Subscribers to *Contemporary Hypnosis* will also be able to subscribe to *AJCEH* at a discounted rate (members of the Australian Society of Hypnosis currently receive *AJCEH* as part of their membership of the Society).

AJCEH subscribers and ASH members wishing to subscribe to *Contemporary Hypnosis* should write to Whurr Publishers Ltd, 19b Compton Terrace, London N1 2UN, United Kingdom (tel 0171 359 5979; fax 0171 226 5290). *Contemporary Hypnosis* is published four times a year for the British Society of Experimental and Clinical Hypnosis.

Barry J. Evans
University of Melbourne
November 1998

THEORIES OF HYPNOSIS: DO THEY MEET KUHN'S CRITERIA FOR THE EVALUATION OF SCIENTIFIC THEORIES?

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According to Kuhn's (1977) criteria for evaluating scientific theories no one theory adequately explains hypnosis. Initially it seems as if theories of hypnosis are still pre-science because the scientific community has not yet selected one paradigm to the exclusion of other paradigms. Within the terms of Kuhn's theory this indicates that the theories of hypnosis have not yet entered the stage of normal science and the real work of science has not yet begun. However, it can be demonstrated that the real work of science has been occurring in the field of hypnosis for many years, and that there are valid reasons for the abundance of theories purporting to explain hypnosis. An alternative view, which will be presented in this paper, is that the theories of hypnosis are all part of the same paradigm and that hypnosis is, in fact, in the stage of normal science.

Hypnosis has been part of human experience for centuries and has a modern history of over 200 years (Bányai, 1991). Since the time of Franz Anton Mesmer (1733–1815) hypnosis has been investigated extensively and many theories have been proposed to explain the phenomenon. In the following paper, theories purporting to explain hypnosis will be evaluated, using Kuhn's (1977) criteria for the evaluation of scientific theories. While only three major theories will be evaluated, these are representative of the general range of theories of hypnosis.

CRITERIA FOR EVALUATING SCIENTIFIC THEORIES

Laudan (1977) proposes that the central test of any theory involves assessing its adequacy as a solution for certain empirical and conceptual problems. To test whether a theory is an adequate explanation of hypnosis phenomena, it is necessary to have some criteria which can be applied to a theory in order to assess its adequacy. A number of criteria considered significant have been stipulated in the philosophy of science literature and, although there is contention regarding which of these are most important, such a debate is not the purpose here.

Kuhn (1977) proposed five criteria which he considers as standard for evaluating theory adequacy

1. Accuracy: A theory should be accurate within its domain and the deductible consequences be consistent with experimental results and observations. It follows that a theory must have testable assertions and be falsifiable. The predictive and explanatory power of a theory are dependent on this criterion.
2. Consistency: A theory should have internal consistency and also be externally congruent with other accepted theories pertaining to related phenomena.
3. Scope: The consequences of a theory should extend beyond the particular observations, laws, or sub-theories it was designed to explain.
4. Parsimony: A simple, parsimonious theory should unify phenomena that would in its absence be confused and isolated.
5. Fruitfulness: To be fruitful a theory should stimulate new research findings and disclose new phenomena or previously unnoted relationships.

THE HYPNOTIC STATE AND PHENOMENA

Explanations of hypnosis have ranged from it being a sleep-like state, to a trance state induced by magnetism (Mesmerism). Reber (1985) has defined hypnosis as follows:

- a. although it [hypnosis] superficially resembles a sleep-like state, the EEG pattern does not resemble any of the stages of sleep;
- b. normal planning functions are reduced, a hypnotised person tends to wait passively for instructions from the hypnotist;
- c. attention becomes highly selective, the individual may hear only one person to the exclusion of others;
- d. role-playing is readily accomplished, the hypnotised person frequently becoming thoroughly immersed in a suggested role; and
- e. post-hypnotic suggestion is often observed, frequently a specific amnesia where the subject cannot recall things he or she has been told to forget. (p. 334)

Reber notes that these effects are all characteristic of a person who has

voluntarily given up conscious control, and therefore shows extreme suggestibility. A further observation that needs to be included in Reber's definition is that, although the state of hypnosis is usually induced by another person, self-hypnosis is possible.

The phenomena of hypnosis can be divided into two broad categories; (a) the observed behaviour, and (b) the subjective experience (Rowley, 1986). The observed behaviour includes such phenomena as hidden observer, non-volition, hypnotic amnesia, and hypnotic responsiveness.

The hidden-observer phenomenon is the name given to that part of an individual's consciousness which is aware of the suggested unseen, unfelt, or unknown aspects of hypnosis. This part of the subject's consciousness seems to require the permission of the practitioner to become conscious.

Non-volition refers to the compliance of the hypnotised individual, seemingly without the individual's conscious intention. When it is suggested to a subject that their arm is rising, and the arm rises, hypnotised individuals often report that the arm rose of its own accord. There is a broad range of responsiveness across individuals from low to high, which within individuals is stable over time. Controversy exists as to whether this stability is an individual trait and whether it is modifiable.

Hypnotic amnesia may occur as the result of direct suggestion. Specific suggested events or periods of time or the entire hypnotic experience may be forgotten. The suggestion to be unable to remember something after hypnosis is terminated is given to the subject while in the state of hypnosis. This is known as post-hypnotic suggestion. Hypnotic amnesia may also occur spontaneously.

Finally, there is the subjective experience of hypnosis that needs explaining. In some theories the subjective experience is given little importance, while in other theories it is incorporated as an integral part of the theory.

THEORIES OF HYPNOSIS

Theories of hypnosis may be categorised into single- or multiple-factor theories (Lynn & Rhue, 1991a). The dissociation theories are in the single-factor category and the sociocognitive, role-theory, integrative, and ecosystemic approaches are in the multiple-factor category. A third category is the interactive-phenomenological approach which includes the synergistic, contextual, social-phenomenological and social-psychobiological theories (see Lynn & Rhue, 1991a for a review). Lynn & Rhue describe this compilation of theories as a heuristic framework. Although many of the theories overlap, two major perspectives can be identified, the dissociative and the sociocognitive perspectives (Bowers & Davidson, 1991). These two perspectives view hypnosis in fundamentally different ways. The social psychobiological theory from the phenomenological approach will also be reviewed. This third approach employs some of the factors from the neodissociation and the sociocognitive theories but in addition includes a phenomenological-interactive component.

Neodissociation Theory

Neodissociation is a single process theory which maintains that a single process, trait or mechanism is at the heart of the hypnotic phenomena (Lynn & Rhue, 1991a). Dissociation is the loss of familiar associative processes of consciousness. The theory proposes that, under certain circumstances, lower levels of conscious control can function in a manner that are dissociated from higher levels of conscious control. Some examples of this are as follows: in sleep people do not fall out of bed; can respond to a baby's cry; and awoken to the pressure of a full bladder. The subsystems of consciousness remain responsive to locally significant information. Although each of these actions serves a purpose, it is not necessarily performed on purpose, which implies a conscious intention to perform an action. A sleeping subject cannot have this conscious intention, therefore the action is not consciously performed.

Hilgard (1991) proposes that hypnotic suggestions can more-or-less directly activate these subsystems of control which are then temporarily dissociated from intentional volitional control. Hilgard, who is the major proponent of the neodissociation theory, initially offered a developmental-interactive theory. The developmental component referred to the innate propensities which exist within an individual and the modification by early social interactions with parents and others. By interactive it was proposed that the propensities for hypnosis acquired in the interaction between nature and nurture still had to be capitalised upon through appropriate current interventions if the hypnotic potential were to be realised.

Neodissociation theory defines hypnosis as an altered state and this conception is a source of controversy. Currently, Hilgard (1991) prefers to think of state as simply a different state from awake (cf. drunkenness or sleep). The hypnotic state is not an all or nothing change from the waking state as there can be partial dissociation which is termed gradualism.

According to Hilgard (1991) three assumptions underlie neodissociation theory:

1. There are subordinate cognitive systems, each of which has some degree of unity, persistence, and autonomy of function and these systems are interactive but can become isolated from each other as in hypnosis;
2. A hierarchical control manages the interaction or competition among these cognitive systems; and
3. There is a monitoring or controlling structure.

Sociocognitive Theory

The traditional view of hypnosis has been the dissociation theory. The sociocognitive theory (Spanos, 1991) challenges some of the basic assumptions of this traditional view. The main assumption challenged is that hypnosis is an altered state of consciousness and that it occurs in highly hypnotisable

individuals. Subjects who are easily hypnotised and respond better to suggestions are known as highly hypnotisable or highly responsive.

According to Spanos (1991), although hypnotic behaviours assume a non-ordinary appearance they are fundamentally similar to other more mundane forms of social action and therefore it is not necessary to resort to special psychological states or processes in an attempt to explain these behaviours. The theoretical concepts and principles of Spanos's (1991) sociocognitive theory are that individuals are sentient agents who are continually involved in organising sensory inputs into meaningful categories or schemas which are used to guide actions. Hypnotised individuals are agents who are attuned to contextual demands and guide their behaviour in terms of their understanding of situational contingencies and of the goals they wish to achieve (Spanos, 1989).

Interactions among people usually proceed smoothly because people know what is expected of their common situation and their reciprocal roles. These interactions proceed through mutually negotiated self-representations and reciprocal role validation. This form of role enactment is rule-governed. That is, there is a tacit understanding among individuals of how the situation is defined and the behaviours that are considered appropriate to the definition of the situation. Responding is context-dependent and in the hypnotic situation the subject's behaviour is not only dependent on their understanding of their situation as a hypnotic subject but upon their willingness, their interpretation of the ambiguous communication that constitutes hypnotic test situations, their abilities to generate the imaginal and other experiences called for by the suggestions; and, finally, by how the feedback from the practitioner of hypnosis and from their own responding influences the definitions they hold of themselves as hypnotic subjects. Therefore, hypnotic behaviour is not unusual because of its causes but because the situation calls for unusual behaviour (Spanos, 1991).

Social-Psychobiological Theory

Éva Bányai (1991) integrated interpersonal and intrapersonal aspects of hypnosis into a multi-dimensional framework known as the social-psychobiological approach. This form of understanding of the central mechanisms of hypnosis is a reaction to the debates, over the past three decades, of state versus trait, cognitive versus social, and subject-centred versus practitioner-of-hypnosis centred explanations (Bányai, 1991). Bányai conceptualises hypnosis as an altered state of consciousness that may have adaptive value. This state arises in a special social context as a result of reciprocal interactions between the subject and the practitioner of hypnosis. Hypnosis, according to this theory, is influenced by personal characteristics and physiological predispositions of both the subject and the practitioner of hypnosis, which includes their attitudes, expectations, characteristic cognitive styles, and relationship with each other. Physiological, behavioural, and

subjective experiential modifications which accompany the process of inducing and testing hypnosis are also influential. Within the context of this theory, hypnosis is an ever-changing process and seeks to delineate the interdependence of diverse elements of the practitioner of hypnosis and subject interaction. Bányai also rejects the search for linear causal relationships as simplistic and ultimately fruitless.

The altered state of consciousness as proposed in this theory is not a total change from the waking state, but it is more like a fuzzy set, as in concept formation (Bányai, 1991). This is helpful in delineating the family resemblance of hypnotic phenomena, which converge in their being accompanied by perceived alterations in experience. In this way, Bányai suggests, the hypnotic state is no more ill-defined than the way natural concepts are organised in everyday life. It simply helps to serve the function of organising our knowledge of hypnosis.

An essential feature of the social-psychobiological approach is the subjective experience of altered consciousness (Bányai, 1991). One reason for focusing on the subjective experience is that, although the subjective experience and responsiveness to suggestion often correlate, there are occasions where they diverge. The emphasis on the role of social context is felt to be important as no other altered state of consciousness exists that is so closely related to an interaction between two persons. This highlights the importance of the practitioner of hypnosis and subject relationship not only at the current level of personal attraction but at the deeper, more archaic patterns of relating to another person. Archaic patterns of relating refer to the past relationships of both the practitioner and the subject and how they may influence the current relationship on a deeper level. For example, if the practitioner's personality or mannerisms reminded the subject of his/her father with whom s/he had a poor relationship, then this is likely to interfere with the necessary establishment of a good rapport between the practitioner and the subject. The term reciprocal interactions is used because this theory is opposed to the traditional view of a passive subject and an active practitioner. Both the subject's and practitioner's behaviour affect each other in a recursive fashion. Unfortunately this focus on the interactions between the practitioner of hypnosis and subject does not allow an analysis of self-hypnosis.

Physiological mechanisms may bring about somatic as well as behavioural and experiential changes during hypnosis (Bányai, 1991). Therefore, physiological concomitants of individuals who vary in hypnotisability are of interest. This theory also highlights the role of personal characteristics and physiological predispositions of the interactants. The personal style of the practitioner of hypnosis is considered important and this is generally overlooked in other theories.

Bányai (1991) suggests an adaptive value for hypnosis which has existed for thousands of years. She postulates that perhaps hypnosis modulates psychic tension and facilitates the acquisition of new experiences and insights by

engaging the participants in an intensive interpersonal relationship without undue risk to themselves or others. In this way hypnosis helps the participants function more adequately, constructively, and creatively in the social-biological milieu.

APPLYING KUHN'S CRITERIA TO THEORIES OF HYPNOSIS

Accuracy

The most obvious problem with the accuracy of neodissociation theory is that it is not made explicit how or why dissociations occur. Hilgard (1991) states that appropriate current interventions are necessary to realise the hypnotic potential, but what these appropriate interactions are or how they cause dissociations is not made explicit. It is not stated whether it is the presence of the practitioner of hypnosis, the social context, the induction, or some other intervention which is the cause of the dissociations. For example, the hidden observer is explained by this theory as dissociations in the mental structures. Without specifying how and why dissociations occur, it is not clear how this aspect of the theory can be directly tested or refuted.

In contrast, the sociocognitive theory explains the hidden-observer phenomenon as goal-directed responding on the part of the subject. Spanos, Flynn, and Gwynn (1988) gave subjects a negative hallucination and subjects were then shown a page with the number 18 printed on it. Half of the subjects who reported a blank page were given standard hidden-observer instructions; that the hidden part knew the number, and half were told that the hidden part reversed everything it saw. All of the subjects in the standard condition reported an 18 and all in the reversed condition reported an 81. Spanos et al. (1988) suggest that, rather than reflecting hidden information that could not be accessed, these reports indicate that subjects use contextual information to generate enactments that are congruent with their beliefs. The results of this experiment support the sociocognitive theory but do not refute the neodissociation theory. The subjects may have dissociated, through the information available to them via the instructions in the reverse condition. These instructions may have served the same purpose as allowing the subjects to access dissociated information. Unfortunately this cannot be easily tested and therefore poses a problem for the neodissociation theory.

Neodissociation theory satisfactorily explains the experience of non-volition, and gives examples from everyday life to illustrate the process of dissociation. The subject experiences non-volition because the intention or control which ordinarily reflects executive control over behaviour is minimised or bypassed when a hypnotised subject enacts the suggested state of affairs (Hilgard, 1991). An everyday example of the activation of a control subsystem is when people dial a more familiar but incorrect telephone number.

The sociocognitive theory offers a poor explanation for this phenomenon.

The subject's reports are not taken at face value (Spanos, 1991). It is implied that the subject is mistaken in interpreting their behaviour as non-volitional and that the subject is not competent to judge. When the behaviour is consistent with what is asked of the subjects, the interpretation is that they actively, purposefully and with volition achieve the experience, regardless of how the subjects report and experience it. Spanos (1986a) reinterprets subjects' reports of non-volition as contextually cued interpretations which are made by subjects about behaviours that are, in fact, purposeful, goal-directed actions. An everyday example offered by Spanos (1991) to clarify this issue is when individuals misrepresent their private experience to facilitate smooth interactions. This can be viewed as problematic because in the everyday situation individuals are usually aware of misrepresenting their experience, whereas in the hypnotic situation the experience is actually felt as non-volition. The main problem with the sociocognitive explanation is that it conflates goal-directed behaviour and behaviour that is non-volitional. It implies that hypnotic behaviour is goal-directed and therefore volitional, whereas the neodissociation theory accepts that behaviour can be goal-directed and experienced as non-volitional which does not deny the experience of the subject.

The neodissociation and sociocognitive theorists offer alternative explanations of hypnotic amnesia. It is proposed by Spanos (1991) in the sociocognitive view that hypnotic amnesia is a successful attempt to forget something while the neodissociation view is that it is a failed attempt to remember something (Bowers & Davidson, 1991). The wish not to remember is to present oneself as a deeply hypnotised individual, and therefore forgetting is a voluntary act. Spanos (1991) experimented with highly hypnotisable subjects to force them to breach hypnotic amnesia by fooling them into believing that they were having a lie detector test which would reveal all that they knew. These subjects breached amnesia easily when it was the expected response of highly hypnotisable subjects. Therefore, it was concluded that they had voluntary control over their memory processes and only lied initially because they did not want to compromise their self-presentation as hypnotised subjects. Spanos does offer the suggestion that the subjects may not have actually lied but that they convinced themselves that they could not remember.

A contradiction and methodological problem is that Spanos (1991) uses a specific principle of encoding to explain the retrieval of a forgotten list or chunk of words learned earlier in the session. For selective retrieval of forgotten specific numbers or words within a list, Spanos suggests that subjects need to use a totally different strategy. Spanos's reasoning for the necessary use of these different strategies is that attention to relevant retrieval cues does not ensure successful recall of words selectively targeted for amnesia, only for chunks or entire list amnesia.

In contrast to this view, neodissociation theorists Bowers and Davidson (1991) state that, in its fully realised form, post-hypnotic amnesia resembles the social situation when we forget a friend's name (whom we would like to

introduce) even with the salient cues of our friend's physical presence. Schacter (1989) explains that hypnotic amnesia activates this kind of forgetting as the output of an activated memory does not necessarily activate consciousness of that memory if activating information and activating consciousness are separate and distinct processes. A further neodissociation explanation of this phenomenon is that there may be a temporary breakdown of specific mnemonic mechanisms that ordinarily generate access to memories and represent them in conscious experience (Hilgard, 1991).

Although the neodissociation theory offers a deeper and more satisfactory explanation than the sociocognitive theory, it is difficult to empirically test and falsify. The sociocognitive theory denies the subject's experience as an integral part of the explanation, as well as being inconsistent and encountering methodological problems.

The social-psychobiological theory does not offer any detailed explanations of the hidden-observer, non-volition, and hypnotic amnesia phenomena. Four assumptions underlie the social-psychobiological theory: (a) Hypnosis is a socially altered state of consciousness; (b) It has adaptive value; (c) It occurs in a special social context; and (d) It relies on reciprocal interactions between the hypnotic practitioner and the subject (Bányai, 1991). To obtain an explanation of the above phenomena, one would have to extrapolate from these four assumptions. Adaptive value is a functional explanation and as such is not amenable to empirical testing. Bányai suggests that mutual attunement of the practitioner of hypnosis and the subject is like being on the same wavelength which characterises close relationships that have a crucial role in the maintaining of comfort and optimal arousal level of the organism (Field, 1985).

While the above omissions pose a problem for the social-psychobiological theory, this theory offers explanations in areas which are not covered by the neodissociation and sociocognitive theories. These are interaction synchrony and the style of the practitioner of hypnosis (Bányai, 1991). These two concepts highlight the importance of the relationship between the practitioner and the subject and explain some of the subject's reactions to hypnosis. For example, Bányai has developed the Interactional Experiential Analysis Technique which shows that during certain periods of the hypnotic process, subjective experiences of the subject and practitioner converge, symbolically and in terms of mood (Varga 1986, cited in Bányai, 1991). The social-psychobiological theory's main focus is the interdependence of the practitioner and subject, which affect each other in a recursive fashion. While this furthers explanation in some areas, Bányai does not explain how this relates to self-hypnosis, where there is only one person involved.

Both the neodissociation and sociocognitive theories can offer more accurate explanations of self-hypnosis. The neodissociation theory focuses on the loss of familiar associative processes and the need for appropriate current interventions for the hypnotic state to occur. The sociocognitive's theoretical concept is that people are sentient agents who are continually involved in organising sensory

inputs into meaningful categories. These two theories allow a more accurate explanation of self-hypnosis as neither of them necessarily depends on input from another person for the hypnotic state to occur. Current interventions need not mean interventions from another person and organisms' sensory inputs also does not require another person.

All three theories offer an explanation of hypnotic responsiveness, which has been shown to be stable over time with correlations of $r = 0.60$ across different scales (Bowers, 1983), and $r = 0.90$ when the same scales are used (Hilgard, 1965). The neodissociation view of this response stability within subjects is that it is a stable trait, while the sociocognitive view holds that it is a modifiable state. This is problematic for the sociocognitive view which proposes that situational factors are more important than individual factors in accounting for hypnotic responsiveness, and yet individual responsiveness is stable. Spanos (1991) argues that individual differences provide an illusion of stability but that recent studies are showing responsiveness to be a modifiable characteristic (Garossini & Spanos, 1986). Spanos and Garossini use the Carleton Skill Training Program for modifying hypnotisability. After a 75-minute course, subjects with low hypnotic responsiveness can have high hypnotic responsiveness. An unanswered question for the sociocognitive view is: to what extent does the program genuinely enhance hypnotic responsiveness, and to what extent does it provoke outward compliance in the absence of the altered experience (Hilgard & LeBaron, 1984)? Although this was tested, the results were inconclusive as the low subjects were asked to fake a high responsiveness and they scored higher than the actual subjects who had learned the programme.

The neodissociation theory offers a more accurate explanation for variation in hypnotic responsiveness. Evans (1991), in support of the neodissociation theory, suggests that individual differences in hypnotisability may reflect one aspect of a more general ability to access, regulate and alter states of consciousness. This ability to gain access to different cognitive, psychological, and physiological states as needed can be seen in everyday life, and has been meaningfully correlated with hypnotic responsiveness. For example, during sleep adults do not fall out of bed as they have bed-defined as well as partner-defined limits, to which they adhere when asleep and otherwise outside of awareness.

The neodissociation theory suggests that hypnotic responsiveness is a trait (i.e., an aptitude dimension) whereas the sociocognitive view is that it is a set of sociocognitive skills and attitudes. The social-psychobiological theory resolves this dilemma by combining the two ideas and adding an extra dimension of context. Bányai (1991) contends that there is no intrinsic conflict between the contention of hypnosis modifiability and enhancement, and the notion that certain personal attributes and abilities exist that are stable, enduring, and perhaps sometimes resistant to modification. Therefore, the social-psychobiological theory offers a broader and possibly more accurate explanation of the variation in hypnotic responsiveness. Support for this hypothesis is given

by studies which show that some of these stable and enduring qualities are trance capacity (Shor, 1979), capacity for imaginative involvement (Hilgard, 1979), and absorption (Tellegen & Atkinson, 1979). The common factor among these various abilities is flexibility in changing the ways of functioning (Bányai, 1991). A positive correlation has been found between high responsiveness and cognitive flexibility (Kihlstrom et al., 1989). This ability of highly responsive subjects to be cognitively flexible has been supported in a number of studies. There is a positive correlation between high responsiveness and the ability to alter states of consciousness (e.g., falling asleep more easily and in more unusual places). Behavioural and central electrophysiological data (40-Hz EEG) indicate that responsiveness is also related to flexibility in shifting the focus of selective attention and that highly responsive subjects have a greater ability to ignore stimuli unrelated to the task (DePascalis & Penna, 1990). The social-psychobiological theory offers more concrete evidence to support its hypothesis about the variability in hypnotic responsiveness than either the neodissociation or the sociocognitive theories and therefore can be considered more accurate in this respect.

The sociocognitive view of subjective experiences tends to explain them away by suggesting that the subjects are mistaken about their attributions of the experience. Similarly, when subjects feel they are in a different state, the sociocognitive view does not give this any credence. In contrast, neodissociation theory does not deny the subjective experience of being in a different state is valid. However, recently Hilgard (1991) redefined his view of state as being simply another form of consciousness (cf. sleep or drunkenness), and not a special trance state.

The social-psychobiological theorists agree with the subject's phenomenological experience that they are in an altered state. Bányai cites evidence which shows that hypnosis is not a sleep-like state as the brain waves are different (Meszdos & Bányai, 1978, cited in Bányai, 1991), but supports the proposition that it is a socially altered state of awareness. Bányai conceives that this altered state occurs via the induction process, through a process of mutual attunement, in which the practitioner Bányai (1991) introduces the concept of interaction synchrony (matching of individual rhythms) which is central to current interaction research in the field of hypnosis. Her conception of interaction synchrony includes physical and physiological and subjective experiences.

The social-psychobiological theory is far more accurate, and provides more support for its views and its explanation of subjective experiences than both the neodissociation and the sociocognitive theories. Unlike the sociocognitive theorists, Bányai does not deny the subject's phenomenological experience. Bányai supports her proposition more fully than neodissociation theorists who until recently held the view that hypnosis was a trance-like state but now propose that it is simply a different state from being awake but do not offer further detailed explanation.

Consistency

The criteria of consistency encompasses both internal and external congruency. To be externally congruent, the three theories must be congruent with other accepted theories pertaining to related phenomena. As the three theories each use different concepts to explain the same phenomena none of the theories has external congruency. The social-psychobiological and the neodissociation theories are fairly internally consistent, but Spanos's (1991) sociocognitive theory loses internal consistency when he proposes that different principles are necessary for an understanding of amnesia and later recall of all the words learned in a previous hypnotic session as compared to selectively forgetting and recalling a single item from a hypnotic session (Spanos, 1986b). Another concern with the sociocognitive theory is Spanos's inconsistency in believing subjective reports. Subjective test reports of low versus high responsiveness are accepted after subjects were taught a responsiveness modification program, even though it had been suggested that the program may have provoked outward compliance and not genuinely enhanced hypnotic responsiveness. In contrast, Spanos does not take subjects' reports regarding non-volition at face value, but states that the subject is not competent to judge.

The major problem within the sociocognitive theory is that it explains away the phenomena of hypnosis rather than explaining it. Hypnosis phenomena can occur and be produced in any place at any time. For example, native tribes have tribal trance states induced during particular ceremonies. Spanos's view is puzzling because he investigates a phenomenon which he states does not really exist, as it is simply the same as other mundane forms of social action. In order to investigate hypnosis it must be possible to identify a certain set of phenomena as something other than normal mundane behaviour. If it is just like normal behaviour, how does one identify it? Perhaps Spanos's view is that hypnotic behaviour is simply the extremes of normal behaviour. If so, how does one determine which extreme and how extreme the behaviour needs to be to qualify as hypnosis? Spanos's argument seems to be circular.

To investigate a phenomenon such as hypnosis, it must be identifiable and therefore it exists; it cannot then be explained away as behaviour that does not exist because it is the same as normal behaviour.

Scope

Although the theory with the broadest scope is the social-psychobiological theory, the neodissociation theory has broader scope than the sociocognitive theory. Investigators have drawn links between dissociation and phobias. Phobic patients have been shown to have higher responsiveness scores than control subjects (John, Hollander, & Perry, 1981; Frischolz, Spiegel, Spiegel, Balma, & Markell, 1982), and phobias are often considered paradigmatic for dissociative processes. Bulimics and anorexics who used vomiting to control weight and

particularly those who used abstaining rather than vomiting had higher hypnotic responsiveness scores than control subjects. Pettinati, Home, and Staats (1986) suggest that perhaps vomiting has dissociative roots.

Scope is limited for the sociocognitive theory as it explains hypnosis away rather than explaining it and it also emphasises situational factors at the expense of relational factors. The theory proposes that hypnotic behaviours are fundamentally similar to other more mundane forms of social action and therefore it is not necessary to resort to special psychological states or processes in an attempt to explain these behaviours.

The social-psychobiological theory has the broadest scope as it has the ability to draw into its realm wide-ranging concepts. It purports that hypnosis must be investigated via social, physiological, behavioural, phenomenological, and relational data. It even poses a relation between archaic involvement (a deeper involvement between the practitioner of hypnosis and subject) and shows that this exists in subjects who have had at least one experience of hypnosis, as well as suggesting an adaptive value for hypnosis.

Parsimony

The social-psychobiological theory is the least parsimonious theory as it incorporates both the developmental aspect of the neodissociation theory and the situational aspects of the sociocognitive theory. All three theories attempt to bring order to phenomena, which in their absence would be isolated, although the social-psychobiological theory does not attempt to explain and therefore bring order to all the phenomena. The neodissociation and sociocognitive theories both attempt to explain the same phenomena but the most parsimonious theory is the neodissociation theory as it is a single-factor theory and purports to explain all the hypnosis phenomena by the one process of dissociation.

Alternatively, it could be argued that the sociocognitive theory is the most parsimonious theory because it does not have to resort to any special processes or psychological states in order to explain the phenomena. It holds that hypnotic behaviours are fundamentally similar to other forms of social action. It is questionable whether order is brought to the phenomena if no special process is invoked.

Fruitfulness

There are two ways of assessing fruitfulness: (a) the impact a particular theory has on contemporary research within psychology; and (b) whether the theory discloses new phenomena or previously unnoted relationships. The impact and heuristic value of neodissociation theory within psychology are formidable (Lynn & Rhue, 1991b). It has served as a platform for a great deal of contemporary research. In particular, the sociocognitive approach has been brought into relief by the contrast. Bányai formulated her social-psychobiological

theory and incorporated the developmental aspect of the neodissociation theory after studying with Hilgard at Stanford University. The sociocognitive theory has been similarly fruitful and utilised by many other theoreticians. Both neodissociation and sociocognitive theory have so far been more fruitful than the social-psychobiological theory in as far as inspiring contemporary research. This is to be expected as the neodissociation theory is the traditional theory, then the sociocognitive theory posed a challenge, and finally the social-psychobiological theory was formulated in 1982 (Bányai, 1991).

When considering the second aspect of fruitfulness, whether a theory discloses new phenomena or previous unnoted relationships, the social-psychobiological theory is the more fruitful theory. The social-psychobiological theorists have noted the importance of intrapersonal and interpersonal aspects of hypnosis. Bányai introduces to hypnosis theory the concept of interaction synchrony (matching of individual rhythms) which is central to current interaction research. This concept includes physical and physiological as well as subjective experiences. Interaction synchrony varies as a function of the practitioner's style, of which Bányai (1991) has noted two distinct forms; the physical/organic, which relies more on bodily cues, and the analytic/cognitive which relies more on thoughts. The subjective experiences and intensity of relationship appear to be an outcome of the style of the practitioner of hypnosis.

SUMMARY

The neodissociation, sociocognitive, and social-psychobiological explanations vary in their ability to accurately explain hypnosis phenomena. Accuracy is often the most highly valued criterion, as predictive power and explanatory power depend on this criterion. Often the accuracy of a theory is the sole determinant of whether a theory is accepted or rejected (Gibbs, 1972; Kuhn, 1977). Particular theoretical approaches dictate what is studied, how it is studied and the range of phenomena that are subject to experimental inquiry. A comparison could be made between the sociocognitive and neodissociation theories as they target similar phenomena for study, but the social-psychobiological theory uses a different, and broader range of determinants. This makes comparison with the other two theories difficult. How does one determine which theory is more accurate? By calculating the number of phenomena supported by each theory, or by rating each supported phenomenon according to its importance, or by calculating how many phenomena are explained by each theory? Any course pursued would be problematic.

For example, the hidden observer is important for support of the neodissociation theory, but not mentioned in the social-psychobiological theory, which brings in new areas of study such as the interaction between the practitioner of hypnosis and subject and the practitioner's style. For the sociocognitive theory importance is placed upon demand characteristics, leading to study of such phenomena as

non-volition. Perhaps to help with the evaluation of the accuracy criterion, a consensus should be reached about which phenomena are included in a theory of hypnosis as well as the importance of each phenomenon, but this, as has already been discussed, is difficult, as different theories revolve around different phenomena.

None of the three selected theories has external congruency as they all explain the same phenomena in different ways. The neodissociation and social-psychobiological theories show internal consistency but the sociocognitive theory does not. Both the neodissociation and the social-psychobiological theories have more scope than the sociocognitive theory but this is at the expense of simplicity. The sociocognitive theory has little scope as it emphasises situational variables at the cost of developmental contingencies.

Fruitfulness, within hypnosis theories, can have a temporal quality, which places the sociocognitive and social-psychobiological theories at a disadvantage, but fruitfulness when disclosing new relationships favours the social-psychobiological theory.

It can be seen from this evaluation of theories of hypnosis that no one particular theory meets all the required criteria fully in explaining hypnotic phenomena. A wide range of theories, explanations, and models exist and as yet the scientific community has not adopted one specific paradigm. Therefore, according to Kuhn (1977) the real work of science in the field of hypnosis has not yet begun and hypnosis theories are still in the pre-scientific stage.

GENERAL DISCUSSION

Is it possible to get a clearer picture of the current diversity of theories of hypnosis by going beyond the shared criteria and looking at the characteristics of the individual scientists who formulated the theories? Kuhn (1977) asks the questions: (a) In what part of the field was the scientist at work when confronted by the need to choose? (b) How long had s/he worked there? (c) How successful had s/he been? and (d) How much of her/his work depended on concepts and techniques challenged by the new theory?

The background and ideas of the three theorists differ greatly and offer an insight into the different theoretical choices. Spanos, of the sociocognitive approach, received a doctorate in sociology, while Hilgard, who formulated the neodissociation theory, received his doctorate in experimental psychology (Lynn & Rhue, 1991a). Hilgard (1991) takes an eclectic position, known as functionalism, and explains how the functionalist position influenced his theorising: (a) functionalists are tolerant, and can use a variety of psychological concepts such as behaviour, consciousness, unconscious processes, states of awareness, and physiological substrata; (b) continuities are preferred to discontinuities, which shows in Hilgard's reference to the partial dissociations as gradualism; and (c) functionalists like to drive issues back to specifics.

Spanos's (1991), sociocognitive view is built on the work by Barber and Sarbin, and is a reaction to the traditional neodissociation view. Spanos received a doctorate in sociology and is a social psychologist. Sarbin was the first theorist to explicitly reject the notion that hypnotic responding required an explanation in terms of altered states of consciousness (Spanos & Chaves, 1989). He conceptualised hypnotic responding from a dramaturgical perspective. Barber, who also influenced Spanos, delineated the social psychological antecedents that lead to hypnotic responding.

Bányai (1991), who formulated the social-psychological approach, has her roots in Hungary, where the only kind of psychology that was acceptable, at the time, had some connection with the higher nervous system. This school of thought was Pavlovian physiological psychology. A second influence for Bányai was the gestalt-oriented experimental tradition and the third was the psychoanalytic tradition of the Budapest school. Bányai worked in diverse areas in the realm of hypnosis at the Department of Comparative Physiology of Eotvos Lorand University, and later during her postdoctoral year at Hilgard's Laboratory of Hypnosis Research at Stanford University. Social-psychological research directed Bányai's attention to the possibility of analysing hypnosis in terms of social influence (Bányai, 1991). The role enactment theory of Sarbin and Coe also influenced Bányai as it pointed to the importance of including the social context among the fundamental factors influencing hypnosis.

Given the diverse background and variety of influences, it is logical that the three theorists espouse different theories. The question is whether this is useful and where in the scientific realm does it place hypnosis? Lynne and Rhue (1991b) state that according to Kuhn (1977) this places hypnosis theories in the pre-science, pre-paradigmatic stage. Interestingly, there is more than one way of applying Kuhn's evaluation to the hypnosis debate. Some theorists have noted that hypnosis is not pre-science as paradigm shifts have occurred. In 1968, Chaves (Bowers, 1983) postulated that a paradigm shift was occurring and the alternative accepted paradigm was based on the social psychological work by Barber, Sarbin, and Coe. These approaches are the historical roots of the sociocognitive theory evaluated in this paper. Another opinion given by Fellows (1986) is that another scientific shift is occurring, and that the cognitive or special state paradigm will be replaced by the imagination paradigm.

An alternative way of conceptualising the paradigm problem is to assume that the three selected theories of hypnosis are actually part of the one paradigm. Kuhn (1977) states that different paradigms regard the world as being made up of different things and are therefore incompatible. For example, the Aristotelian paradigm saw the universe as being divided into two distinct and different realms whereas later paradigms saw the world as being made up of the same kinds of substances (Chalmers, 1982). Unlike this example, the theories of hypnosis are not in this sense totally different although the dissociation theory holds that the hypnosis state is the result of dissociation of mental processes and the sociocognitive theory that hypnosis is a skill of the individual. It can be seen

that these two concepts are not totally incompatible as the social-psychobiological theory combines and subsumes both these ideas to some extent.

A period of normal science, according to Kuhn (1977) will provide the opportunity for scientists to develop the esoteric details of a theory. This is what may very well be happening within the field of hypnosis. Furthermore, Kuhn allows that different scientists or groups of scientists may interpret and apply the paradigm in a different way. Kuhn's criteria for assessing scientific theories are not so precise that they do not allow individual interpretation; they are not like an explicit set of rules (Chalmers, 1982). The set of criteria are more like a set of values that do not determine choice but influence it. Kuhn (1977) explicitly states that: "two men deeply committed to the same values may nevertheless, in particular situations, make different choices as, in fact, they do" (p. 331). Chalmers (1982) suggests that this has the advantage that the number of strategies attempted will be multiplied and the chances of long-term success increased.

In conclusion, it is proposed that what is occurring in the scientific community with regard to the theories of hypnosis is that a number of different strategies are being employed in an attempt to explain hypnosis. These different strategies are not different paradigms as they are not incompatible. Hilgard and Spanos have chosen to investigate hypnosis in different ways and it can be seen that the diversity of the theories of hypnosis has inspired the formulation of Bányai's social-psychobiological theory of hypnosis which expands the explanation of hypnosis using social, physiological, behavioural, phenomenological and relational data. It is a moot question whether hypnosis is pre-science or whether the real work of science begins when the scientific community adopts a paradigm, as the real work of science is being undertaken in the realm of hypnosis, but in many different fields simultaneously.

REFERENCES

- Bányai, É. I. (1991). Toward a social-psychobiological model of hypnosis. In S. J. Lynn & J. W. Rhue (Eds.), *Theories of hypnosis: Current models and perspectives* (pp. 564–600). New York: Guilford Press.
- Bowers, K. S. (1983). *Hypnosis for the seriously curious*. New York: Norton.
- Bowers, K. S., & Davidson, T. M. (1991). A neodissociative critique of Spanos's social psychological model of hypnosis. In S. J. Lynn & J. W. Rhue (Eds.), *Theories of hypnosis: Current models and perspectives* (pp. 105–143). New York: Guilford Press.
- Chalmers, A. F. (1982). *What is this thing called science?* St Lucia: University of Queensland Press.
- DePascalis, S., & Penna, P. M. (1990). 40Hz EEG activity during hypnotic induction and hypnotic testing. *International Journal of Experimental and Clinical Hypnosis*, 38, 125–138.
- Evans, F. J. (1991). Hypnotizability: Individual differences in dissociation and the

- flexible control of psychological processes. In S. J. Lynn & J. W. Rhue (Eds.), *Theories of Hypnosis: Current models and perspectives*. (pp. 144–168). New York: Guilford Press.
- Fellows, B. J. (1986). The concept of trance. In P. L. N. Naish (Ed.), *What is hypnosis?: Current theories and research*. Milton Keynes: Open University Press.
- Field, T. (1985). Attachment as psychobiological attunement: Being on the same wavelength. In M. Reite & T. Field (Eds.), *Behavioural biology: The psychobiology of attachment and separation* (pp. 415–454). Orlando: Academic Press.
- Frischolz, E. J., Spiegel, D., Spiegel, H., Balma, D. L., & Markell, C. S. (1982). Differential hypnotic responsivity of smokers, phobics, and chronic-pain control patients: A failure to confirm. *Journal of Abnormal Psychology*, *91*, 269–272.
- Garossini, D. R., & Spanos, N. P. (1986). A socialcognitive skills approach to the successful modification of hypnotic susceptibility. *Journal of Personality and Social Psychology*, *50*, 1004–1012.
- Gibbs, J. (1972). *Sociological theory construction*. Hinsdale, IL: Dryden Press.
- Hilgard, E. R. (1965). *Hypnotic susceptibility*. New York: Harcourt, Brace and World.
- Hilgard, J. R. (1979). *Personality and hypnosis: A study of imaginative involvement* (2nd. ed.). Chicago: University of Chicago Press.
- Hilgard, E. R. (1991). A neodissociation interpretation of hypnosis. In S. J. Lynn, & J. W. Rhue (Eds.), *Theories of hypnosis: Current models and perspectives* (pp. 83–104). New York: Guilford Press.
- Hilgard, J. R., & LeBaron, S. (1984). *Hypnotherapy of pain in children with cancer*. Los Altos, CA: William Kaufmann.
- John, R., Hollander, B., & Perry, J. (1981). Hypnotisability and phobic behaviour: Further supporting data. *Journal of Abnormal Psychology*, *92*, 390–392.
- Kihlstrom, J. F., Register, P. A., Hoyt, I. P., Albright, J. S., Grigorian, E. M., Heindel, W. C., & Morrison, C. R. (1989). Dispositional correlates of hypnosis: A phenomenological approach. *International Journal of Clinical and Experimental Hypnosis*, *37*, 249–263.
- Kuhn, T. S. (1977). *The essential tension*. University of Chicago Press: Chicago.
- Laudan, L. (1977). *Progress and its problems: Toward a theory of scientific growth*. Berkeley, CA: University of California Press.
- Lynn, S. J., & Rhue, J. W. (1991a). Theories of hypnosis: An introduction. In S. J. Lynn & J. W. Rhue (Eds.), *Theories of hypnosis: Current models and perspectives*, (pp. 1–18). New York: Guilford Press.
- Lynn, S. J., & Rhue, J. W. (1991b). Hypnosis theories: Themes, variations, and research directions. In S. J. Lynn, & J. W. Rhue (Eds.), *Theories of hypnosis: Current models and perspectives*. (pp. 601–626). New York: Guilford Press.
- Pettinati, H. M., Home, R. L., & Staats, J. M. (1986). Hypnotisability in patients with anorexia nervosa and bulimia. *Archives of General Psychiatry*, *42*, 1014–1016.
- Reber, A. S. (1985). *The Penguin dictionary of psychology*. Harmondsworth: Penguin Books.
- Rowley, D. T. (1986). *Hypnosis and hypnotherapy*. Philadelphia: The Charles Press.

- Schacter, D. L. (1989). On the relation between memory and consciousness: Dissociable interactions and conscious experience. In H. L. Roediger & F. I. M. Craik (Eds.), *Varieties of memory and consciousness* (pp. 355–389). Hillsdale, NJ: Erlbaum.
- Shor, R. E. (1979). A phenomenological method for the measurement of variables important to an understanding of the nature of hypnosis. In E. Fromm & R. E. Shor (Eds.), *Hypnosis: Developments in research and new perspectives* (2nd. ed.) (pp.105–135). Chicago: Aldine.
- Spanos, N. P. (1986a). Hypnotic behaviour: Special process accounts are still not required. *Brain and Behavioural Sciences*, 9, 776–781.
- Spanos, N. P. (1986b). Hypnotic behaviour: A social-psychological interpretation of amnesia, analgesia, and trance logic. *Brain and Behavioural Sciences*, 9, 449–467.
- Spanos, N. P. (1989). Experimental research on hypnotic analgesia. In N. P. Spanos, & J. F. Chaves (Eds.), *Hypnosis: The cognitive behavioural perspective* (pp. 206–240). Buffalo, NY: Prometheus Books.
- Spanos, N. P. (1991). A sociocognitive approach to hypnosis. In S. J. Lynn, & J. W. Rhue (Eds.), *Theories of hypnosis: Current models and perspectives* (pp. 302–324). New York: Guilford Press.
- Spanos, N. P., & Chaves, J. F. (1989). The cognitive behavioural alternative in hypnosis research. In N. P. Spanos & J. F. Chaves (Eds.), *Hypnosis: The cognitive behavioural perspective*. (pp. 9–17). Buffalo, NY: Prometheus Books.
- Spanos, N. P., Flynn, D. M., & Gwynn, M. I. (1988). Contextual demands, negative hallucinations, and hidden observer responding: Three hidden observers observed. *British Journal of Experimental and Clinical Hypnosis*, 5, 5–15.
- Tellegen, A., & Atkinson, G. (1979). Openness to absorbing and self-altering experiences (absorption), a trait related to hypnotic susceptibility. *Journal of Abnormal Psychology*, 83, 268–277.

NOT THE STATE, BUT THE TERRITORY

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With the current growth of interest in spirituality, the interface between hypnosis and religious practices takes on new significance. Cautions have traditionally been expressed about the hypnotic state, with fears about control and willpower. While developments in the ethical use of hypnosis make such concerns less pressing, there remain significant paradigm issues which are being explored in the literature. These include pursuit of the age-old-question, “Who are the legitimate healers in a society?” The territory of the church and the territory of the clinic are not entirely separate, so issues arise regarding the relative authority of practitioners to intervene in people’s lives, and what such interventions should look like. Many Christians who might benefit from hypnosis have been warned to be totally against it. Evidence will be brought forward to challenge this and make it safer to look to therapeutic hypnosis without compromising beliefs.

The map is not the territory. We operate out of our sensory representations of the world and not on “reality” itself . . . It is not the “world” itself that dictates our fulfilment or unhappiness, it is each person’s own *version* of it. Most (or perhaps all) of our behaviour is mediated by internal constructions and experiential representations of our world. (Lankton, 1980, p. 17.)

There is a further theme, which hinges on the concept of “reality,” and what we consider to be reality, which Lankton places in quotation marks, identifying the ambiguities that surround the term. It has been explored in an interesting manner in John Schumaker’s 1995 book on hypnosis entitled *The Corruption of Reality*, (reviewed by Campbell, 1997, in *AJCEH*, and Shum, 1997), with a subtitle referring to religion, hypnosis, and psychopathology. He writes as an avowed rationalist who has rejected an earlier Catholic upbringing, and now perceives his world through the eyes of empiricism. Consequently, as he traces fascinating links among the three themes of his subtitle, he makes repeated disparaging references to religion for being the essence of the corruption of reality. I find the links he makes with hypnotic experience and religious

experience to be persuasive, and readily agree that the mechanisms of dissociation and those involved in hypnosis show a great affinity.

From there, he and I part company since his rationalist perceptions to my mind are directed only to the map, and fail to do justice to the territory or experience which includes the transcendental. For him, reality is bounded by the findings of traditional science so that religion is a corruption of this. For me, the religious dimension of experience opens up a new window on reality, so that we can see not merely a map, but a territory more awesome than that which extends from Alice Springs to Darwin. Indeed, the whole book can be read by someone who perceives from a religious perspective as not about the corruption of reality, but the *expansion* of reality.

So I take that as my springboard for a broader consideration of state and territory, looking at the long-standing tensions between practitioners of hypnosis, and those from some parts of the Christian church who have so vigorously condemned any involvement with hypnosis. It is a topic I have explored in recent years while writing a book now called *Hypnosis Healing and the Christian* (Court, 1997). While some of the debate from Mesmer onwards has focused on the phenomena of hypnosis, and concerns about the state that people are in, I will suggest that there is also another agenda which has more to do with territorial disputes.

THE STATE

If indeed hypnosis is a state, then there are a number of religious objections raised by some in the Christian tradition. I say “some” because it is clear that most of the mainline denominational traditions have looked carefully at the subject, and concluded with cautious support for its practice when ethically undertaken by trained professionals. Kroger (1963) gives an overview of various religious traditions and their attitudes to hypnosis. It was a foundational element in Christian Science, and has become widely practised in the New Age movement (Kelly, 1990). In all these settings, the experience of an altered state of consciousness produced deliberately has been valued as a means of gaining some expanded religious experience or enlightenment.

Such acceptance of the state explains partly why other groups have taken such a strong stand *against* hypnosis. In my experience, the most powerfully antagonistic writings have come from those within the conservative evangelical tradition of the church, and those within pentecostalism. These groups share a fundamental approach to biblical interpretation and raise issues that relate to the hypnotic state. They differ dramatically in their acceptance of the phenomena of altered states, with evangelicals typically preferring to stand firmly on reasoned faith supported by scholarly, logical interpretation of biblical text, whereas pentecostals adhere closely to the text and at the same time place a strong emphasis on ecstatic phenomena, with charismatic experiences such as speaking in tongues and falling over in a manner called “slaying in the Spirit.” These

latter phenomena, and others like them, look remarkably like hypnotic phenomena induced in other settings, but are interpreted quite differently, as having spiritual significance. The two groups differ vastly on their acceptance of these behavioral manifestations, yet there is some convergence on objections to hypnosis which superficially are objections to people going into an altered state in response to the instructions of another. What I will call “state objections” may be summarised as follows.

From a conservative evangelical stance, the following express it well:

“Because hypnosis places responsibility outside the exercise of objective, rational, fully conscious choice, it does violate the will.” (Bobgan & Bobgan, 1984, p. 35).

“We believe it is not only unnecessary to use hypnosis but potentially dangerous. Even sincere medical hypnosis may be a disguised doorway and subtle enticement into the demonic realm.” (Bobgan & Bobgan, p. 48)

“Hypnotism is demonic at its worst and potentially dangerous at its best.” (Bobgan & Bobgan p. 53)

Although it is usual for this tradition to rely on careful Biblical exegesis, with a collection of sources identifying a common theme, rather than a single proof text, it is worth noting that authors who share this view invariably cite a single verse from Deuteronomy (18:11) which speaks of the dangers of “charmers,” or “those who cast spells.” While Bobgan and others claim that the term is clearly synonymous with hypnosis, it is noteworthy that the same Hebrew term is used elsewhere to be clearly referring to “snake-charming” — an activity not widely practised in the Australian Society of Hypnosis. Psalm 58:5 refers unmistakably to snake-charming, saying “Their venom is like the venom of a snake, like that of a cobra that has stopped its ears, that will not heed the tune of the charmer, however skilful the enchanter may be.”

I checked out the meaning of the Hebrew with a Middle Eastern languages scholar who was a colleague of mine and he expressed the opinion that “To use these passages as a reference to hypnosis is exegetically indefensible” (Bush, personal communication, 1994).

Objections from the pentecostal tradition follow similar lines of argument to those I have mentioned, plus additional emphasis on the dangers of opening the mind to demonic involvement. A good example is offered in a book entitled *A Comprehensive Guide to Deliverance and Inner Healing*. The authors warn:

Hypnotism is strictly forbidden. One reason for this is that we are not to surrender our will to anyone other than Jesus. A second reason is that such surrender opens inner psychic doors that only the Lord should enter. A third is that no one besides Christ can be trusted to rule our will. (Sandford & Sandford, 1991, p. 329)

In a similar vein, H. E. Freeman published *Angels of Light?* including a sweeping rejection of hypnosis in any form. In a strongly worded condemnation, he wrote:

One of the most subtle and potentially dangerous forms of magical practice is hypnosis, an ancient occult method of influence or control of the mind and action of others. The greatest threat lies in the fact that in the hypnotised state of the surrendered will, the individual is open to the invasion of evil spirits. (Freeman, 1969, p. 56)

In 1971, D. and R. Bennett followed in Freeman's footsteps, asserting that hypnosis can allow access to satanic forces and involves control of one person by another rather than by the Holy Spirit. "Hypnosis, by placing the soul in a passively receptive state, opens the door to morbid spiritual influences" (Bennett & Bennett, 1971, p. 50).

These warnings have been widely endorsed in many churches and taught as unassailable truth, though more recently I had the opportunity to explore these issues with one of the Bennetts, who has now offered a significantly revised and more favourable perspective (see Court, 1997, p. 131).

In considering these state objections, they can be summarised as making certain assumptions.

1. Hypnosis is associated with non-Christian religious practices, and is therefore intrinsically spiritually dangerous to Christians (one might make the same point about prayer, music, and religious dance).
2. Hypnosis involves taking over the will of another (a stereotype from Mesmer's day and perpetuated in stage hypnosis). Contra Brown (1991), who refers to three forms of hypnotic induction — the authoritarian, the standardised, and the cooperation approaches.
3. Hypnosis risks opening oneself to demonic influence through hypnotic control (an important religious concern if the will were indeed relinquished — a dubious proposition).
4. Hypnosis is associated with passivity in the client, and hence open to undue influence. (Probably true under some circumstances, but by no means essential, and not characteristic of much contemporary work.)
5. Hypnosis is condemned in the Old Testament (the ultimate argument for these authors, but not proven). By contrast, the term "trance" has very positive connotations in the New Testament — see especially Acts 10.10 and Acts 22.17.

It will be apparent to colleagues that these objections arise more from the uninformed beliefs of those who follow what others have written, than from first-hand experience of contemporary practice of hypnosis. Without experiencing or at least observing clinical hypnosis as currently practised, the morass of myth and stereotype which continues to surround the subject makes it difficult to present a clear understanding of what is involved, or to show the lengths taken to avoid or at least minimise the dangers that are identified. One response to those who emphasise the horrendous outcomes, and warn against exposure to hypnosis under any circumstance, has to be, "Show me one example of significant harm clearly linked to the use of hypnosis." Even our own

professional colleagues are able to unearth surprisingly few examples that are convincing, though not for want of trying (Judd, Burrows, & Dennerstein, 1985; West, Fellows, & Eaton, 1995).

While these state objections typically assume that hypnosis is used in an exploratory and therapeutic context, accessing emotional material from the unconscious, they encounter difficulty when the question of hypnosis for other purposes is raised. What is one to say to the use of hypnosis for pain management and in dental work for anaesthesia? At this point the Sandfords are honest in saying, “Concerning its use in orthodontal operations, for people who cannot take anesthetics, I said I could not say, only that the Word of God forbids its use” (Sandford & Sandford, 1991, p. 329)

They are inclined to admit reluctantly that it may have appropriate medical uses, even though this creates cognitive dissonance. Although it is supposed to be the very state which is the problem, the greater good of its use in pain control enables some to grant a kind of exemption to the use of hypnosis for that purpose. In this vein, Koch, a medical missionary widely cited as opposed to the use of hypnosis, is careful to say his objections do not refer to the way

the medical profession uses hypnosis for diagnosis and therapy ... our concern is not with the professional use of hypnosis. Our main aim is to show by means of a few examples the dangers involved when hypnosis and suggestion are used by magic charmers and unqualified practitioners. (Koch, n.d., p. 71)

Which leads me to the second part of this paper — not the state but the territory.

THE TERRITORY

Historically, we have seen that hypnosis is associated with disputes over territory. This was a notable feature of Mesmer’s experience, when it was less a question of whether mesmerism produced results than whether he was a charlatan for attributing his results to animal magnetism (Laurence & Perry, 1988). He was found to be at fault both by the Royal Society of Medicine, and the Benjamin Franklin Commission ordered by King Louis XVI in 1784. That episode sidelined hypnosis for the medical fraternity for a long time. It is only in living memory that we have seen hypnosis become accepted as legitimate practice within the mainline healing professions.

Over the same period, there was also resistance from the church, since Mesmer appeared to be moving in the spiritual realm. By the 1830s, there was a period of confrontation in the United States associated with the Second Great Awakening, a time of intense spiritual revival in that country, when “mesmerism” was presented as a kind of alternative spiritual answer to human need (Fuller, 1982), thereby creating two competing claims for allegiance. That kind of objection has continued to the present day as I have indicated above. While the major denominational churches have promulgated statements indicating the

acceptance of clinical hypnosis (e.g., for Catholic statements, see Mangan, 1959; Venn, 1986), others have continued to resist the approach.

The spiritual objections can certainly be cast in terms of the spiritual dangers that might be implicit in experiencing a profoundly altered state of consciousness, but when the objections are withdrawn for procedures like pain control one has to ask what else is at stake.

I suggest that a major issue is paradigmatic, and based on a perception of human nature that separates us into body, mind and spirit. This convenient subdivision of parts has been around at least from Greek times, and provides us with three identifiable territories with their associated professional practitioners. We have allocated care of the body to the medical profession (including dentistry), care of the mind to the psychological profession, and care of the spirit (or soul) to pastors in the church. For most purposes this eliminates the problems of demarcation disputes that occur in other areas, but not entirely. Psychiatry for example, moves obviously across the boundaries of body and mind, and some fear it also transgresses across to the spiritual realm. Pastoral counselling occupies some middle ground between psychology and theology with overlapping interests in spiritual and psychological welfare.

With the emergence of an increasing variety of so-called alternative therapies, we are now seeing many new players in the field. The fact that they are called “alternative” clearly indicates that there is a mainstream establishment whose territory is now being invaded. The private health funds have recently recognised this by including benefits payable for a whole new range of therapeutic strategies. We now have multiple paradigms for understanding what health is about, how problems should be treated, and criteria for determining whether these interventions have been effective. At the United Nations level, there is now a pressure to include spirituality within the definition of good health.

Formal hypnosis has a place in many parts of the territory of health care, but if we broaden the concept to altered states of consciousness, then most, if not all, of the players on the field are involved. When we use terms like “trance,” “meditation,” “prayer,” “imagery,” and “anaesthesia” we have covered a lot of ground. No one professional group can lay claim to this territory.

John Schumaker comments that the traditional churches have largely abandoned the very effective vehicle of trance states, and in so doing may have removed something vital to the maintenance of religious belief:

In our well meaning effort over recent decades to bring religion down to earth, we have unknowingly stripped religion of many of its historic vehicles for trance, thereby also forfeiting the central mechanism by which religious suggestions are made palatable, or believable, to people. (Schumaker, 1995, p. 104)

By contrast, the emergence of pentecostalism has been associated with an endorsement of such experiences. It has been claimed that, in a culture which values experience over learning, the church can be expected with Godly

approval to function within the cultural context. So, for example:

Since ours is largely a Dionysian culture — a culture of addicts looking for ecstasy — God has chosen to operate during this time of refreshing by permitting many ecstatic phenomena — such as shaking, fainting, falling over, weeping, laughing, roaring, and generally drunken behaviour. All of this looks to outsiders just like Dionysian abandonment. It feels to cynical observers like possession, inebriation, loss of control and so on. But in a Dionysian culture, God graciously respects the needs of the hour. (Stibbe, 1995, pp. 84–85)

In the light of the earlier objections to hypnosis, it is worth noting here the reference to “loss of control,” which is dismissed as the view of the cynic, but which might equally relate to the hypnotic state, where critics attribute loss of control while participants report that it is not like that at all.

Christian objections to the use of hypnosis, lest it provide a vehicle for access to occult influences, come most stridently from those who themselves are using altered states most vigorously within the church. An hour spent at the performance of a stage hypnotist can look remarkably like an hour at a pentecostal revival meeting, except that in the latter there are more people experiencing profound alteration of consciousness, singing, dancing, falling down, speaking in tongues, or making noises. More significantly from the territorial perspective there are people who are reporting profound healing experiences in this setting. This is not something claimed by the stage hypnotist, but of course that claim is made in the clinical application of hypnosis.

So here we have groups of practitioners, each with their own paradigm for healing who typically criticise the alternative strategies used in other contexts. Medicine says something like “beware that you are acting in ignorance of physical factors you do not understand and claiming healing where it does not exist medically.” Psychology says that medicine often misses the psychological conflicts and relational issues that sustain a physical disorder, while the church fails to recognise the powerful effects of suggestion and demand characteristics that can occur in an emotionally charged worship service. Theology says that medicine and psychology are too reductionist, failing to acknowledge a spiritual dimension to health so that attempts at healing ignore the most profound dimension of healing that must address issues of faith, morality, and a relationship with God. The alternative therapists seek other ways of enhancing health, with approaches that rely on naturally occurring resources, while commonly also embracing a strong sense of the spiritual, expressed in non-traditional ways, and in doing so, challenge all the previously established healing groups.

We can expect these territorial differences to continue since there are strong traditions and beliefs at stake. One shift that might make it easier to acknowledge one another would be to rethink the fundamental assumption about body, mind and spirit which has so shaped our theological and scientific heritage. The Hebrew tradition of the Old Testament provides little support for this tripartite

view, and seems more to favour a wholistic understanding of interacting elements rather than separated entities (Benner, 1988; Chamblin, 1993). So, for example, it makes no sense in our tripartite system to read the words of Job, immortalised for many in Handel's *Messiah*, saying "Though worms destroy my body, yet in my flesh shall I see God." The psychology of perception in the spiritual world of hereafter in a physical body that no longer exists, sounds like a conundrum at best. Yet it is a supreme statement of hope that transcends our usual categories of body, mind, and spirit to recognise continuing and personal experience.

I am persuaded that the healing movements of the church have authenticity when they acknowledge that healing is not just a spiritual thing, and not just a physical thing. Remarkable healings do occur at times, and do not have to be explained away. Medical practice is enriched when healing is seen as not merely physical recovery, but as having elements of psychological and spiritual significance. In my own psychological work, I am pleased to find people not only feeling better or behaving more healthily, but also enriched spiritually, and recovering from physical disorders, most commonly those we now call somatoform disorders. Each profession can benefit from respectfully challenging the others to acknowledge dimensions of well-being with which we have less familiarity.

REFERENCES

- Benner, D. G. (1988). *Psychotherapy and the spiritual quest*. Downers Grove, IL: InterVarsity Press.
- Bennett, D., & Bennett, R. (1971). *The Holy Spirit and you*. Plainfield, NJ: Logos International.
- Bobgan, M., & Bobgan, D. (1984). *Hypnosis and the Christian*. Minneapolis, MN: Bethany House.
- Brown, P. (1991). *The hypnotic brain: Hypnotherapy and social communication*. New Haven, CT: Yale University Press.
- Campbell, A. (1997). [Review: The corruption of reality: A unified theory of religion, hypnosis and psychopathology]. *Australian Journal of Clinical and Experimental Hypnosis*, 25, 173–174.
- Chamblin, J. K. (1993). Psychology. In G. F. Hawthorne, R. P. Martin, & D. G. Reid (Eds.), *Dictionary of Paul and his letters* (pp. 765–775). Downers Grove, IL: InterVarsity Press.
- Court, J. H. (1997). *Hypnosis, healing and the Christian*. Carlisle, UK: Paternoster Press.
- Freeman, H. E. (1969). *Angels of light?* Plainfield, NJ: Logos International.
- Fuller, R. C. (1982). *Mesmerism and the American cure of souls*. Philadelphia, University of Pennsylvania Press.

- Judd, F. K., Burrows, G. D., & Dennerstein, L. (1985). The dangers of hypnosis: A review. *Australian Journal of Clinical and Experimental Hypnosis*, 13, 1–15.
- Kelly, A. A. (1990). Hypnosis and self-hypnosis. In J. G. Melton, J. Clark & A. A. Kelly (Eds.), *New Age Encyclopedia* (pp. 228–233). Detroit: Gale Research.
- Koch, K. (n.d.). *The devil's alphabet*. Berghausen: Evangelistic Publishers.
- Kroger, W. S. (1963) *Clinical and experimental hypnosis* (2nd ed.). Philadelphia, J. B. Lippincott.
- Lankton, S. (1980). *Practical magic*. Cupertino, CA: Meta Books.
- Laurence, J.-R., & Perry, C. (1988). *Hypnosis, will, and memory: A psycho-legal history*. New York: Guilford Press.
- Mangan, J. T. (1959). Hypnosis: A medico-moral evaluation. *Linacre Quarterly*, 26, 39.
- Sandford, J., & Sandford, M. (1991). *A comprehensive guide to deliverance and inner healing*. Grand Rapids, MI: Fleming Revell.
- Schum, N. (1997). [Review of *The corruption of reality: A unified theory of religion, hypnosis and psychopathology*]. *Australian Psychologist*, 32, 143–144.
- Schumaker, J. F. (1995). *The corruption of reality: A unified theory of religion, hypnosis and psychopathology*. New York: Prometheus Books.
- Stibbe, M. (1995). *Times of refreshing: A practical theology of revival for today*. London: Marshall Pickering.
- Venn, J. (1986). Hypnosis for Christians. *Journal of Christian Healing*, 8 (2), 3–6.
- West, V., Fellows, B., & Eaton, S. (1995). The British Society of Experimental and Clinical Hypnosis: A national survey. *Contemporary Hypnosis*, 12, 137–142.

DISSOCIATION, COPING STRATEGIES, AND LOCUS OF CONTROL IN A NON-CLINICAL POPULATION: CLINICAL IMPLICATIONS

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The present study examined the relationship between dissociative experiences, the use of emotion-focused and problem-focused coping strategies, and locus of control orientation. Analysis of data from 130 non-clinical adult subjects revealed that: (a) dissociative tendency is positively related to an external control orientation; (b) use of escape-avoidance coping strategies is positively related to chance orientation; and (c) those who show high dissociativity are more likely to utilise escape-avoidance coping strategies. The paper concludes with a review of the clinical implications of these findings.

Dissociation is the process whereby the usually integrated functions of consciousness, memory, identity, or perception of the environment are disrupted. Dissociative experiences are characterised by a compartmentalisation of consciousness, that is, certain mental events that are ordinarily processed together (e.g., thoughts, emotions, sensations, memories, and attitudes) are isolated from one another and rendered inaccessible to consciousness and/or voluntary recall (DSM-IV; American Psychiatric Association 1994).

The past two decades have seen an increased interest in dissociative phenomena, with research centring on the role of dissociation in the psychopathology of mental disorders. More recently, interest has turned to the nature and prevalence of dissociative experiences of members of non-clinical, or non-pathological, populations (Giolas & Sanders, 1992; Norton, Ross, & Novotny, 1990; Sanders, McRoberts, & Tollefson, 1989).

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NON-PATHOLOGICAL DISSOCIATION

Dissociation is popularly conceptualised as a continuous variable, experienced to a greater or lesser extent by all people, that is, as existing upon a continuum ranging from brief, normative dissociative states to the more chronic, pathological forms such as Dissociative Identity Disorder (DID; Nemiah, 1980). At the normal end of the continuum are the phenomena of *absorption*, and *imaginative involvement* and mild, transient forms of depersonalisation (Bernstein & Putnam, 1986; Frischholtz, et al., 1991; Norton et al., 1990; Putnam, 1989; Tellegen & Atkinson, 1974; Waller, et al. 1996).

More recently, theorists have suggested it is unclear which dissociative phenomena should be considered in distinguishing between pathological and non-pathological dissociation (Bernstein & Putnam, 1986), and that there may well be two types of dissociative phenomena: pathological and non-pathological. The former is characterised by such processes as amnesia, identity alteration, depersonalisation and derealisation, the latter by absorption and imaginative involvement (Waller et al., 1996). In other words, the two types are qualitatively different.

Absorption is characterised by episodes of total attention or enthrallment where the individual is “absorbed” by external stimuli to the point that focal attention is increased and peripheral awareness is significantly diminished (Frischholtz et al., 1991). Examples are becoming so engrossed in a television program that one does not hear the telephone ringing or smell the dinner burning. During absorption, all of the individual’s representational resources are devoted to the attentional object, resulting in an imperviousness to distractions and a heightened sense of reality regarding the attentional object (Tellegen & Atkinson, 1974).

Imaginative involvement often occurs when an individual is bored or performing an unpleasant or monotonous task. The imaginatively involved individual “tunes out” from their environment and enters a trance-like state (Kirmayer, 1994). In contrast to absorption, imaginative involvement often includes “an alteration in the individual’s sense of self, [for example] appearance, physical and mental abilities, or sexual prowess” (Putnam, 1995, p. 584). With both absorption and imaginative involvement, however, the individual usually has little or no recall for events that occur around them during the episode.

In studies exploring the connection between dissociativity and hypnotisability in non-clinical populations, researchers have found that highly dissociative individuals tend to be highly hypnotisable. However, not all highly hypnotisable individuals are highly dissociative (Carlson, 1994). While these findings suggest the two phenomena are distinct measures, it appears that they intersect in some way (Norton et al., 1990; Putnam, 1995; Tellegen & Atkinson, 1974).

ADAPTIVE AND DEFENSIVE FUNCTIONS OF DISSOCIATION

Given the evidence linking dissociative phenomena to traumatic experiences, dissociation is regarded as an adaptive, “defensive operation, invoked by individuals caught in situations that they wish to escape or avoid” (Putnam, 1995, p. 585). Putnam ascribes the following adaptive-defensive functions to dissociation:

Automatisation — the process whereby well-learned activities are performed unselfconsciously while consciousness is directed to other, usually internal, activities (e.g., conducting a conversation while driving in heavy traffic). Automatisation of behaviour “frees up” conscious attention to deal with unexpected or unusual situations.

Compartmentalisation — involves the sectioning-off of aspects of consciousness allowing for the suppression of overwhelming experiences, the isolation of conflicting emotional material, and the preservation of psychological functioning in the face of disruptive influences.

Alteration of identity — transfers the subjective experience of trauma onto “the other.” The process of denial is transformed from “it’s not happening” to “it’s not happening to me” (Putnam, 1995).

Protection from unbearable pain — enables the individual to endure severe or repetitive abuse and to continue functioning, albeit in a diminished capacity.

These phenomena of non-pathological dissociation are relevant to the hypnotic experience: all may be observed in a client in hypnotic trance, who is using non-pathological dissociation.

COPING STRATEGIES

The term “coping” encompasses a wide range of behaviours produced with the intention of reducing or managing stress. The notion of “stress” describes a transactional relationship that exists between individuals and their environment, that is appraised by individuals as taxing or exceeding their resources and endangering their well-being (Folkman, 1984). In this view, coping strategies are cognitive and behavioural techniques an individual *consciously* employs in order to reduce or tolerate the demands created by the stressful transaction.

Coping strategies are broadly classified as either problem-focused (attempts to manage or alter the problem), or emotion-focused (attempts to regulate emotional responses to stressful situations). Although there may be some overlap in the two categories, an individual’s coping style will be predominantly either emotion- or problem-focused (Evans, Coman, Stanley, & Burrows, 1993).

In this view of stress and coping, coping strategies are adaptational activities which involve conscious selection. As such they are quite dissimilar to unconscious automatic behaviours (Folkman & Lazarus, 1988; Stone & Neale,

1984). This distinction, however, is put into question by an examination of the phenomenological similarities between emotion-focused coping strategies and various dissociative reactions.

Dissociative reactions are regarded as defensive-adaptive processes that protect the individual against unacceptable physical and psychological experiences. Conceptualised in this way, dissociative reactions may also be seen as coping strategies (Bliss, 1984; Giolas & Sanders, 1992; Ludwig, 1983; Putnam, 1995; Sanders et al., 1989). An important indicator of dissociation is the spontaneous occurrence of symptoms, that is, dissociative reactions tend to be effortless, automatic processes. Despite the automatic nature of dissociative reactions, they share marked phenomenological similarities with a range of behaviours regarded as emotion-focused coping strategies. Behaviours described in the literature as being both emotion-focused coping strategies and dissociative reactions include emotional distancing, imaginative involvement, absorption, avoidance, depersonalisation, derealisation, and alterations of identity.

It may be that the spontaneous nature of dissociative reactions reflects a qualitative shift in the way in which some emotion-focused coping strategies are performed. Strentz and Auerbach (1988) note that escape-avoidance type emotion-focused coping strategies are most useful in the early stages of prolonged trauma, a claim echoed in the literature relating the emergence of dissociative symptoms to chronic trauma. It is plausible, then, that with repeated use, emotion-focused coping strategies may transform from being consciously produced behaviours to the effortless, automatic processes that characterise dissociative reactions. Conversely, the use of emotion-focused coping strategies may represent the conscious invocation of dissociative-type states.

LOCUS OF CONTROL

Dispositional factors have been heavily implicated in coping processes. One of the most important of these is an individual's generalised beliefs about control, or *locus of control* (Folkman, 1984; Strentz & Auerbach, 1988).

While there is evidence to suggest that an individual's decision to use either emotion- or problem-focused coping strategies is influenced primarily by situational variables, there is some evidence to suggest their locus of control orientation will also be a determining factor (Folkman, 1984; Strentz & Auerbach, 1988).

The decision to employ a particular coping strategy is affected by one's perceptions of personal control over the stressful situation. In this regard, control beliefs can be seen as "pre-existing notions about reality that serve as a perceptual lens . . . [determining] how things are in a given [situation]" (Folkman, 1984, pp. 840–841). Where an individual perceives a stressful situation to be beyond their control, they are more likely to utilise emotion-focused coping strategies. Where the individual believes they have some control, problem-focused coping strategies may be preferred. Thus, researchers have

found individuals demonstrating a predominantly external locus of control orientation (both Chance and Powerful Others) are more likely to employ emotion-focused, rather than problem-focused coping strategies, given that a perceived lack of control is integral to their cognitive schema. Conversely, individuals demonstrating a predominantly internal locus of control orientation exhibit a greater tendency to utilise problem-focused coping strategies over emotion-focused coping strategies (Conway & Terry, 1992; Evans et al., 1993; Folkman, 1984; Folkman & Lazarus, 1988; Lefcourt, 1982; Strentz & Auerbach, 1988).

DISSOCIATION, COPING STRATEGIES, AND LOCUS OF CONTROL

While presented as distinct theoretical constructs, it appears that dissociation, emotion-focused coping strategies and the development of Chance and Powerful Others locus of control orientations intersect with one another conceptually.

The development of dissociative symptoms has been associated with experiences of a traumatic nature; and the literature on coping reveals strong phenomenological similarities between such dissociative reactions and a range of emotion-focused coping strategies (Bliss, 1984; Giolas & Sanders, 1992; Ludwig, 1983; Putnam, 1995; Sanders et al., 1989). Furthermore, differences between dissociative reactions and emotion-focused coping strategies (i.e., the issue of automaticity) may reflect qualitative differences in the way in which these behaviours are produced rather than differences of type. If this is so, one would expect the use of emotion-focused coping strategies to be associated with the tendency to experience dissociative phenomena. Conversely, given that emotion- and problem-focused strategies serve separate coping functions, one would expect the use of problem-focused coping strategies to be unrelated to the use of both emotion-focused strategies and the tendency to experience dissociative phenomena.

Preference for emotion-focused strategies has been associated consistently with the possession of an external locus of control orientation, both Chance and Powerful Others (Conway & Terry, 1992; Evans et al., 1993; Folkman, 1984; Folkman & Lazarus, 1988; Lefcourt, 1982; Strentz & Auerbach, 1988). External expectancy beliefs are, in turn, related to the experience of dissociative phenomena in two ways; firstly, via the relationship between external locus of control orientation and the preference for emotion-focused coping strategies; and secondly, with regard to the common antecedents of both the development of dissociative symptoms and the development of external locus of control orientation (i.e., a history of traumatic experiences, childhood maltreatment and, according to the developmental model of dissociation, the failure of parents or significant others to provide adequate nurturance).

Within this conceptual framework, one would expect external locus of control orientation to be related to both the use of emotion-focused coping strategies and the tendency to experience dissociative phenomena. As the

possession of an internal locus of control has been positively associated with the use of problem-focused coping strategies, and negatively associated with the use of emotion-focused coping strategies, it is also to be expected that internal locus of control orientation would also be negatively associated with the tendency to experience dissociative phenomena.

THE PRESENT STUDY

This study was a preliminary exploration of the relationship between self-reported dissociative experiences, the use of emotion- and problem-focused coping strategies and locus of control orientation in members of a non-clinical population. The term “non-clinical population” described a group in which members “were not specifically identified as having a particular mental disorder, but . . . were not screened to determine whether any disorder was present” (Carlson, 1994).

It was expected that:

1. Dissociativity is positively associated with the use of emotion-focused coping strategies, but not with the use of problem-focused coping strategies.
2. Dissociativity is positively associated with external locus of control orientation, both Chance and Powerful Others, and negatively associated with internal locus of control orientation.
3. External locus of control, both Chance and Powerful Others, is positively associated with the use of emotion-focused coping strategies.

Participants in the study were 130 adults: 92 females, 37 males and one gender not specified, with ages ranging between 18 and 58 years ($M = 25.57$).

Each participant completed Levenson’s Locus of Control questionnaire (LLC; Levenson, 1972), the Ways of Coping Questionnaire (WCQ; Folkman & Lazarus, 1988), and the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986).

The WCQ is a self-report measure of coping processes with eight empirically derived scales: Confrontive Coping, Distancing, Self-controlling, Seeking Social Support, Accepting Responsibility, Escape-Avoidance, Planful Problem Solving, and Positive Reappraisal (Folkman & Lazarus, 1988). Although the authors acknowledge the capacity of the questionnaire to distinguish between emotion-focused and problem-focused coping strategies, they do not categorise the coping strategies described in the questionnaire according to this functional distinction. We identified those WCQ scales containing *only* emotion-focused items and those scales containing *only* problem-focused coping items, providing two emotion-focused scales, “Distancing” and “Escape-Avoidance,” and two problem-focused scales, “Confrontive Coping” and “Planful Problem Solving.” To preserve the integrity of the questionnaire, participants completed the full WCQ, but only the four scales mentioned above were scored.

RESULTS

Descriptive statistics for DES, age, the four WCQ scales and the three LLC scales are shown in Table 1. The results of all analyses have been reported at an alpha level of .05, two-tailed, in order to capture the full range of directional effects.

Table 1: Descriptive Statistics for DES Scores, Age, Locus of Control Orientation, and Coping Scales

	<i>Mdn</i>	<i>Mean</i>	SD	Skew	Kurt	<i>D</i>
DES	13.66	17.51	13.25	0.98	0.53	.16
Age ^a	22.00	25.57	8.86	1.87	2.99	.26
Locus of control						
Internal	35.00	34.89	4.91	-0.36	0.29	.08 ^b
Chance	21.00	21.62	6.05	0.17	0.03	.05*
Powerful Others	21.00	22.12	5.38	0.31	-0.28	.10
Coping						
Distancing	0.83	0.96	0.60	0.64	-.017	.13
Escape-Avoidance	1.00	1.03	0.61	0.29	-0.61	.08* ^c
Confrontive Coping	1.00	1.07	0.68	0.38	-0.53	.10
Planful Problem Solving	1.50	1.56	0.68	-0.03	-0.57	.06*

Note: Skew = Skewness; Kurt = Kurtosis; and *D* = Kolmogorov-Smirnov test statistic. *N* = 130 except ^a*n* = 127.

^b*D* = .0801. ^c*D* = .0767.

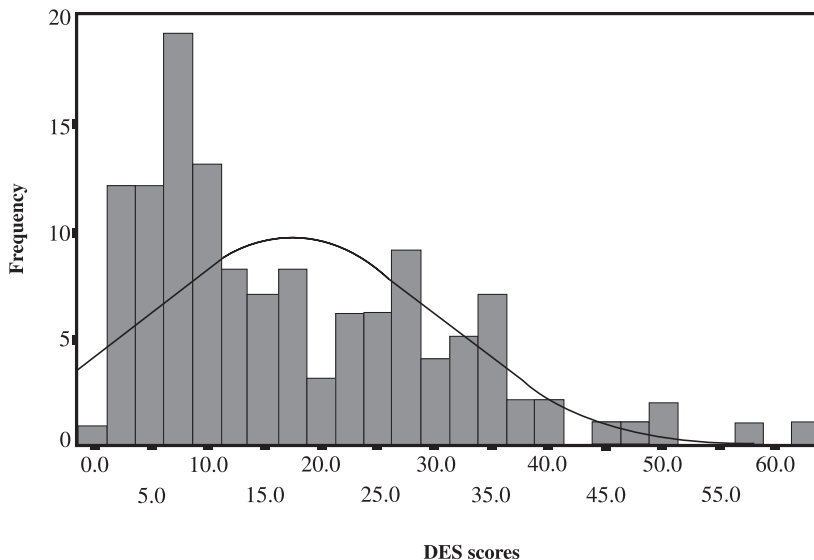
**p* < .05, two-tailed.

Scores were normally distributed only for the Escape-Avoidance, Planful Problem Solving coping strategies, and Chance locus of control measures. As expected, the distribution of DES scores was positively skewed and leptokurtic. Frequency distributions for DES scores are shown in Figure 1.

Median and mean scores for internal locus of control were considerably higher than those obtained for Chance and Powerful Others orientation, with the latter two producing similar central scores. Median and mean scores for the four coping scales were generally within the lower half of the possible score range of 0–3. The most frequently utilised class of coping strategies was Planful Problem Solving while Distancing strategies were the least frequently employed.

The correlation matrix for DES scores, locus of control orientation and coping scales are presented in Table 2. Pearson's correlation coefficients are reported for correlations between the three normally distributed measures (i.e., Escape-Avoidance, Planful Problem Solving and Chance locus of control); the remaining values are Spearman's rank correlation coefficients.

Figure 1: Frequency Distribution of DES Scores



In general, associations between measures were small to moderate. Significant positive correlations were obtained for DES scores and Escape-Avoidance ($r_s^2 = .18$), Chance orientation ($r_s^2 = .07$) and Powerful Others orientation ($r_s^2 = .04$). A significant negative correlation was obtained for DES and internal locus of control ($r_s^2 = .05$).

Table 2: Correlations for DES Scores, Locus of Control Orientation, and Coping Scales

	DES	LOC-I	LOC-C	LOC-P	EA	DIST	CC	PPS
DES		-.22*	.26**	.21*	.43**	.10	.13	.03
LOC-I			-.20*	-.08	-.19*	.01	-.06	.07
LOC-C				.49**	.24** ^a	-.03	.05	-.04 ^a
LOC-P					.13	-.06	.04	-.13
EA						.15	.10	.01 ^a
DIST							.05	.17*
CC								.31**

Note: DES = Dissociative Experiences Scale; LOC-I = Internal locus of control; LOC-C = Chance locus of control; LOC-P = Powerful Others locus of control; EA = Escape-Avoidance; DIST = Distancing; CC = Confrontive Coping; and PPS = Planful Problem Solving Values are Spearman's rank correlation coefficients except ^a Pearson's product-moment correlation. * $p < .05$, ** $p < .01$, two-tailed.

Chance orientation was significantly associated with Escape-Avoidance ($r^2 = .06$), but not with Distancing; Powerful Others was not significantly associated with any of the coping scales. There was a significant negative association between internal locus of control and Escape-Avoidance ($r_s^2 = .04$); internal locus of control was not significantly associated with any other coping scales.

Correlations between the four coping scales showed a significant positive relationship between the two problem-focused scales (Confrontive Coping and Planful Problem Solving [$r_s^2 = .10$]), while the two emotion focused scales (Escape-Avoidance and Distancing) were not significantly related. Correlations across the two coping functions were non-significant with the unexpected exception of a small significant positive correlation between Distancing and Planful Problem Solving ($r_s^2 = .03$).

Among locus of control measures, there was a significant positive correlation between Chance and Powerful Other ($r_s^2 = .24$), and a significant negative correlation between Chance and internal orientations ($r_s^2 = .04$). Internal and Powerful Others orientations were unrelated.

DISCUSSION

These results provide partial evidence for the proposed relationships between self-reported dissociative experiences, the use of emotion- and problem-focused coping strategies, and locus of control orientation in members of a non-clinical population.

DISSOCIATIVITY AND COPING

Our hypothesis that dissociativity is associated with the use of emotion-focused coping strategies was partially supported, in that dissociativity was associated with “Escape-Avoidance” strategies but not with “Distancing” strategies.

Distancing strategies imply the recognition and a degree of resignation regarding the stressful situation (e.g., “Went along with fate; sometimes I just have bad luck”). On the other hand, Escape-Avoidance strategies imply attempts to avoid actually registering the stressful signs and symptoms and a failure to accept the reality of the stressful encounter (e.g., “Refused to believe it had happened”). So while Distancing strategies serve to modify the personal meaning of the stressful encounter, Escape-Avoidance strategies serve to suppress from consciousness, or *compartmentalise*, the stressful experience. It may be that the association between DES scores and the use of Escape-Avoidance coping strategies reflects the compartmentalising function shared by the two variables.

The hypothesis that dissociativity is unrelated to the use of problem-focused coping strategies was supported.

DISSOCIATIVITY AND LOCUS OF CONTROL

The hypothesised positive relationship between dissociativity and Chance and Powerful Others locus of control orientation was found as was the hypothesised negative relationship between dissociativity and internal locus of control orientation.

This finding provides some support for the proposed connection between the development of dissociative tendencies and external locus of control orientations, based upon their common antecedents. The link between dissociation and Chance orientation in particular, was further strengthened by the relationship between external locus of control and the use of emotion-focused coping. While we hypothesised that the use of emotion-focused coping strategies would be positively associated with external locus of control orientation, both Chance and Powerful Others; this relationship was found to exist only between the use of Escape-Avoidance strategies and Chance orientation. This suggests that individuals possessing a predominantly Chance locus of control orientation also possess a tendency toward the experience of dissociative phenomena and the use of Escape-Avoidance coping strategies.

DISTANCING COPING STRATEGIES AND LOCUS OF CONTROL

The hypothesised positive relationship between external locus of control orientation, both Chance and Powerful Others, and the use of emotion-focused coping strategies was partly supported, in that the relationship was found to hold only between Chance locus of control orientation and the use of Escape-Avoidance coping strategies.

The predicted inclusion of Distancing coping strategies in the relationship between dissociative experiences, the use of emotion-focused coping strategies, and external locus of control orientation was not confirmed. The exclusion of Distancing coping strategies from this relationship may be understood in light of the different modes by which Distancing and Escape-Avoidance strategies act to regulate emotional responses to stressful situations.

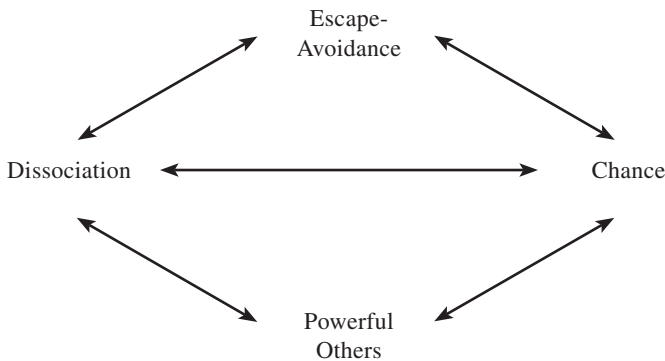
As has been suggested, Distancing coping strategies involve the conscious registering and acceptance of the stressful situation while Escape-Avoidance strategies are characterised by attempts to *avoid* consciously registering the stressful situation. Although both strategies clearly serve the function of regulating emotional responses, Distancing strategies include an element of “action” or “planfulness” in that the individual actively modifies the personal meaning of the situation. Viewed in this way, Distancing might be regarded as an *active* emotion-focused strategy and Escape-Avoidance regarded as a *passive* emotion-focused strategy. The active-passive distinction is useful in understanding the correlation between DES scores and the use of Escape-Avoidance strategies and the independence of DES scores and the use of Distancing strategies. In addition to serving a compartmentalising function,

both dissociative reactions and Escape-Avoidance coping strategies involve an attitude of emotional passivity toward the stressful situation; a feature not shared by Distancing strategies.

DISSOCIATION, ESCAPE-AVOIDANCE COPING STRATEGIES, AND CHANCE LOCUS OF CONTROL ORIENTATION

The results provide evidence of a relationship between dissociation, the use of Escape-Avoidance coping strategies, and Chance locus of control orientation. Dissociation is also associated with Powerful Others locus of control orientation. These associations are presented graphically in Figure 2.

Figure 2: Associations Found Between Dissociation, the Use of Escape-Avoidance Strategies and Chance, and Powerful Others Locus of Control Orientation



The unifying theme in this relationship appears to be a defensive emotional withdrawal in the face of unpleasant or unacceptable situations, grounded in a perceived inability to control the situation. The inclination toward emotional withdrawal in such situations may represent the reproduction (conscious or otherwise) of induced defensive behaviours that have proved successful in the past in enabling the individual to tolerate stressful situations (de Man, Hall, & Stout, 1990; de Man Leduc, and Labreche-Gauthier, 1992; Giolas & Sanders, 1992; Levenson, 1981; Putnam, 1995).

IMPLICATIONS FOR CLINICAL PRACTICE

As stated previously, not all highly hypnotisable individuals are high dissociators; however, highly dissociative individuals tend to be highly hypnotisable (Carlson, 1994). It may be appropriate for clinicians to evaluate the dissociative capacity of clients who are good hypnotic subjects, because of the likely relationship with locus of control.

From our data, it is likely that high dissociators will also have an external locus of control — a belief that their life is influenced by powerful others or by chance. Therapeutic suggestions may be quite different for these clients, compared to those who believe they exert control over important life events. Clients with external locus of control may hold certain rigid beliefs about the nature of the world and have stereotypical ways of coping with stress. Therapeutic strategies which presuppose a belief in personal control over life events are unlikely to be effective. For these clients, changing beliefs regarding control may be an important goal of therapy.

By the same token, a clinician's knowledge of their client's internal locus of control may be useful in understanding and overcoming resistance during induction. Such knowledge regarding the client's internal control beliefs may aid both the client and clinician in recognising sources of resistance, thus facilitating the hypnotherapeutic process. In such cases, indirect or non-directive approaches are likely to be more effective.

Locus of control orientation also impacts on clients' use of coping strategies, with external locus of control associated with a tendency to utilise escape-avoidance coping strategies. An awareness that one employs escape-avoidance modes of coping with stress is the first step in addressing that problem. Knowledge of an externally oriented client's coping patterns may well also impact on therapeutic suggestions, both in and out of trance. Training in the use of more problem-focused strategies may be beneficial where a client displays an over-reliance on escape-avoidance strategies. It may also be useful for the therapist to be aware of her/his client's tendency to use such strategies. Too confrontationalist an approach could result in the client avoiding therapy altogether.

REFERENCES

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, *174*, 727–735.
- Bliss, E. L. (1984). A symptom profile of patients with multiple personalities, including MMPI results. *Journal of Mental and Nervous Disorders*, *171*, 197–202.
- Carlson, E. B. (1994). Studying the interaction between physical and psychological states with the Dissociative Experiences Scale. In D. Spiegel (Ed.), *Dissociation: Culture, mind, and body* (pp. 41–58). Washington, DC: American Psychiatric Press.
- Conway, V. J., & Terry, D. J. (1992). Appraised controllability as a moderator of the effectiveness of different coping strategies: A test of the goodness of fit hypothesis. *Australian Journal of Psychology*, *44*, 1–7.
- de Man, A., Hall, V., & Stout, D. (1990). Family environment and multidimensional locus of control. *Social Behavior and Personality*, *18*, 197–200.

- de Man, A., Leduc, F., & Labreche-Gauthier, L. (1992). Parental control in child rearing and multidimensional locus of control. *Psychological Reports, 70*, 320–322.
- Evans, B. J., Coman, G. J., Stanley, R. O., & Burrows, G. D. (1993). Police officers' coping strategies: An Australian police survey. *Stress Medicine, 9*, 237–246.
- Folkman, S. (1984). Personal control and stress and coping processes: A theoretical analysis. *Journal of Personality and Social Psychology, 46*, 839–852.
- Folkman, S., & Lazarus, R. S. (1988). *Ways of Coping Questionnaire*. Palo Alto, CA: Mind Garden.
- Frischholtz, E. J., Braun, B. G., Sachs, R. G., Schwartz, D. R., Lewis, J., Schaeffer, D., Westergaard, C., & Pasquotto, J. (1991). Construct validity of the Dissociative Experiences Scale (DES): 1. The relationship between the DES and other self-report measures of DES. *Dissociation, 4*, 185–188.
- Giolas, M. H., & Sanders, B. (1992). Pain and suffering as a function of dissociation level and instructional set. *Dissociation, 5*, 205–209.
- Kirmayer, L. J. (1994). Pacing the void: Social and cultural dimensions of dissociation. In D. Spiegel (Ed.), *Dissociation: Culture, mind, and body* (pp. 91–122). Washington, DC: American Psychiatric Press.
- Lefcourt, H. M. (1982). *Locus of control: Current trends in theory and research* (2nd ed.). Hillsdale, NJ: Erlbaum.
- Levenson, H. (1972). *Distinction within the concept of internal-external control: Development of a new scale*. Proceedings of the 8th Annual Convention of the American Psychological Association, 261–262.
- Levenson, H. (1981). Differentiating among internality, powerful others, and chance. In H. M. Lefcourt (Ed.), *Research with the locus of control construct: Vol. 1. Assessment methods* (pp. 15–63). New York, NY: Academic Press.
- Ludwig, A. M. (1983). The psychobiological functions of dissociation. *American Journal of Clinical Hypnosis, 26*, 93–99.
- Nemiah, J. C. (1980). Dissociative disorders. In A. M. Freedman & H. I. Kaplan (Eds.), *Comprehensive textbook of psychiatry* (pp. 1544–1561). Baltimore: Williams & Wilkins.
- Norton, G. R., Ross, C. A., & Novotny, M. F. (1990). Factors that predict scores on the Dissociative Experiences Scale. *Journal of Clinical Psychology, 46*, 273–277.
- Putnam, F. W. (1989). Pierre Janet and modern views of dissociation. *Journal of Traumatic Stress, 2*, 413–429.
- Putnam, F. W. (1995). Development of dissociative disorders. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 2. Risk, disorder, and adaptation* (pp. 581–608). New York: John Wiley and Sons.
- Sanders, B., McRoberts, G., & Tollefson, C. (1989). Childhood stress and dissociation in a college population. *Dissociation, 2*, 17–23.
- Stone, A. A., & Neale, J. M. (1984). New measure of daily coping: Development and preliminary results. *Journal of Personality and Social Psychology, 46*, 892–906.

- Strentz, T., & Auerbach, S. M. (1988). Adjustment to the stress of simulated captivity: Effects of emotion-focused versus problem-focused preparation on hostages differing in locus of control. *Journal of Personality and Social Psychology*, *55*, 652–660.
- Tellegen, A., & Atkinson, G. (1974). Openness to absorbing and self-altering experiences (“absorption”), a trait related to hypnotic susceptibility. *Journal of Abnormal Psychology*, *83*, 268–277.
- Waller, N. G., Putnam, F. W., & Carlson, E. B. (1996). Types of dissociation and dissociation types: A taxometric analysis of dissociative experiences. *Psychological Methods*, *1*, 300–321.

HYPNOSIS USED IN PARKINSON'S DISEASE: A CASE STUDY

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This paper describes the use of hypnosis in a case of Parkinson's disease. Hypnosis was used as part of therapy to help the client not only control some symptoms of the disorder, but to help him reframe the nature of his illness and his reaction to it. In the short term, hypnosis appeared to be efficacious in halting the progression of the disorder.

Paul is a 46-year-old architect with Parkinson's disease. He sought therapy because he wanted to feel "more in control," of his condition. His primary goal was to stabilise the disease so that it would not progress any further. He also described two secondary goals: getting back in touch with his real self; and dealing with the stress of "administrivia" that cluttered his life and kept him from engaging in "essential pursuits."

Parkinson's disease is a condition which affects the basal ganglia, the clusters of neurons which play a significant role in the initiation and regulation of movement. It has been found that there is a significant reduction of dopamine in the basal ganglia of people with this disease. Cells located in a brainstem nucleus called the substantia nigra are responsible for releasing the dopamine onto the neurons in the basal ganglia. These neurons in those affected by Parkinson's disease deteriorate and die (Kimble, 1988).

The effects of this condition are mainly to do with movement. Tremors of increasing degree, a constant backwards and forwards movement, are usual symptoms. Rigidity can be caused by over-contraction of muscles. With the progression of the disease, dementia can occur. One patient cited by Vaughn (1984, p.14) remarked, "I have to engage in self-deception, whereby any personal interest in the fulfilment or goal of an action must be removed from consciousness." This statement describes what is known as the "intention tremor," whereby actions become more difficult to perform if the patient has an

emotional stake in the outcome; that is, the more anxious and frustrated they become, the more difficult it is to complete an intentional movement. A simple example described by the above patient is the overwhelming difficulty of carrying a cup of coffee across the room if he at any moment stops to think about the consequences of spilling it.

Miller (1991), taking a different view of Parkinson's disease, asks this question: "Doesn't the inability to take a first step, the inability to initiate movement, seem the same as being trapped, not being able to move in any direction?" (p. 222). He has found success with reducing the symptoms in patients through re-experiencing and deprogramming past sensitising events which, he believes, have led to incoherent neural discharges that become negatively conditioned habit patterns.

Treatment of this disease is symptomatic. Not a great deal is known about its cause. There is some evidence that it could be viral, in which case the immune system would be involved. The fact that thought processes can influence the effectiveness of movements implies that cerebral input plays a significant part. The influence of stress on the immune system has been well documented (Chopra 1990; Simonton, Matthews-Simonton, & Creighton, 1978). More discoveries are constantly being made in this area. The field of psychoneuroimmunology in particular has seen an explosion in the last decade, with research showing links between the CNS and the immune system. Stress has been shown to have an adverse effect on the immune system, while relaxation/meditation and psychosocial interventions have been shown to have the opposite effect (Booth, 1998).

All of these considerations indicated that hypnosis would be useful in Paul's case. One of the most remarkable things about Paul during his first visit was his calm certainty that hypnosis would have a beneficial effect, not only on the way he perceived and dealt with stress in his life, but also on the progress of the disease itself. The original diagnosis had frightened Paul a great deal. The specialist informed him bluntly that his disease was fatal, that it would progress inexorably and quickly, and the only thing medication could do would be to control the symptoms. Paul came away with a sense of powerlessness. He felt shaken and depressed. Fortunately, he sought a second opinion.

The second specialist who spoke to Paul told him that he wished to "return power" to Paul. He spoke enthusiastically about the efficacy of positive thinking, and introduced Paul to a range of positive visualisations, based on the ideas and work of Simonton et al. (1978). By the time Paul made his first visit to me he was already familiar with exercises that encouraged him to visualise the substantia nigra as increasing in blackness and density (a healthy sign of increased neuronal activity) and his daily medication was seen as a little army of soldiers which were consciously sent "to the right places" where they could be "most effective."

Paul was highly motivated to begin hypnotherapy. His beliefs about the onset of his disease were also very important. He believed that, as a child and young

man, he had an exceptionally strong immune system. The last ten years of his life had been extremely stressful. He believed strongly that stress had weakened his immune system and made him vulnerable to the development of Parkinson's disease. He was quietly certain that hypnosis would make a positive difference in his life, and he had the encouragement of his new specialist, "who treats me like a human being," to support him in his decision.

While hypnosis was, therefore, the obvious adjunct to his treatment, it was important to keep a balanced perspective. As Hammond stated: (1990, p. 4) "Hypnosis is often most effective when it is combined with other non-hypnotic interventions." The reframing and reprogramming aspects of cognitive therapy must not be neglected.

TREATMENT PLAN

It was decided that each session would consist of four parts.

1. At the commencement of each session, we would briefly review progress; how the week had been experienced.
2. The second part would involve an hypnotic induction and deepening, and associated therapy. The hypnotic experience would involve such elements as progressive muscle relaxation, visualisations, use of symbols, age regression, and ego strengthening. The purpose of the progressive muscle relaxation would be to reduce stress. Most of the visualisations used during hypnosis would remain the same each time, to encourage the development of self-hypnosis skills through familiarity and confidence building. Consistent visualisations and symbols would include: a journey on a familiar path; a waterfall of light; a still pool with honeycomb patterns of sunlight reflected in it; steps leading downward (deepening) fashioned from natural materials such as earth, stone, and wood; a very old building; and a small golden box. These symbols were chosen as images of calmness, natural elements, and strength in order to encourage in Paul a sense of his own strengths and capabilities. Some symbols would change each time, for example, the "strength symbol" which Paul would find in the box and the "person" who might or might not be in the building would vary according to his current needs and insights.
3. After Paul had been brought out of hypnosis, we undertook a more cognitive exploration of the images and symbols arising from each hypnotic experience.
4. Paul would be taught self-hypnosis, so he could practise on his own every day and continue to benefit and progress.

SESSION 1

One of the first tasks was to clarify Paul's goals and expectations. Unrealistic goals are counterproductive. When Paul arrived for his first session, he said, "I

believe this treatment will cure the disease. I will recover from Parkinson's." The word "cure" was gently removed from the goal-setting process and replaced by other words such as "healing" and "wellness." Paul was encouraged to think of his progress day by day; not to look far ahead, but to concentrate on making each day as enjoyable and stress-free as possible.

It seemed important to me to separate out goals to do with healing his physical condition, and goals which concerned Paul's emotional and personal development. And yet — both of these areas are deeply connected. Waxman (1989, pp. 272–273) stated "hypnosis can be used to afford symptomatic relief in certain chronic physical diseases. It does this partly by reducing tension, anxiety and apprehension, and partly by exercising a direct influence on the patient's attitude to the symptoms and to the illness itself." Paul had already formulated his own goals clearly and with great hope. It was decided to work towards these, affording each the priority with which he had invested it, namely: (a) stabilising the disease; (b) getting back in touch with what Paul referred to as his "real self" (this would involve age regression, and a process of self-discovery); and (c) dealing with the stress caused by "administrivia."

Another goal of Paul's first session was to understand his story. It was during the telling of this story that the importance of symbols became clear. Born in Scotland of wealthy parents, Paul had spent his life up to the age of 36 studying, working, and travelling. Literature was of great importance to him. His first degree had been in literature and he responded at a very deep level to poetry, myths, and legends. He also had a great love for the land. As a boy, he had roamed over the hills of his native country, and he later roamed the world, living and working in many countries. It was his love of earth and stone which had finally led him to study architecture, and he was now well known in his field, and the head of a successful architectural firm.

As Yapko (1984, p. 73) pointed out: "the main advantage of using hypnosis in psychotherapy lies in its ability to use the many extraordinary resources of the unconscious mind. The unconscious mind contains a lifetime of experiences and learnings, and is a resource that must be used with a proper amount of respect and appreciation." Paul's wealth of symbolic and literary knowledge would be a powerful tool if used creatively in his therapeutic journey.

Ten years earlier, Paul's life had changed dramatically. He came to Australia, met an Australian girl and married her. After 36 years on his own, adjustment to married life and children was not easy. He felt a lack of freedom and a sense of solitariness. His profession was not an easy one either, especially as he now had responsibilities; the days were gone when he could please himself and move on whenever he became bored or frustrated. He often missed his home country, but had made up his mind to embrace Australian ways and culture. His mother, living in Scotland, was his only close surviving relative.

He was convinced that the relentless stress of the last ten years had been responsible for the development of Parkinson's disease. His doctor had agreed that stress could not be ruled out as a contributive factor.

At present, the disease was not seriously affecting him; at least the medication was dealing with most symptoms. There was very little tremor. The stiffness that he experienced on most days varied a great deal in intensity. His left hand felt weak, and sometimes his left shoulder as well. His neck was often stiff and sometimes painful. He was always conscious of the presence of the disease, on some days more so than on others. He was worried for the future.

Having gained some insight into Paul's story, and clearly formulated his goals for therapy, it was time to turn to hypnosis. Paul was eager to learn about it and to experience it. The explanation given was based on the suggestions offered by Hammond (1991). Three elements of hypnosis were emphasised: the use of the imagination, a powerful force; the presentation of healing and strengthening images; and the possibilities that existed for unconscious exploration. It was important to reassure Paul that, far from losing control, he would be gaining it. He and the therapist would be a team, dedicated to the goal of his healing. At no time would he be "out of control." Hartland (in Waxman, 1989) stresses the importance of dealing with all of the client's anxieties and misconceptions about hypnosis before any inductions are attempted. It was emphasised that it would be an opportunity to reassess and reorganise inner psychological complexities and utilise his own inner strengths.

A light trance was then induced, using progressive muscle relaxation. A visualisation of a pleasant place was added. After being brought out of trance, Paul expressed optimism and enthusiasm about continuing with therapy.

SESSION 2

This session began with further telling of Paul's story. Several important themes emerged. Paul's connectedness to the land and his love of literature are integral parts of his inner beliefs. Symbols used in the visualisations might well come from these sources.

Since coming to Australia, Paul has felt "an incredible loneliness." He now believes that "it is possible to be surrounded by people, and yet feel no connectedness." Since his marriage, he has often found that he misses the company of other men. He also misses his native land, and is having trouble adjusting to Australian culture.

Hypnosis was then induced. Hypnosis was to play a central part in his therapy, and it was important to begin the process in a meaningful way, so that each session would build on the previous one. The goal of each session would be for Paul to gain strength and a sense of control over the day to day implications and effects of Parkinson's disease. Bearing in mind that stiffness was one of the most obvious and ever present effects, a sense of relaxation and flexibility would be hoped for. Stanton (1994) defined hypnosis as involving three elements: relaxation; suggestion; and mental imagery; and placed particular importance on the latter. Visual imagery would be an integral part of each hypnotic experience for Paul.

The induction consisted of progressive muscle relaxation. Visual symbols were then introduced, beginning with the waterfall of light. As Paul's left hand was stiff and weak, it was suggested that this might be the hand which was first lifted to the waterfall. Time was allowed to watch the prismatic colours of the waterfall play over this hand. Gradually, Paul stepped into the waterfall, so that the light could flow over and through him. A tingling feeling was introduced, to suggest the healing power of the light. Moving onward, Paul approached a still pool. The surface of the pool was gleaming with honeycomb patterns of light. Taking off his shoes and socks, Paul stepped off the edge of the pool and felt the shock of the cold water as he waded "strongly" across the pool. Deepening then occurred, through the use of 10 steps leading downwards. The track now led to an old wooden building. A sense of loving welcome emanated from this building and, once inside, the only thing to see was a small golden box on an old wooden table. The box contained a symbol of the strength Paul needed to keep going on with his life, and to heal. Paul found two symbols and took them out of the box. After holding them for a while and examining them, he felt them melting into his hand. The strength of the symbols was now a part of him.

After Paul had been brought out of hypnosis, he discussed the experience. He had found it extremely peaceful and refreshing. He was particularly interested in the symbols he had discovered when he opened the lid of the golden box. He had been told that he would find a symbol there of the strength he needed. One was a black lacquered stick. The other was a tear-shaped stone. It was white, and looked like granite. Speaking about his symbols enabled him to get in touch with some of his sadness, and translate into more accessible terms some of the helplessness he had been feeling (but not acknowledging) about his condition.

SESSION 3

Paul's experiences with hypnosis so far had demonstrated his hypnotisability clearly; however, it was decided to test his hypnotisability to expand possibilities for imagery and define Paul's dominant mode. He achieved a perfect score on the Stanford Scale and the Gordon Test. On the Tellegen Absorption Scale (TAS; Tellegen & Atkinson, 1974), he scored 24 out of a possible 34. The few difficulties Paul had experienced were mainly due to colour perception, which he had already been told was slightly impaired. Testing for hypnotisability has a role to play in the exploration of new possibilities for the client. It also provides a useful format for further discussion of the power and benefits of hypnosis for the client. Testing and the resultant discussion occupied this session. Paul's attitude to hypnosis and his sense of its benefits were very strong.

SESSION 4

One of the main goals of this session was to teach Paul how to apply his experiences with hypnosis in his everyday life. Self-hypnosis would give him a sense of control and help him to relax, countering the stiffness associated with movement, especially in his left hand, arm and shoulder, and neck. The connection between anxiety and muscle tension was again discussed. This was particularly important in Paul's case because of the possibility of his developing the "intention tremor" symptom, typical of his condition. The role of stress in weakening the immune system was again explained and discussed.

To facilitate his own practice, the same induction would now be used in each session. Paul would be asked to imagine walking through an empty classroom towards the blackboard and straining (with eyes closed) to look upwards to read a word written on the very top of the board. He would slowly make out each letter (R..E..L..A..X) and then, when he had completed the word, would let his eyes relax. As he did so, the relaxation that he felt would act as a metaphor for his whole body, which would now feel the same sense of relaxation and rest stealing through it.

As the hypnotic trance was developed and deepened during this session, the following suggestion was built in: "and you will continue to experience these feelings every day . . . just as surely . . . just as powerfully when you are back home again . . . as when you are with me in this room."

SESSION 5

Paul began by reporting successful practice of self-hypnosis on most days following the previous session. He was excited by a greater sense of physical flexibility and commented that he was very aware of stiffness on the one or two days that he was not able to practise it. He expressed some anxiety, however, about "doing it right." It was important to reassure him. He was reminded there is no "right way," and that he did not actually have to "do" anything. Reardon (1995, p. 10) remarks: "of one thing I'm certain. There is no *getting* calm. It only comes . . . when you *let* it."

Paul's doctor had suggested that swimming would be a valuable therapeutic exercise, but Paul felt tentative about it, even though he had once been an excellent swimmer. He felt anxious about his left arm, and expressed doubt as to whether he would ever be able to swim in anything but an awkward way. A pool was built into the visualisation during this session, and Paul was able to experience the physical sensation of moving powerfully through the water. It was decided to include this as part of the visualisation from now on.

The waterfall of light was again a powerful symbol of strength. The symbol that he found in the box this time was a goblet, made of copper, encrusted with jewels. For him it represented a melding of the feminine and masculine strength; the "feminine spirituality" of literature, art and, creativity, supported by the

strong round “masculine” cup. During the hypnotic experience he had been aware of the presence of two figures. One was an old man who was gentle, who might or might not have been God. The other was a flickering image, “like a hologram” of a young man, a warrior. Paul said that neither was “ready” to speak to him yet.

The inclusion of the pool in the imagery had been useful, but Paul was still struggling with the idea of actually swimming as he had once been able to. Again he mentioned his “weak arm” and said it felt “too difficult.” I hoped that the constant practice of mental rehearsal in future hypnotic sessions would overcome this feeling.

At this stage Paul was confronted with a very significant question: “What does Parkinson’s disease do for you?” This question brought about a very lengthy silence. Eventually, he replied: “It allows me to feel OK about relaxing. It gives me permission to step off the treadmill.”

I suggested that there might be other more effective ways of doing this.

SESSION 6

Paul had now begun to learn Tai Chi. He was sure that the first symbol he found in the golden box (the black lacquered stick) had led him to seek this out. He said the gentle exercise was “very spiritual” and he was glad that he had begun. However, the movements, slow and deliberate as they are, had emphasised for him his “disability.” He found some of the hand movements “very difficult,” but resolved: “I will work *with* the impediment, I won’t let it stop me.” It was interesting to note that he now referred to his condition as an “impediment” rather than a disease.

During the hypnotic experience, I wanted to allow Paul to feel what it would be like if he was free of the disease. The waterfall of light was directed into streams of power that would mobilise the body’s defences. The word “firing” was emphasised, to give the idea that synapses were occurring with lightning speed and effectiveness. It was like a surge of power. It was also important for him to visualise what it would be like if he were free of the disease. For example, when he needed to remove shoes and socks to enter the water, and also when he later put them back on, he was able to do this easily and quickly, balancing effortlessly first on one foot, then the other. This time the symbol in the golden box was a spearhead fashioned from copper or bronze.

Paul had processed the question posed in the last session much further. “What does Parkinson’s disease do for you?” The response was: “It does lots. It lets me come back, with honour, to myself. It lets me say that I don’t have to do every bloody thing.”

His final comment for this session was, “I have come back to myself.”

SESSION 7

A difference in Paul was noticeable. He exuded a sense of vitality and optimism. He immediately described his visit to the neurologist on the previous day, for a check-up. The neurologist had not seen him for six months. To Paul's great satisfaction, he was given a very positive report. His disease had not advanced at all since the last investigation. Despite his fears about the stiffness in his left side, there had been no noticeable advance whatever. Paul was convinced that the neurologist had been about to say that the disease had diminished, but caught himself in time because he was afraid of arousing false hopes. Paul's current medication was still adequate, and nothing more was required. The neurologist was very pleased with his progress, and did not want to see him for another six months.

Self-hypnosis was proceeding very satisfactorily. Hypnotic trance was induced and carried out as usual and Paul's buoyant, optimistic mood prevailed during the entire session.

SESSION 8

In order to ensure that residual anger because of the Parkinson's disease was not impeding progress, it was decided to incorporate the silent abreaction technique centred around a large boulder covered with moss and dirt, situated in the middle of a clearing. Picking up a hammer, the client smashes the boulder with all their strength. The boulder symbolises feelings such as frustration or resentment, encased in the stone. After the smashing of the boulder, the client moves on to a peaceful place to rest. While resting there, ego-strengthening is introduced, in the form of affirmations.

This did not appear to be a successful hypnotic experience. After coming out of hypnosis, Paul described his experience with the boulder as one of disinterest. He had actually drifted off to sleep at this point, ignoring the boulder. He commented, however, that he would have attacked it with gusto if the boulder had actually represented Parkinson's disease.

SESSION 9

I decided at the start of this session to revisit the boulder. Paul seemed even more invigorated as a result of the positive report from the neurologist. He was also very pleased to describe his return to swimming — he had amazed himself by finding it “so much easier than I had expected.” This was possibly due to the inclusion of the pool imagery and the experience of floating and swimming effortlessly during the hypnotic experiences of the previous sessions.

This time the boulder was strongly identified as representing Parkinson's disease. Paul was asked to pick up the sledge-hammer lying in the grass and attack the boulder. He was to signify his completion of this task with a nod of the head. About four minutes went by before he nodded his head. Ego-

strengthening was then introduced, and he was then asked to make positive affirmations by completing the sentence, “I am . . .” three times. After coming out of hypnosis, Paul was asked to describe his experience with the boulder, and he said, with quiet pride, “I smashed it to pieces.”

This experience brought about a change in perception. Paul explained that he now saw Parkinson’s as a “pest,” whereas before his experience with the boulder it had been “a bit of a friend” — it gave him some support in withdrawing somewhat from difficulties, “not having to deal with things.” His affirmations were that he possessed “strength” and “sensitivity.” He now “felt strong.” He felt he could be a beacon. Standing up for everyone to see.” His attitude to Parkinson’s was now, “I’ll beat this. Maybe it won’t go away, but it will be manageable and will not get worse.” He made this statement with quiet but very strong conviction.

I decided Paul was now equipped to continue with his own practice of self-hypnosis, and that regular sessions would not continue. The option was always open for him to return to therapy at any time in the future.

DISCUSSION

Hypnotherapy had been very successful for Paul. Through the use of visual imagery in his hypnotic experiences he had come to reframe his perceptions of his disease. Relieving his muscle tension and reducing his anxiety through hypnosis had a positive effect on the symptoms of his disease. There was strong evidence of a stabilising effect. He was holding it in check. Perhaps it was too much to hope for, but Paul left at the end of his final session with a strong conviction that he would continue to work towards healing, to the point where he would be able to actually reduce the effects of the disease. Cognitive therapy had also been employed to deal with the insights raised by the imagery experienced during hypnosis. Symbols had been employed successfully to explore ways of getting back in touch with his “real self.”

Paul felt empowered and back in control. It was up to him to maintain this program of self-hypnosis, but already his lifestyle had changed in a positive way. He was doing Tai Chi, and swimming on a regular basis. It seemed that the use of hypnosis had been successful in significantly improving the outcome for a client suffering from Parkinson’s disease. It is not known whether this improvement will continue into the future, but results so far have been very encouraging.

REFERENCES

- Booth, R. J. (1998). Psychoneuroimmunology, and mind-body healing. In B. Evans & G. Burrows (Eds). *Hypnosis in Australia* (pp. 111–134). Heidelberg: Australian Society of Hypnosis.
- Chopra, D. (1990). *Quantum healing*. New York: Bantam Books.

- Hammond, D.C. (Ed.)(1990). *Handbook of hypnotic suggestions and metaphors*. New York: Norton.
- Hammond, D.C. (Ed.) (1991). *Hypnotic induction and suggestion: An introductory manual*. Des Plaines, IL: American Society of Clinical Hypnosis.
- Kimble, D.P. (1988). *Biological psychology*. New York: Holt, Rinehart & Winston.
- Miller, E. (1991). *Opening your inner "I"*. Millbrae, CA: Celestial Arts.
- Reardon, R. (1995). Taking the stress out of managing stress. In I. Gawler (Ed.). *Mind, immunity and health* (p. 10). Yarra Junction: The Gawler Foundation.
- Simonton, O. C., Matthews-Simonton, S., & Creighton, R. (1978). *Getting well again*. New York: Bantam Books.
- Stanton, H. (1994). Reduction of performance anxiety in music students. *Australian Psychologist*, 29, 124–127.
- Tellegen, A., & Atkinson, G. (1974). Openness to absorbing and self-altering experiences ("absorption"), a trait related to hypnotic susceptibility. *Journal of Abnormal Psychology*, 83, 268–277.
- Vaughn, I. (1984). Living with Parkinson's disease: Learning the tactics of coping. *The Listener*, 112, 13–14.
- Yapko, M. (1994). *Trancework: An introduction to clinical hypnosis*. New York: Irvington.
- Waxman, D. (1989). *Hartland's medical and dental hypnosis* (3rd ed.). London: Ballière Tindall.

HYPNOSIS IN THE TREATMENT OF SEVERE ANXIETY

Noelene Brown

Psychologist

This case demonstrates the use of hypnosis for the treatment of severe anxiety in a 50-year-old woman. It highlights the benefits of hypnosis as an adjunct to mainstream therapies, particularly illustrating how much can be achieved at an unconscious level without the therapist knowing the content.

PRESENTING PROBLEM

Mary was placed on a bond for offensive language, and was referred by her probation officer for counselling for severe anxiety and depression. While she claimed to have no memory of making several abusive phone calls while intoxicated, she accepted the consequences of her behaviour. She had never been before a court for a criminal offence prior to this situation, and was very embarrassed at the circumstances surrounding our first meeting in a clinical setting. Since the offence she has drastically reduced her consumption of alcohol. Although she presented as very anxious, Mary recognised she had a lot of anger and wanted help to deal with this.

HISTORY

Mary was born in New South Wales and was immediately fostered to her aunt and uncle, by whom she felt loved and nurtured. She was reclaimed by her biological parents at age four, and did not see her aunt and uncle again. She moved into a family of strangers, including four brothers and a sister, and the brothers teased and tormented her.

Mary was sexually abused by her father from age six until she was rescued by her older sister and taken to live with her, at age 14. The sister had also been

molested by her father. A group of males raped Mary when she was 15, as a result of which, she believed, she contracted cervical cancer in her late twenties.

Mary had been married three times, the first at 17, which produced three children. One child died a week after birth, and she adopted an Aboriginal daughter shortly after. She gave no reason for ending this first marriage, as her husband was “good to her.” She believed she was too young at the time she married, and did not really love her husband. Mary’s second marriage was a very loving and satisfying one for 10 years, until she discovered her husband was sexually abusing both her daughters. She was devastated and left the marriage. A third marriage lasted only three weeks, as this husband became very abusive towards Mary. She came to South Australia to escape his violence. Although her children remained in New South Wales, Mary has regular contact with them, including her adopted daughter. This relationship was described as “difficult” as her daughter seems to have unresolved anger about her sexual abuse, and often blames Mary for her current problems. Their interaction (usually by phone) has often left Mary agitated and in tears.

At the time of our first interview, Mary had been in a relationship for 15 months. Although she wanted the relationship to last, she stated she was “untrusting, panicky” and “ready to run” as she feared being “let down again.”

MEDICAL/PSYCHIATRIC HISTORY

Mary had a hysterectomy at age 28, after being diagnosed with cervical cancer. She has a steel pin in her right ankle which causes chronic pain, and suffered also hip and back pain. She took Panadeine Forte daily.

From her late teens, Mary had periodic admissions to psychiatric hospitals. She had counselling and drug therapy for her anxiety and depression, and various instances of counselling for the rape and sex abuse issues. At the time of our first meeting she was taking Prozac, but expressed a wish to function without drugs. Until recently, Mary used alcohol to “deaden the memories” she constantly recalled. A poor sleeper, she also took prescribed sleeping pills on a regular basis.

SESSION 1

We agreed to embark on a program of cognitive behaviour therapy, which would include assisting Mary to uncover the beliefs and cognitions she held that were contributing to her anxiety and anger. A good rapport was soon established. Mary felt hopeful we could achieve good results together. She had many years of intense counselling and therapeutic interventions which she believed had helped her deal with her problems, although she claimed she had never been able to deal with her anger and anxiety.

Mary was given a cognitive skills questionnaire to complete for our next session in a week’s time.

SESSION 2

At this session we focused on problems in Mary's relationship, particularly the difficulty she had sharing feelings and communicating her needs to her partner, Jim. Working through the results of the questionnaire, we identified a number of cognitions or beliefs which were contributing to her current situation. I suggested Mary might bring Jim to a session for couple's therapy, to assist her to communicate with him. She agreed, although she was anxious. She wanted me to tell Jim how she felt. I told her I would facilitate the interaction, and encouraged her to express her feelings to Jim.

SESSION 3

This session was successful in that Mary was able to communicate her feelings and needs to Jim. He responded by sharing some of his doubts and fears. Both left the office with more understanding and insight, and a commitment to work on their relationship.

SESSION 4

Mary was very pleased with the joint session and the increased closeness she felt with Jim. She was still presenting as very anxious, saying she had lots of anger. She felt it was consuming her. I suggested she might like to try hypnosis for relaxation to reduce anxiety. There were also techniques we could use in hypnosis to explore the reasons for her anger, and deal with it. Mary did not think she would be a good candidate for hypnosis as she found it hard to relax. However, she agreed to try the process, as she wanted to get on with her life. She also expressed a lot of trust in me, which was a good motivator.

RATIONALE FOR USING HYPNOSIS WITH THIS CLIENT

1. Mary quickly developed trust in me. A very good rapport had been easily established.
2. Mary was highly motivated to deal with her anxiety and feelings of anger.
3. Her presenting symptoms were amenable to hypnosis. The aim was to teach her self-hypnosis, to manage her anxiety and increase her self-esteem.
4. There were no contraindications.
5. Hypnosis was to be used as an adjunct to cognitive therapy.

SESSION 5

The Chiasson induction technique (Crasilneck & Hall, 1985) was initially used with Mary, followed by progressive relaxation. Having noted she had a wide range of fears and phobias about animals, insects, enclosed and dark environments, etc., a simple garden scene was used for imagery to deepen the trance state.

An arm levitation was elicited to demonstrate to Mary the power of her unconscious mind and her own ability to bring about change. She appeared at this time to be in a good depth of hypnosis, for example, eyelid fluttering, and she barely opened her eyes to observe her levitating arm.

Ego strengthening and confidence building suggestions were incorporated into the session. Before termination of the trance state Mary was taught self-hypnosis, and encouraged to practise it regularly over the next week.

Before leaving, Mary reported she felt very relaxed after the session, and her back pain had almost disappeared. She seemed very surprised she had actually entered the trance state and had no memory of the experience, except for a feeling of hearing my voice as if a great distance away. She later reported her back pain had returned within an hour of the session. She was, however, surprised and pleased with the initial loss of pain. The experience probably increased her motivation and trust in the process, for future sessions.

SESSION 6

Mary reported that self-hypnosis attempts had been unsuccessful and she had been feeling a “bit low” the past week. She was, however, keen to continue, and hypnosis was induced with visual imagery and progressive relaxation. At this point, I offered ego-strengthening suggestions to help Mary to feel more self-worth. I then explained that during this, and future hypnosis sessions, we would be working together, with Mary tapping into her own inner strengths and resources for solutions.

Ideomotor signalling was established. Regression techniques were used after Mary signalled with her “yes” finger that she was ready to explore further the reasons for her acute anxiety and anger. She was asked to imagine she had a beautiful old leather book. Each page represented a year in her life. I suggested she might slowly turn the pages from the back page (50), until she reached a page she felt drawn to. This page represented a time in her past that was significant. Through the use of questioning and ideomotor signalling, Mary regressed to age 26. Although she did not speak throughout the session, she was visibly distressed, occasionally whimpering softly.

Through questioning, I established Mary had regressed to the time her baby son had died. (Later it was established the baby had died a week after his birth.) The prevalent feelings at the time were of guilt and anger.

I suggested that the 26-year-old part of Mary might like to talk to 50-year-old Mary who had raised three babies. Also she might like to get the doctor, nurses and anyone else she felt could help her understand the baby’s condition, and help her to realise she had done her best and it was not her fault he had died. Mary signalled with her “yes” finger this was what she wanted to do. When she was satisfied she had enough information and understanding, she could signal to let me know. She did this and I then gave her ego-strengthening messages, suggesting she say a loving goodbye to the baby and tell him she was sorry. She

was then asked to say or do whatever she felt she needed in order to feel forgiveness. She indicated she was feeling angry. I asked her to visualise walking through a beautiful garden to a house on a hill which was her special, private place. She alone had the key to this house.

With her permission, we went inside together. She was then given the opportunity to express her anger in a safe way in a cage designed especially for that purpose. When she signalled she had finished, we left the house, which she locked with the only key, then pocketed the key. I suggested she spend some time in the beautiful garden sitting under a very large tree and experiencing the warm, safe, and peaceful environment.

The session was then terminated. Mary felt tired and peaceful. She had no memory of particular events, only recalling screaming and yelling at some point. She also remembered hugging the large tree. Mary was given a personalised relaxation tape, and encouraged to use it regularly.

SESSION 7

At the beginning of the session, Mary reported she had been having flashbacks and was having trouble sleeping. The flashbacks were of a variety of situations, including her mother's death, and scenes of her father abusing her. I reassured her this may happen in future and she could use her hypnosis tape to relax at any time, even when she was feeling anxious. We could also explore issues around any of the flashbacks, if she wished, during future hypnosis sessions.

Hypnosis was induced and deepening occurred through visual imagery (garden scene). I then asked Mary to choose a "safe place" and bask in the warm, peaceful yet energising feelings she was experiencing.

Using the "book of time" technique, Mary then regressed to 38 years of age. Her facial expressions indicated she was experiencing intense emotional feelings. I suggested to Mary she might want to vocalise what she was feeling. She softly murmured the words "painful" and "betrayed." Through ideomotor signalling it was established that her husband and children were in this scene. Mary had just found out her husband had sexually abused her two daughters.

Although Mary had left with the children at the time of this discovery, she had never expressed her anger and betrayal, or seriously confronted her husband. I suggested she could do this now in hypnosis.

Mary decided to take the children to a safe place — the lovely garden — while she returned to confront her husband. We then called on her 50-year-old self and partner Jim, and myself to help 38-year-old Mary "kick" her husband out of the house. With the use of ideomotor signalling it was established that Mary was experiencing a lot of anger and guilt. She was encouraged to get out as much anger as she wanted. Given suggestions of a range of strategies by which she might do this, she decided to fill up as many garbage bags as were needed to dispose of the angry feelings. Then the necessary number of trucks were dispatched with the full garbage bags to the top of a very distant hill, and

thrown into a deep canyon, where they could hurt no-one. After several minutes, ideomotor signalling indicated that she had completed this task, and had nothing more that she needed to do with her husband.

Hypnosis was terminated after Mary had spent time in the garden with the children and Jim. She reassured the children that they were safe, and that she loved them, and asked their forgiveness for what had happened to them. Then 38-year-old Mary and the children said goodbye, and 50-year-old Mary remained in the garden hugging Jim. Ego-strengthening and affirmation messages were offered to increase Mary's wellbeing, inner strength and courage.

At the end of our session, Mary reported feeling drained, yet light and peaceful. She remembered shouting and screaming at some point. Her strongest memories were of being "cuddled" by Jim in the garden.

SESSION 8

This session was two weeks later and Mary was feeling sad and depressed. She did not want hypnosis, just to talk. Two days previously, a close friend aged 47 years had died suddenly. Mary was shocked and saddened at this. In addition to this, she had been told by doctors she had osteoporosis, and would be in a wheelchair in a few years. She reported feeling a loss of confidence and doubted whether she would get married in a few months, because of her disability.

During this session, I suggested to Mary she was handling these two situations much better than she previously would have. She brightened considerably, admitting that, in the past, she would have been admitted to a psychiatric hospital for lesser traumas.

Although Jim had been supportive, Mary was disappointed he had not seemed as affectionate as before. I suggested Mary might talk with Jim and express her feelings. She agreed, and realised that she felt quite comfortable about doing this. I reinforced that this was a new and positive behaviour for her. Mary reported feeling much better. She remembered she had rung her estranged sister a week earlier, and was surprised and pleased at the good response. She felt some forgiveness towards her sister, and decided to ask her to be bridesmaid at the wedding in a few months time.

SESSION 9

Mary was very pleased to report she had discussed with Jim her feelings about wanting more affection and cuddles, in particular for him to initiate this. He had responded well, sharing what was happening with him, and admitted he had sensed that she was withdrawing. He agreed to work on what was a new experience for him, openly showing affection. Mary realised she needed to give him more time to learn these new behaviours. She was very pleased with the way she had approached him to discuss her feelings.

This hypnosis session focused on the positive changes already made, and images of the wedding day, and a happy future with Jim. I reminded Mary she could be happy and did not have to fear the future. She has many hobbies and interests to pursue, including learning to play the guitar.

I included pain reduction messages to help in the way she handles the osteoporosis. These were based on ego-strengthening, particularly her courage and strength, and ability to take control of her life.

With ideomotor signalling, Mary indicated there were no particular issues to explore at this time. The session finished with Mary reporting feeling refreshed and very positive.

SESSION 10

This was a further counselling session and Mary was very positive. She had been using the relaxation tape regularly. Recently she responded assertively to her daughter on the phone. In the past she would have “burst into tears” when her daughter criticised her or was angry. This time, Mary told her she loved her, then asserted her own rights and responsibilities, and quickly ended the conversation. She was very pleased with herself and saw this as a positive turn in their relationship.

The wedding plans were going very well. Mary was catering for the wedding to which 80 people had been invited. The reception was to be at home. All the arrangements were well in hand, and she reported no anxiety. I congratulated her and we made a final appointment in one month, a week before the wedding.

SESSION 11

Mary was relaxed and very positive at the beginning of the session. She reported no problems. Everything was going smoothly for the wedding the following week. She also said she had lost 12 kilograms in weight since we began hypnosis three months earlier.

In hypnosis, Mary was asked to review all of the positive gains she had made over recent months. Following this, I added positive suggestions for the future, including that her health and weight loss would continue to improve. I talked about her wedding day as being the beginning of a new direction in life and suggested she visualise her future with Jim. Mary was smiling during the hypnosis session. After the termination of the trance, she was still smiling. She was amazed at the vision she had of herself and Jim, looking intently and lovingly into each other’s eyes. The feelings of love and warmth were intense, and she continued for ten minutes afterwards, still referring back to that scene.

SUMMARY AND COMMENTS

In all, Mary attended 11 sessions with me. Of these, five included the use of hypnosis, and the other six were a blend of basic counselling and cognitive behaviour therapy. At the conclusion of the intervention, she was presenting as more relaxed, able to handle difficult situations well, without “bursting into tears” or “rushing off to the psychiatrist.” Most importantly for Mary, she no longer experienced the angry feelings she had previously felt were “always present.” She had re-established ties with several friends, and her sister and younger daughter.

She planned to return to geriatric care work the following year. (She had given up working in this field because of her discomfort at having to wash and clean up after elderly male patients)

It would seem that the first big breakthrough came for Mary after the hypnosis session using age regression and hypnoanalysis. She was able to re-experience and re-evaluate a traumatic event. She also expressed some of her repressed anger. Although she did not make use of the self-hypnosis technique, she regularly used the personalised relaxation tape, which seemed to have helped her to reduce her anxiety.

Of note is the fact that only two hypnosis sessions dealt with traumatic events of the past. Mary did not seem to need to recall and deal with events around sexual abuse by her father, abandonment, betrayal by her mother, etc. It is possible that some of these issues may have to be dealt with in the future, but for the present, Mary was able to look forward to a positive and rewarding future.

REFERENCES

- Crasilneck, H. B., & Hall, J. A. (1985). *Clinical hypnosis: Principles and applications* (2nd ed.). New York: Grune and Stratton.

HYPNOSIS IN THE TREATMENT OF MIGRAINE HEADACHES

Jacqueline Yeoh

Medical Practitioner

This paper describes the use of hypnosis in treatment of migraine headaches. The author gives a detailed history of the patient, then fully explains how hypnosis was used to control the antecedents of the headaches and their severity when they did occur.

JH is 27-year-old single man, living with a friend in rented accommodation. He works as a printing machinist for a local newspaper. He presented in April 1997 requesting hypnotherapy for treatment of migraine headaches. He was referred by a general practitioner working in the same practice as the therapist. She had seen him a week before, and thought that hypnosis might be helpful for his migraine headaches, especially as JH preferred to avoid the use of medication.

JH was already known to the therapist as a general practice patient, but had not previously been seen by the therapist in relation to his migraines.

History of Presenting Problem

JH gave a long history of migraines headaches from the age of approximately ten years. He described the pain as a “thudding ache” behind and just above the right eye on most occasions, although once or twice he had experienced the pain in the region of the left eye. Associated with the pain were nausea, vomiting and mild photophobia. There were no classical aura symptoms such as altered perceptions of taste or vision, but he said that he did get a warning sign about 5 to 10 minutes before the onset of the headache in the form of a sharp twinge in the corner of his right eye. He had noticed that the headaches tended to be triggered by fatty food and also by stress. At times he would wake with a headache, but usually they seemed to come on while he was at work. He had found that if he took medication at the first sign of a migraine that he could “take the edge off it,” but even so the pain would last for one to two days.

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Sometimes he was able to keep working with a migraine, but at times the pain was so bad that he would have to lie down in a darkened room until it resolved.

At the time of presentation the migraines were occurring every fortnight, although previously they had troubled JH only once every two to three months. He tried not to take time off work, as he needed the money, but by April he had already used over half of his sick leave entitlement for the year (two weeks paid leave). This was the main reason for seeking medical help at this time, as he was trying to save enough money to make a deposit on a house. On questioning, he said that he enjoyed his job, but that there had been some conflict with his employer over a stress claim two years ago. Although this had been resolved in JH's favour, he felt that some of his co-workers remained angry with him and at times this led to an unpleasant atmosphere at work. In addition, redundancies at his workplace had led to an increase in his workload over the last six months and he was finding this quite tiring.

JH said that he had tried paracetamol, mersyndol and Panadeine Forte for his headaches, but that he was reluctant to use medication, partly because he was fearful of becoming addicted to it and partly because he believed that he should be able to manage his headaches by more "natural" means. He had tried several herbal remedies (the ingredients of which he was unsure of), prescribed by a naturopath, but had not found these to be helpful. To some extent he was able to distract himself from the pain by working, but he found that the pain would be much worse by the end of the day if he did this. He had heard about a flotation tank therapy, and was considering trying this also.

On enquiry, JH remembered that his first migraine had occurred while at school, although he was unable to remember the exact details. He did remember the accompanying nausea and lying down in the school sick room feeling afraid that something must be very wrong with him because the pain was so severe. He said that he would also get the migraine when he attended football matches with his father at the weekends, chiefly when he became very excited by what was happening on the field.

A thorough history and general physical examination had already been undertaken by the referring general practitioner, revealing no abnormality. In addition, a CT scan performed at the age of 12 had been found to be normal. As the character of the headaches had not changed despite their increase in frequency, it was not thought necessary to repeat this investigation.

Psychosocial History

JH's mother had a normal pregnancy, but a difficult delivery, with a long labour culminating in a painful forceps delivery because "I got stuck." Despite this, JH was a healthy baby with no perinatal complications. JH is an only child, whose parents separated soon after his birth. He was raised by his mother, but with close contact from his father, as the relationship between his parents remained

amicable despite the separation. When asked about the reason for the marriage breakdown, JH said that his parents had told him that they had “just grown apart.” He has remained close to his father, whom he described as a “fun-loving, outgoing” man with whom he shared a love of football. He had very fond memories of spending weekends with his father and of them attending matches together.

JH described his mother as a “really good mother.” “She’s a very generous woman, she’d do anything for you.” He said that she was also prone to migraines. Interestingly, he said that she had “had a headache since I was born.” He remembered having to be very quiet when his mother had a migraine, and that she would lie down in a darkened room for several hours. He thought that her migraines had also been triggered by stress. He said that his mother had always been very caring when he had a migraine “because she knows how bad they can be.”

Although JH described his childhood as happy, he added that he had always wished that he had a brother or a sister and that at times he had been a rather lonely child. He was an average student but didn’t really enjoy school because he found it difficult to make friends. He thought that this might have been partly due to his headaches because at times he would have to be absent from school for several days, “and the other kids thought I was bludging.” Things improved in high school when he discovered a talent for football and was selected for the A-grade team. On leaving school he worked for a short time for a fast food chain before getting an apprenticeship which subsequently led to his current position. He said that he enjoyed his work — “I’m one of the best workers they have” — but that he was enjoying it less since an incident in 1995 which had resulted in a worker’s compensation claim. At the time he had been working night shift, but was becoming very tired and stressed by this. He had seen a doctor, who had given him a certificate stating that he should be given a day-shift position. His employer had initially agreed to this and he was told that he would be given the next day-shift position that became available, but his employer subsequently reneged on that decision. The claim then went to court, where JH’s right to a new position was upheld, much to his satisfaction. He found his day-shift position less stressful, but said that some of his workmates were jealous and thought that he was a “wuss” for making a stress claim.

JH was single at the time of presentation, but had had a series of steady girlfriends from the age of 17 years. He said that he did not feel ready to settle down at this point in his life, but that he hoped at some stage in the future to have a family. He described himself as a “bit of a stress-head — I like to do things properly or not at all.”

Past Medical History

JH had a history of migraine headaches, as described. Other medical history included pneumonia in 1996 and a severe bee-sting allergy with facial swelling. He was otherwise fit and healthy, taking Panadeine Forte intermittently for the migraines, but on no other medications.

Other than the stress claim already described, JH denied any history of depression, psychotic illness or other psychiatric illness.

Family History

As already stated, JH's mother had a history of migraine headache. There was no other family history of physical or psychological illness.

Mental State Examination

Appearance: neat, casual dress, well groomed.

Behaviour: appropriate.

Conversation: normal rate and form, articulate.

Affect: mildly anxious initially, later relaxed and cheerful.

Perception: no abnormalities evident.

Cognition: no abnormalities evident.

Insight: reasonable insight into link between psychological stress and physical illness.

Judgement: intact.

Clinical Summary

In summary, JH had both a genetic and an environmental predisposition to migraine headache. There was the likelihood of secondary gain from the headaches, both in childhood and at present. As a child JH received extra attention and care from his mother, and was able to avoid school, which he found unpleasant, as a result of his headaches. The therapist considered also the possibility that the current headaches allowed him legitimately to escape from a hostile work environment without resorting to a second stress claim. However this gain was becoming overridden by his financial needs, causing further stress and possibly worsening the headaches.

There was evidence that the headaches were worsened by emotional stress (e.g., excitement during a football game) and JH had already made this link.

Hypnotic Experience

JH had no previous experience of hypnosis, but he had an interest in the paranormal, and had some knowledge of hypnosis from his reading on the subject. He had a strong expectation that hypnosis would be able to help with

his problem. He was intensely curious about hypnosis and quite excited about trying it, although he was not entirely sure how it would work.

Discussion of Hypnosis

Given JH's source of information with its possible inaccuracies, the therapist was careful to spend time fully explaining and discussing the theories of hypnosis, and debunking any myths. JH was familiar with the concept of the conscious and unconscious mind. Their relative roles in hypnosis and their use, including the increased susceptibility of the unconscious mind to suggestion and the ability to communicate more fully with the unconscious mind during hypnosis, were discussed. Time was spent discussing the effects of hypnosis on the autonomic nervous system, as an understanding of this would be particularly important in the management of migraine by hypnosis. It was emphasised to JH that he would retain control throughout trance, and that it would be through his own efforts that he would achieve mastery over his headaches, the therapist acting as a guide or teacher. The therapist explained that JH would be shown self-hypnosis and that it would be necessary to practise this outside therapy sessions in order to use the techniques which would be demonstrated during therapy. It was also explained to JH that hypnotisability and depth of trance would vary from time to time and from person to person.

JH said that he enjoyed music (especially the blues) and walking on the beach. He disliked insects, particularly spiders.

ASSESSMENT OF SUITABILITY FOR HYPNOSIS

JH's highly positive expectations of hypnosis and his interest in non-drug methods of management for his headaches made him a suitable candidate for hypnotherapy. He was intelligent and had already made the connection between emotional stress and physical symptoms. Although he was achieving some possible secondary gain, he was also motivated by his financial concerns to deal with the headaches and it was felt by the therapist that this was the stronger motivation at present. There were no contraindications to hypnosis identified. A good level of rapport was already present between JH and the therapist, given their prior contact in general practice.

The handclasp test was carried out as an assessment of suggestibility. JH was asked to clasp his hands together tightly and to place them above his head with the palms facing outwards. He was then asked to close his eyes and to squeeze the fingers tightly together until his hands were locked so tightly together that he would find it very hard to separate them. The fact that JH found it hard to pull his hands apart indicated a relatively high degree of suggestibility.

JH's ability to visualise was also tested. JH was asked to close his eyes and imagine a scene. He was then asked to give details of the scene and was able to do so with great vividness. This suggested good visualisation ability, which would be useful in hypnosis.

Hypnosis is well documented as a useful treatment for headache (Drummond, 1981). Crasilneck and Hall (1985), stress the need to know the psychodynamics of the patient in order to address any underlying conflict, as well as seeking to reduce symptoms of pain. Crasilneck and Hall also state that “at times the roots lie in childhood, perhaps from identification with a parent or other significant adult who also suffered from head pain” as was the case with JH. They emphasise the need to check with the unconscious mind whether the symptom is continuing to serve a purpose (such as punishment) or whether it has become an empty but habitual response and can be “let go” by the unconscious.

The causes of headaches are many, but the two main groups consist of migraine and tension type headaches. Some authors would suggest that this division is rather artificial, and that in fact there is more of a continuum, with a large group of headaches falling into an intermediate category, possessing features of both types of headache. It is also possible to get tension headache on a background of migraine headache. Migraine headache is thought to be associated with changes in blood flow, with initial vasoconstriction causing aura symptoms, followed by vasodilatation associated with pain, whereas tension headache is thought to be related to muscle tightening in the region of the scalp. Various techniques of symptom control have been used to manage headache based on these two theories, from relaxation alone to visualisation of blood vessel calibre changes, handwarming techniques (Bowers, 1976), and transfer of muscle tension to other parts of the body (Damsbo, 1979).

TREATMENT

Treatment Goals

The following treatment goals were negotiated by therapist and patient:

1. To teach JH a method of relaxation.
2. To decrease the frequency and severity of the headaches.
3. To give JH a “drug free” method of relieving his headaches.
4. To improve JH’s stress management skills.

JH was also asked to keep a headache diary during therapy, noting the severity of his headaches, when they occurred, and his activities, feelings and thoughts at the time. This was intended both to allow JH to become aware of how stress affected him and which particular situations exacerbated the headaches, and to serve as a record in order to determine how effective different approaches were proving.

Hypnotic Techniques

1. progressive muscular relaxation and other deepening techniques;
2. demonstration of phenomena (arm levitation);
3. ego-strengthening;
4. self-hypnosis;
5. direct suggestions (relaxation, calmness);
6. use of imagery to relax facial and scalp muscles;
7. ideomotor finger signals;
8. time distortion.

SESSION 1

To begin with, patient comfort was ensured and permission was obtained to touch. An eye fixation and distraction induction was then carried out, this being a technique familiar to the therapist. This was followed by progressive muscular relaxation, during which the patient was asked to clench and relax each muscle group in turn. As he did so, he was invited to “become aware of the sense of relaxation that you feel throughout your body, increasing as each muscle lets go of all that tension. Notice how it feels to be really, really tense and then how it feels to go completely limp and loose.” Some time was spent on this procedure, as the therapist planned to use it in a later technique for managing the headaches. For this reason, particular attention was paid to the muscles of the scalp, face and neck. An arm levitation was then performed. It was suggested to the patient that following a light touch on the hand, feelings of lightness and floating would begin to develop in the hand, then spread to the arm, until the arm began to float upwards. This was done in order to further develop a positive mind set and to demonstrate to the patient his ability to control body functions under hypnosis. Levitation occurred quickly and easily, and a smile appeared on the patient’s face at the same time. The arm was then replaced on the bed, with the suggestion that as the arm descended, the sensations of lightness and floating would disappear and the patient would go deeper into trance.

The patient was then asked to imagine himself on the beach. He was told that he would find this a pleasant, peaceful, and relaxing place. He was asked to gradually become aware of the environment around him, using each sense in turn. He was told that he would find that this was a “special place,” where he could “choose to spend as much or as little time as you wish, enjoying the feelings of serenity and relaxation and allowing your body to refresh and repair itself. And you will find that a little time here can seem like a lot, so that even a short time here will leave you feeling relaxed and rejuvenated as if you’d just been on a wonderful holiday.”

Instructions were then given for self-hypnosis. Suggestions about safeguards were given, namely that JH would be able to induce hypnosis when he chose to, and that he would be able to choose not to do so if in an inappropriate situation

(for example when driving a car), that he would be able to re-alert himself readily if something required his attention or he needed to do so and that each time he went into hypnosis he would be able to do so more quickly and easily. The suggestion was given that he would be able to induce hypnosis by closing his eyes, taking three deep breaths and “allowing the breath to float him down.” He was told that he would be able to re-alert himself by counting from 5 down to 1. Self-hypnosis was then practised several times, and it was reiterated to JH that each time he used hypnosis it would become quicker and easier for him and he would go deeper into trance.

Prior to re-alerting, suggestions for calmness and serenity were given. Re-alerting was then performed using a technique adapted from a lecture given by Dr G. Wicks (ASH SA Hypnotherapy training course, 1996/1997) as follows:

5. Any feelings of lightness, heaviness or any unusual feelings leaving your body, returning to the here and now.
4. Feelings of vigour and energy flowing back into your body.
3. Keeping the sense of relaxation and calmness, able to do whatever you need to today.
2. Becoming more alert and close to being fully awake, eyes nearly open.
1. Eyes open and fully awake, feeling fine.

The hypnoidal state was used to suggest that the patient would be interested to find that just being very relaxed would decrease the number and severity of headaches that he was having.

The trance experience was then discussed with the patient. He said that he had been surprised by how relaxed he felt, particularly during the progressive muscular relaxation, and that he had not previously been aware of how much he was tensing his jaw and face muscles. He was encouraged to continue using self-hypnosis at home for relaxation, and it was agreed that at the next session the therapist would teach him a specific technique for controlling the headaches. In the meantime JH was asked to continue with his headache diary. Stress management skills such as exercising, eating a balanced diet and getting adequate sleep were also discussed.

SESSION 2

JH reported that he had already noticed a decrease in the frequency, although not in the severity of the headaches. He had been using self-hypnosis on most days. He said that he had tried using it during a headache, but had found that the pain interfered with his ability to concentrate in trance and that he was unable to relax.

Given that JH had an early warning sign of headache in that he developed a twinge near the eye shortly before a headache began, it was decided that hypnosis should be induced as soon as this symptom became apparent, in order to intervene before the pain became too severe. JH was comfortable with this

approach, as it was similar to the way in which he used his medication.

Time was spent prior to inducing hypnosis explaining the role of muscle tension in headache. It should be noted at this point that although JH referred to his headaches as migraines, they were not typical migraine-type headaches, and it was felt by both the therapist and the referring doctor that the picture was more consistent with a mixed type headache. This was supported by the effect of relaxation alone on the frequency of JH's headaches. It seemed likely that the recent increase in headaches was related to increased muscle tension on a background of vascular headache. This was explained to JH, and he was told that it was possible to use hypnosis to control muscle tension and so to manage the headaches.

Induction of hypnosis was then performed as before, followed by progressive muscular relaxation as already described. Deepening was carried out by asking the patient to imagine walking down a flight of ten steps, with the suggestion that with each step down he would go deeper and deeper into trance. When at the bottom of the steps he was asked to imagine himself in his special place again. A technique also adapted from the lecture by Dr G. Wick and similar to Damsbo's technique was then used as follows:

Using ideomotor finger signals, the unconscious mind was then asked if it would be acceptable to stop having headaches. After the "yes" response had been observed, it was reiterated to JH that the unconscious mind was able to control the degree of muscle tension and so either bring on or prevent a headache. After being reminded of how it had felt to tense and relax his muscles during the progressive muscular relaxation, JH was asked to bring on the first signs of a headache. He was asked to indicate by raising the "yes" finger when he had been able to do this. When he had done so, he was asked to place his open right hand by his right eye, in the area where he got the first warning twinge. He was then asked to clench his right hand tightly into a fist "and as you screw the hand into a fist, feel the tension moving from the muscles near the eye into the hand . . . feel the hand clenching tighter and tighter as it pulls the tension into it, until it's as tight as it can be. Now take the hand away from the face and throw that tension away from you, letting the hand relax completely." He was asked to repeat this action until the headache was completely gone, "leaving you relaxed and comfortable." The therapist asked him to indicate when this had occurred by using the "yes" finger. After two cycles, the "yes" response was obtained. The sequence was then repeated to allow practice of the technique, and following this the therapist checked, using ideomotor finger signals, that JH felt confident and comfortable with the routine. Suggestions were then given that as JH practised the technique more and more he would become better and better at preventing his headaches and that the headaches would become less and less frequent and less and less severe. He was also told that he would become more and more aware of what was happening in his body so that he would be rapidly aware of the first sign of a headache, enabling him to quickly intervene. Safeguards were put in place so that "if there is something

wrong with your body that requires attention, you will find that this technique will not work for you, and you will know that you need to seek medical help quickly.” This was done to ensure that JH was not able to suppress pain caused by a more sinister event such as an intracerebral bleed.

Re-altering was then carried out using the procedure already described.

Following hypnosis, JH said that he was readily able to produce the headache, but that he had had some qualms in doing so, as he was not entirely sure that he would be able to take away the pain, given his previous experience. He was pleasantly surprised by his success, and commented that this was a relatively simple technique which he could use while at work without occasioning remark from other workers. Once again, he was asked to practise the technique at home, using a tape made of the session. It was stressed to him that he should practise even when he did not have a headache, so that he would be ready to use the technique when it became necessary. He was also asked to continue with his headache diary. Plans were made for the next appointment.

OUTCOME AND DISCUSSION

JH failed to attend for the next appointment. Efforts were made to contact him for the purposes of follow-up, but unfortunately he had moved and not amended his details at the practice. It was later discovered after discussion with another doctor in the practice that he had contracted chickenpox a few days before, and it seemed likely that he had simply forgotten to cancel his appointment.

To this time JH has not attended for further review, but feedback from the referring doctor indicates an improvement in his headaches, to the extent that they are occurring less frequently and with a lesser degree of severity. He had taken two more days of sick-leave. It has been communicated to JH via the referring doctor that he can return for further therapy if he wishes, but he has not taken up this invitation. It is interesting to speculate about the reasons for this. The therapist thought that it was possible that the issues of secondary gain and need to take time away from work with a “legitimate” reason (i.e. a migraine rather than stress) might have outweighed the financial concerns, despite JH’s consciously expressed wish to be free of his headaches. Had JH returned, it might have been helpful to further question the unconscious mind about the purpose played by the headaches and perhaps to explore their meaning to the patient by using an approach such as the “affect bridge.” It is possible that there are unresolved and unspoken issues around the parental separation, even though on the surface this appeared amicable. The therapist had also planned to teach JH a range of techniques for symptom control in order to determine which worked best for him but unfortunately this was not possible.

In retrospect, it might have been better to begin by exploring the meaning of the headaches to JH under hypnosis, rather than starting with symptoms control, in order to bring any unconscious issues to the surface. The therapist chose to start with symptom control partly due to time pressures, as JH was reluctant to

take any more sick leave and so needed a technique quickly that he could use to control his headaches. It was thought safe to do this because the unconscious mind had been queried as to whether it would be all right to dispense with the headaches. It would seem that there may have been reservations of which neither the therapist or JH was aware which prevented further progress in resolving the headaches.

REFERENCES

- Bowers, K. S. (1976). *Hypnosis for the seriously curious*. New York: W. W. Norton.
- Crasilneck, H. B., & Hall, J. A. (1985). *Clinical hypnosis: Principles and applications*, (2nd ed.), New York: Grune and Stratton.
- Damsbo, A. M. (1979). Tension headache treated with hypnosis. In G. D. Burrows, D. Collison, L. Dennerstein (Eds.). *Hypnosis* (pp. 157–164). Amsterdam: Elsevier/North-Holland Biomedical Press.
- Drummond, F. E. (1981). Hypnosis in the treatment of headaches: A review of the last ten years. *Journal of the American Society of Psychosomatic and Dental Medicine*, 28, 87–101.

EXECUTIVE DECISIVENESS AND THE SERENITY PLACE

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Twenty-four business executives from the same firm were matched on their decisiveness thermometer scores. Each was then paired with that person closest to them on decisiveness scores. One member of each pair was randomly allocated to an experimental group and the other to a control group. Those in the experimental group experienced two 50-minute sessions spaced one week apart learning the serenity place procedure as aid to decision-making while those in the control group spent the same amount of time reading articles on problem-solving and decision-making. One week after completion of treatment the decisiveness thermometer was again administered, this process being repeated six months later. The executives also provided unstructured anecdotal reports on these two occasions.

After this six-month measurement had been completed, those in the control group experienced the same two treatment sessions as the experimental group. In this way they acted as their own controls and provided further data on the effect of the serenity place approach.

Results indicated that, although no improvement in decision-making was discernible one week after completion of treatment, a highly significant effect emerged at the six-month follow-up.

Problems are not always easy to solve. To a great extent this is due to the difficulty we experience in clarification of the issues with which we are concerned. In an attempt to achieve such clarification, the neuro-linguistic programmers (e.g., McMaster & Grinder, 1980) have proposed a model, one involving the answering of several key questions, these being:

- What do I have now?
- What do I want to have?
- What stops me getting what I want?
- What do I have to do to get what I want?

In the above model, comparison of what we already have with what we want to have removes the main obstacle to problem-solving, that of identifying what the problem actually is.

The question: “What stops me getting what I want?” is the most vital question for it is usually inner obstacles that prevent us achieving our aims. Fear of failure, lack of confidence, self-doubt, and nervous tension which blocks rational thought are all examples of such obstacles. Yet, few of us ask ourselves this question, the result being that we blame external forces and other people for our problems when it is inner forces that are to blame.

By asking: “What do I need to do to get what I want?” attention may be focused on specific actions to take. A subsidiary question here would be: “Have I ever got it before?” for people forget they have already solved similar problems successfully. If not, they can ask: “Do I know anyone who has solved this problem?” If such a person can be identified, he or she may be used as a model, one of the most effective learning methods we have available to us.

Finally, asking: “How will I know when I am getting what I want?” is a way of making goals concrete and checkable. Answers to the question provide a means of ascertaining that actions taken are actually producing the desired results.

It is instructive to apply this approach to a problem which frequently arises among those executives and administrators who are hesitant about making decisions.

What do they have? — nervousness anxiety, self-doubt, fear of failure, lack of confidence.

What do they want? — self-confidence, decisiveness.

What stops them getting what they want? — inner doubts, fears.

What do they have to do to get what they want?

One way of answering this last question is explored in this article.

AN APPROACH TO DECISION-MAKING

The starting point for the approach is Hammond’s (1990) serenity place metaphor. This is, in most respects, the conventional “special place” metaphor used so widely in hypnotherapeutic work. However, it does have two useful additions, the first of these involving the concept of perspective. In Hammond’s words:

And in this place of serenity and security, things can come into perspective. You can be aware of actual feelings, with a correct sense of proportion, free from the distortions of a mood or set of circumstances. (p. 131)

To this suggestion, I add the concept of a scale. One end point, 10, marks the worst possible thing clients can imagine happening to them, and the other end point, 0, marks total peace and contentment. Patients’ current problems may

then be placed on the scale where it seems appropriate, most people realising that the problem with which they have been so involved may not be worth the importance they are attaching to it.

The second of Hammond's additions involves the establishment of communication with the unconscious mind. His suggestion is:

And in this special place, independent of anything that I say, you can receive what you most need right now. Your unconscious mind knows what you most need. And I don't know exactly how you'll receive that, . . . before awakening, you'll receive from your unconscious a special gift, of an experience or a memory . . . or perhaps you might hear what you need. (p. 131)

Within this framework, I add an exercise suggested by Rosanoff (1988) which provides more direction to people wishing to achieve improved communication with their unconscious minds. She suggests they should imagine a traffic light, placed off to one side of the field of vision, with red at the top for stop, yellow in the centre for caution, green at the bottom for go. People are then to think of a current situation in which they are involved together with a possible solution. The lights are checked to find which light is on, this being accepted as a means of defining intuitive feelings more accurately. Red indicates that the solution may not be a good one; yellow suggests caution, a wait-and-see attitude; and green is the go-ahead, "do it now" message. Other solutions to the problem may be "tested" in the same way.

If visualising the traffic lights as a means of communication with the unconscious mind does not seem to be helpful, an alternative approach is to use the auditory sense. In this case, people are to think of a situation when things did not go as they would have liked.

They are then to listen for their intuition to produce a sound or word. Next, they are to remember a situation where it was necessary for caution to be exercised, identifying how that felt, and allowing their intuition to produce a different sound, such as a tone, a tune, a familiar phrase or word, or a noise to go with this feeling. Finally, they are to recall a situation when they needed to do something, where continued action or new action was required and to identify what that felt like. Again, they are to allow their intuition to produce a sound or word to link with this feeling. These signals are then used with a current problem in their lives, listening for the particular sound that emerges as a response to a proposed solution.

Rosanoff's term "intuition" corresponds reasonably well with Hammond's "unconscious" as may be observed in a further alternative which can be used to focus on feelings rather than sounds and mental pictures. This variant has individuals bring to mind a situation when things did not go right and to focus on the feelings associated with that. Their intuition is then asked to exaggerate this feeling so that it is experienced as a physical sensation. A situation requiring patience and another requiring action are handled in the same way.

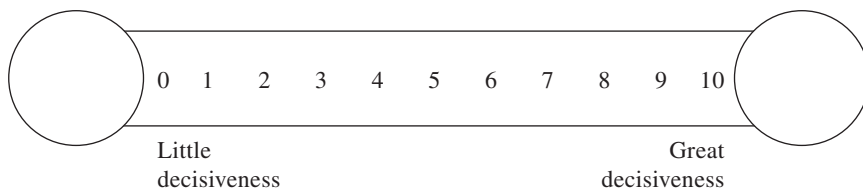
THE STUDY

Measures

Subjects were asked to rate their present level of decisiveness, using the decisiveness thermometer (Francis & Stanley, 1989). The use of this subjective form of measurement was influenced primarily by the work of Allport (1960) and Combs and Snygg (1959), who have emphasised that the most important element in personality measurement is a person's own perception of the way he or she is functioning. If people say they are decisive, they are likely to behave in a manner reflecting that state.

The decisiveness thermometer (Figure 1) was selected for its familiarity, ease of administration, reliability, and high face validity (Francis & Stanley, 1989).

Figure 1: Decisiveness Thermometer



Imagine that this is a thermometer recording the level of your decisiveness.
Please indicate whereabouts you usually are on this thermometer by
circling the appropriate number.

The executives also completed unstructured anecdotal reports which permitted participants to set down their thoughts on the experiment, the technique, and the results they achieved.

Procedure

The subjects, 24 executives from the same firm (19 male, 5 female), agreed to participate in the study as a result of their attendance at a previous management training seminar. At this time, they expressed a need for more help in solving problems and making decisions.

In the first stage of the experiment, the executives were paired on their thermometer scores, one member of each pair being allocated, at random, to either a control or experimental group. Two 50-minute sessions were used, spaced one week apart. The first session included case taking, establishment of rapport, and guiding the subject through the "serenity place" metaphor. One week later, a second 50-minute session provided an opportunity for subjects to

talk about their experiences of the previous week and for repetition of the metaphor. Control group subjects used this time to read articles on problem-solving and decision-making.

Sessions for both groups were conducted in a thickly carpeted, well-curtained office furnished with comfortable, upholstered chairs. This provided a pleasant environment for the control group's reading and for the experimental group's relaxation as they learned how to use the serenity place procedure to improve their decision-making. The decisiveness thermometer was re-administered to both experimental and control groups immediately after completion of the second session and again six months later.

Anecdotal reports, in which the executives recorded their thoughts about the two sessions, were also completed on these two occasions.

In the second stage of the experiment, the control group experienced the same two treatment sessions as had the experimental group. In this way, they functioned as their own controls, providing further data pertaining to the effect of the serenity place technique.

Results

No sex difference was apparent, so that all data is recorded in Table 1, setting out scores derived from three administrations of the thermometer, one prior to the two treatment sessions, the second one week after their completion and the

Table 1: Mean Scores and Standard Deviations for Two Groups of Executives on the Decisiveness Thermometer Administered Before, Immediately After, and Six Months After Treatment ($N = 24$).

Group	Before treatment	Immediately after treatment	Six months after treatment
Experimental	3.71 (1.08)	3.83 (1.69)	5.83 (1.27)
Control	3.50 (0.93)	3.21 (1.74)	3.33 (1.68)

other six months later.

Stage 1

A repeated measures analysis of variance indicated the existence of a highly significant difference existing between treatments ($F = 11.68$, $df = 5$, $p < .0001$). Although comparison of the immediate after-treatment scores of the experimental and control groups revealed no such difference in decisiveness, operationalised in terms of scores on the decisiveness thermometer, the six

months follow-up scores of the two groups revealed a different picture with the experimental group recording significantly higher thermometer scores (Scheffe $F = 7.70$, $df = 23$, $p < .01$).

A comparison of the experimental group's pre-treatment score with that recorded immediately after treatment indicated that no change had taken place at that time but that, six months after treatment, thermometer scores reflected significant increases (Scheffe $F = 5.57$, $df = 23$, $p < .01$). No such improvement was displayed by the control group.

Stage 2

Table 2: Mean Scores and Standard Deviations for the Control Group on the Decisiveness Thermometer Administered Before, Immediately After, and Six Months After Treatment ($N = 12$).

Group	Before treatment	Immediately after treatment	Six months after treatment
Control	3.33 (1.07)	3.83 (1.47)	6.08 (1.31)

Table 2, which presents the data pertaining to the second phase of the study when control group subjects experienced the serenity place treatment, indicates the existence of this same improvement pattern.

For the control group, the six months follow-up score from Stage 1 of the experiment was used as the pre-treatment score. A repeated measures analysis of variance produced a result similar to that found in Stage 1 ($F = 13.12$, $df = 2$, $p < .001$) with no discernible change being apparent in the "immediately after" scores, but a highly significant increase in decisiveness (Scheffe $F = 11.56$, $df = 11$, $p < .01$) being apparent six months after treatment.

CONCLUSION

These results are quite encouraging. Although the sample is small, executives, according to their anecdotal reports, appeared to feel more decisive after the two sessions than they did prior to treatment. This modification of attitude did not translate into increased decisiveness thermometer scores at this point. However, at the six months follow-up, a significant improvement in decisiveness level, as measured by the thermometer, was apparent.

This improvement appeared to be linked to continued use of the serenity place metaphor during the six-month period after treatment. Such usage was revealed in the anecdotal reports which indicated that approximately 38% of the executives continued to employ the technique on a daily basis as a stress

reduction technique irrespective of whether they had problems to solve or not. This practice often took place after coming home from work and before they involved themselves in domestic activities.

A further 43% of the executives were more irregular in their practice, using the serenity place once or twice a week, whenever they felt a need to do so. However, their reports indicated they enjoyed the experience, believing that it helped them manage their lives more effectively.

The difference in thermometer score between these executives who continued to use the serenity place approach and those who made no further use of the method approached statistical significance at the 5% level.

No attempt was made to measure hypnotisability or depth of hypnosis in the present study. My clinical experience has indicated that depth of hypnotic trance does not appear to exert any strong influence over the response to suggestions. However, further investigation of the particular approach outlined here might indicate an interaction between effectiveness of treatment and hypnotisability.

Because of their gentle and non-intrusive nature, ego-enhancing metaphors such as the serenity place, the “perspective scale”, and “communication with the unconscious mind” seem capable of use with virtually any client. Their great virtue is the manner in which they convey universally applicable messages about the nature and source of therapeutic change and their non-threatening stimulation of clients’ inner resources for self-healing.

Such ego-enhancement is unlikely to cause harm and appears to assist those executives finding difficulty in handling problems and making decisions. Certainly, in the study I have reported, subjects seemed to feel more decisive six months after treatment than they had done beforehand.

Because the technique I have described in this paper makes considerable use of visualisation, it might be argued that its application is limited, due to the inability of some people to see images in their minds. I have not found this to be a problem, for if individuals express inability to “see” images I ask them to describe to me what would be present in their minds if they actually did have this ability. In most cases, they proceeded to describe the images in reasonable detail, realising while doing so that they possessed quite adequate visualisation capabilities.

The technique I have described in this article is simple and easy to learn, points made repeatedly in the anecdotal reports. These reports, analysed primarily in terms of subjects’ opinions as to the effectiveness or ineffectiveness of the treatment, left the overwhelming impression that most executives felt they had improved their decisiveness as a result of the two-session treatment. That such a gratifying outcome had been achieved for the minimum expenditure of time involved is indeed pleasing.

REFERENCES

- Allport, G. (1960). *Personality and social encounter*. Boston: Beacon Press.
- Combs, A. W., & Snygg, D. (1959). *Individual behavior* (2nd ed). New York: Harper.
- Francis, R., & Stanley, G. (1989). Analogue measurement of dental fear. *Australian Psychologist*, *24*, 55–60.
- Hammond, D. C. (1990). *Handbook of hypnotic suggestions and metaphors*. New York: W. W. Norton.
- McMaster, M., & Grinder, J. (1980). *Precision*. Beverley Hills, CA: Precision Models.
- Rosanoff, N. (1988). *Intuition workout*. Boulder Creek, CA: Asian Publishing.

A STUDY OF HYPNOSIS WITH RAYNAUD'S DISEASE

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Pharmacist

This paper is a case study of hypnosis with three clients who have Raynaud's disease. The clients' temperature changes were studied for 30 days prior to hypnosis and for 30 days after treatment with hypnosis. These individuals showed improvement by using visual imagery of a hot summer beach sun under hypnosis. They manifested increased warmth in their hands and feet after eight weekly sessions of hypnosis. Some suggestions for further research are made relative to the use of hypnosis with Raynaud's disease.

Raynaud's disease is a peripheral vascular disorder characterised by bilateral colour changes of the extremities, involving the fingers and toes. Episodes of Raynaud's symptoms are usually elicited by exposure to cold stimulation and/or emotional stress (Najarian, Roger, & Venables, 1989). Patients suffering from Raynaud's disease show a drop in skin temperature at the fingertips (Norris & Huston, 1956). There have been conflicting findings relative to the treatment of Raynaud's disease. Jacobson & Hackett (1973) and Norris & Huston (1956) used hypnosis in the treatment of Raynaud's symptoms and found insignificant results. However, Crasilneck & Hall (1985), Kroger (1977), Spanos & Chaves (1989), and Weitzenhoffer (1989) obtained positive findings in the treatment of Raynaud's disease with hypnosis. These authors motivated this case study on hypnosis and Raynaud's disease.

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METHOD

There are three clients in this investigation. They were referred by their family physicians and were interested in hypnosis for the treatment of Raynaud's disease. The age range was from 25 to 60 years, and the clients were from a middle socioeconomic status. They lived in the middle-Atlantic states and were from a Euro-American background. The clients were college graduates and had upper level professional occupations. These individuals had complete physicals and were in excellent health.

The clients were studied for 30 days prior to treatment with hypnosis and for 30 days after treatment with hypnosis for descriptive temperature changes. The clients tabulated the daily temperature ratings. These individuals were seen for eight weekly sessions of hypnosis for their Raynaud's disease. The sessions averaged about 30 minutes in length.

In each session the clients were told to visualise, under hypnosis, being on the beach on a hot summer day and experiencing warmth in their hands and feet from the hot sun. They were also instructed to practise every day with two 10-minute sessions of visual imagery of a hot summer beach day. The clients were informed that their identities and personal data would be kept confidential. The findings prior to treatment with hypnosis and after treatment with hypnosis were compared and analysed for this study.

The first case study is centred on a 25-year-old single female. Client A is a graduate student, working on her masters degree. She is a very good student who enjoys reading and doing research and is also involved in social functions in her community and in her college. The client has had Raynaud's disease since she was 16 years of age. Her condition became worse at age 18 with her fingers turning blue in response to variable weather conditions. She sought help from her family physician, who referred her for treatment.

At her first session, a case history was taken, and an option for hypnosis was discussed. She had not received any previous treatment for Raynaud's. At the end of the session some information was given relative to hypnosis procedures, and she was told that there would be a total of 10 sessions.

The second session was held a week later. Client A gave her permission and was very interested in receiving help for her condition. Sensory induction techniques of Erickson, Rossi, and Rossi (1976) and Erickson and Rossi (1979) were used to obtain a medium level of hypnosis. Her average induction time was seven minutes. Glove anesthesia (Hilgard, 1965) was the technique used to reach a medium level of hypnosis. Since the client enjoyed being on the beach during the summer, this was used as a stimulus for producing body warmth while under hypnosis. She was instructed to picture herself on the beach during a hot summer day and to visualise a bright sun warming her body, hands, and feet. Also she was told that her warm blood would move through the expanding arterial system of the peripheral vessels, warming her hands, fingers, feet, and toes.

This client needed a 30-minute session in order to achieve some warmth in her hands, fingers, feet, and toes. Toward the end of the session she was instructed to practise a 10-minute visualisation session of the hot summer beach day in the morning and in the evening, in a quiet setting until her next visit, which was scheduled for the following week.

The client was seen for a third session on the following Tuesday. She indicated she practised her visualisation of the beach scene for seven days and had no effect of warmth in her hands or feet. The same induction techniques and hypnotic instructions were used as the second session. During this session the client was more relaxed and reached a medium depth of trance. This hypnosis session ran for 30 minutes with a slightly better success than the second session. She obtained some warmth in her hands and fingers, but no warmth in her feet. At the end of the session she was instructed to practise the 10-minute visual imagery periods throughout the week.

From the fourth through to the ninth hypnosis sessions the same procedures and instructions were used as in sessions 2 and 3. However, she experienced little success until the seventh hypnosis session was conducted. In this session she revealed moderate warmth in her hands, fingers, feet, and toes, which lasted for several days. The ninth hypnosis session was also successful in producing positive symptoms of warmth for five days. The cold features returned for short intervals of time and were not as intense as she experienced before treatment.

The tenth session was used as a summary and discussion of this woman's progress and changes in treatment. Client A reported she continued her visualisation sessions, which have been helpful. Follow-up a month later revealed 67% improvement in her Raynaud's symptoms.

Client B is a 32-year-old married woman with one child. She is a school nurse and enjoys working with elementary school children. She is involved in community activities and volunteer work, while harbouring an ambition to work in the medical field. This individual has had Raynaud's disease since she was 14 years old. She indicated her illness became more severe when she reached age 16, with her feet and hands becoming painfully cold with a drop in temperatures. The client was referred for treatment with hypnosis.

In the first session the client elaborated about her illness. A case history was taken and she reported she had never had treatment for Raynaud's. Client B appeared to be a good candidate for hypnosis. Towards the end of the session a suggestion was made for hypnosis. She was informed there would be eight hypnosis sessions and a follow-up progress session.

Client B was seen a week later for the second session. She was interested in having hypnosis treatment. Sensory induction techniques of Erickson, Rossi, and Rossi (1976) were used to achieve a medium level of hypnosis. However, this client moved into a deep level of hypnosis during most of the sessions. This deep level was manifested through sensory hallucinations (Hilgard, 1992). Her average induction time was four minutes.

Client B enjoyed being on the beach for her vacations so a hot summer beach day was utilised as a stimulus for producing body warmth while under hypnosis. She was told to visualise herself being on the New Jersey beaches on a hot summer day and to picture a bright red sun warming her whole body from her head to her toes. Along with this she was told that her warm blood would move through the expanding peripheral blood vessels which would cause warmth in her fingers and toes.

Client B required a 25-minute hypnosis session to obtain some warmth in her hands, fingers, feet, and toes. She was an excellent client for hypnosis and followed instructions very well. At the end of the session she was instructed to practise a 10-minute visual imagery session of a hot summer beach day, both in the morning and in the evening of each day until her next visit which was scheduled for the following week.

This individual was seen for a third session on the following Friday. At the beginning of the session she reported she practised her visualisation sessions of the hot beach scene for one week and had some mild effects of warmth in her fingers and toes. The client was happy about her efforts during the past week. This session used similar hypnotic techniques as the second session, and client B moved into a deep level of hypnosis. The average time for her sessions was 25 minutes. She received some warmth in each of her sessions.

Sessions four through to nine utilised the same methods and instructions as sessions 2 and 3. Client B showed improvement in each session, but did not obtain the same success as the other two clients. She reported the practice visualisation sessions helped her, but changes in weather conditions gave her some problems.

During the tenth session a summary and analysis was made on this client's progress in hypnosis. Along with this, we discussed her feelings about, and behaviour in, treatment. The client was instructed to continue her visualisation sessions on her own. She was seen a month later in a follow-up session and indicated a 30% improvement from her Raynaud's symptoms.

Client C is a 60-year-old married man, with four grown children. He lives on the east coast and works in an office setting. He enjoyed his job, social activities, and swimming. This individual has had Raynaud's disease since he was 11 years old. He had indicated to his physician that he suffers from cold hands and cold feet throughout the year and wanted professional help from a psychologist.

A full case history was taken in the first session. He was given the option of hypnosis as the treatment method for his disorder, as he showed interest in relaxation techniques. He proved to be a good client for hypnosis and the procedures were discussed after he gave permission for treatment.

The second session was held a week later, as he was motivated to start treatment. Sensory induction techniques of Erickson, Rossi, and Rossi (1976) were used to achieve a light to deep level of hypnosis. This client needed a total of 6 minutes for induction. Glove anaesthesia (Hilgard, 1992) was the technique used to assess achievement of a medium state of hypnosis for this individual.

During hypnosis he was told to visualise being on the beach on a hot summer day and to picture a bright sun warming his body, including his hands and feet. Along with this he was told his warm blood would flow through the expanding peripheral blood vessels, warming his hands, fingers, feet, and toes. After the induction, the client needed 20 minutes to achieve substantial warmth in his hands and feet. At the end of the session, it was recommended he practise a 10-minute visualisation session of the hot summer beach day, in the morning and in the evening throughout the week.

A third session was held a week later. The client reported he practised his visual imagery sessions throughout the week with little effect of warmth in his hands and feet. This session utilised the same induction techniques and hypnotic instructions as the second session and the client moved into hypnosis rather quickly. He was able to reach a medium level of hypnosis. This session ran for 25 minutes with the client obtaining some warmth in his hands, fingers, and feet. He was given post-hypnotic instructions to practise the visual imagery sessions twice per day.

Sessions four to nine used the same procedures and instructions as sessions 2 and 3. During the sixth hypnosis session the client began to experience considerable warmth in his hands, fingers, feet, and toes. This warm experience was maintained throughout the remaining sessions and visualisation periods.

In the tenth session we reviewed and discussed the client's progress in hypnosis. Along with this, some recommendations were made for further treatment if needed. A follow-up was done a month later and the client showed 85% improvement in his condition.

RESULTS

This investigation revealed two of the three clients showed significant improvement in their ability to manifest warmth in their hands and feet after treatment with hypnosis. The remaining client, B, achieved some improvement in her condition and does not experience the extreme cold in her extremities now. Table 1 shows the descriptive temperature changes of the three clients for 30 days prior to the use of hypnosis.

These temperature changes were observed by the clients and tabulated on a

Table 1: Descriptive Temperature Changes of Raynaud's Disease Clients for 30 Days Prior to Hypnosis

Client	Descriptive temperature level				Total days
	Cold	Slightly cold	Mildly warm	Warm	
A	15	5	7	3	30
B	24	3	3	0	30
C	10	15	3	2	30

calendar. There is a vast difference between these prior temperature ratings and those in Table 2, which contains the descriptive temperature level of clients for 30 days after the use of hypnosis. The results showed a positive increase in the clients' descriptive temperature ratings. This improvement in body warmth of the hands and feet continued throughout the year by the client using 10-minute practice sessions of visual imagery, three times per week in response to changes in the weather.

This investigation and previous research by Freedman (1991), Schreiber

Table 2: Descriptive Temperature Changes of Raynaud's Disease Clients for 30 Days After Hypnosis

Client	Descriptive temperature level				Total days
	Cold	Slightly cold	Mildly warm	Warm	
A	2	8	17	3	30
B	12	9	6	3	30
C	3	2	18	7	30

(1991), and Spanos and Chaves (1989) indicate that more work is needed on varying populations, different age groups, and longitudinal studies of hypnosis and Raynaud's disease.

REFERENCES

- Crasilneck, H. B. and Hall, J. A. (1985) *Clinical hypnosis: Principles and applications*. New York: Grune and Stratton.
- Erickson, M. H., Rossi, E. L. (1979). *Hypnotherapy: An exploratory casebook*. New York: Irvington.
- Erickson, M. H., Rossi, E. L., & Rossi, S. (1976). *Hypnotic realities*. New York: Irvington.
- Freedman, R. R. (1991). Physiological mechanisms of temperature biofeedback. *Biofeedback and Self Regulation*, 16, 95–115.
- Hilgard, E. R. (1965). *Hypnotic susceptibility*. New York: Harcourt, Brace and World.
- Hilgard, E. R. (1992). "Divided consciousness and dissociation." *Consciousness and Cognition*, 1, 16–31.
- Jacobson, A. M., & Hackett, T. P. (1973). Raynaud's phenomenon: treatment with hypnotic and operant technique. *Journal of American Medical Association*, 225, 739–740.
- Kroger, W. S. (1977). *Clinical and experimental hypnosis*. Philadelphia: J. B. Lippincott Co.

- Najarian, B., Roger, D., & Venables, P. H. (1989). The construction and preliminary validation of a scale for identifying symptoms of Raynaud's phenomenon in the general population. *Personality of Individual Differences, 10*, 837–844.
- Norris, A., & Huston, P. (1956). Raynaud's disease studied by hypnosis. *Diseases of the Nervous System, 17*, 163–165.
- Schreiber, E. H. (1991). *Abnormal behavior*. Needham, MA: Ginn Press.
- Spanos, N. P., Chaves, J. F. (1989). *Hypnosis*. Buffalo, New York: Prometheus Books.
- Weitzenhoffer, A. M. (1989). *The practice of hypnotism*. New York: Wiley.

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 review the relevant research and clinical literature to justify and explain their use of hypnosis. While the standard criteria for publications in the Journal will not apply to Case Notes, a clear exposition of the ethical professional practice of hypnosis will be required if the material is to be published.

HYPNOSIS AS AN ADJUNCT TO COUNSELLING FOR ANXIETY

Douglas Farnill

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This case illustrates the use of hypnosis as an adjunct therapy with a nine-year-old girl who was afraid of staying away from home overnight at friends' homes and at a school camp.

A worried mother telephoned to make an appointment for me to see her 9-year-old daughter who was refusing invitations to stay overnight at her friends' homes, and who was growing very anxious at the prospects of attending a school camp in three weeks time. If she did not go to the camp she would likely be the only child in her class not to do so, and that would be humiliating. Would

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I hypnotise her daughter to overcome the problem? I explained that I would need to assess the problem and then discuss what might be done. I agreed that it was possible that hypnosis could be useful, but not necessarily so. We discussed issues of confidentiality and fees and I immediately mailed a questionnaire covering family and health history, which she would return to me when they came for their first appointment in a few days time.

CASE ASSESSMENT

I saw Mrs Brown and Margaret (pseudonyms) together at all times. Margaret was a bright and confident child who obviously enjoyed going to school where she had several good friends. Her academic progress was good, as was her general health. Mrs Brown was of anxious disposition and she explained that her regular therapist had recommended that she try to arrange some hypnosis for Margaret.

Although some of her friends had spent nights at her home, Margaret's one attempt to stay overnight at someone else's place had ended in dread, tears, and being brought home before bedtime. Margaret said that she "just couldn't" stay anywhere overnight and she was worried about the forthcoming school camp. Margaret, though articulate, was not able to describe the nature of her fears in an elaborate way. It may have been easier for her had her mother not been present but, as a male therapist, I judged it most prudent for me not to see the girl alone. Though I structured the session in this way to protect myself against the possibility of a future and fantastic allegation of impropriety, I quickly sensed that Mrs Brown's observation of my addressing her daughter as a capable young person was probably an incidental benefit of my caution. I explained that my role as a clinical psychologist was like being a teacher who helped people learn new ways of overcoming their problems. Margaret was ready to admit that she had a problem and wanted to overcome it, but she was not able to describe her problem in much detail.

Accordingly, I used some simple indirect and projective techniques. In response to my invitation to say what animal she would like to be, after a moment's thought she said, "a snake." When I inquired what it was about being a snake that was good, she told me that snakes could hide in the grass because of their colours and they have poison "to scare scary things away." When I invited her to have three wishes, she wished that: she could have a big sister to look after her, just like she helps her mother look after her infant brother; that she could have lots of toys; and that her mother and father would be happy forever.

We then made up a story together. I would venture with a stem such as, "Once upon a time there was a . . ." and she would respond by providing "a little girl." I would continue, "and the little girl went . . ." and she added "for a walk." We proceeded to develop a rather sad picturesque tale of a little girl who went out on adventures but who ultimately went home to a house where there was no

mother but a father who had been given three wishes: that there would be no more wars; that everybody would be happy; and that he would find his lost child and her mother.

I began to hypothesise that Margaret's problem might be due to insecurities about home while she was away rather than fear of unfamiliar sleeping places. Following our "fun" with the wishes and storytelling, Margaret and I were now able to talk in a serious way about her problems. She agreed that the problem was like "homesickness," wishing that one were home rather than worrying about the overnight situation itself.

After discussing the nature of hypnosis with Margaret, introducing it as a skill that I wanted to teach her, I asked her, using an imagery technique once demonstrated to me by Gail Gardner (Gardner, 1980), to characterise the size, shape, texture, and colour of homesickness. Margaret's homesickness was large, lumpy, hard, and blue. Following a brief induction using relaxation and deepening by descending steps into a garden, Margaret visualised her homesickness as she had characterised it previously, and with prompts from me, reduced its size, smoothed, and softened it, and changed it to her favourite shade of green. We discussed the control that such visualisation can give over things and feelings that are ugly. We had been working for an hour and, given the possibility of a night away from home that coming weekend, we arranged a second session in three days time.

HYPNOTIC TREATMENT

Margaret reported that she had practised her hypnosis of changing the ugly homesickness into a more beautiful thing but that it had been hard all by herself and had not worked very well. With coloured pencils we drew some simple goblets, and two bottles of stuff. One bottle of blue stuff we labelled "homesick" and the other, of light green, we labelled "peace." We imagined filling a goblet with homesick, leaving no room for peace, and then filling a goblet with peace leaving no room for homesick. I explained that I was going to help her to imagine her own place of peace, a garden. If she were in her garden of peace and full of peacefulness, it would be hard for any homesick to fill her life and distress her. I had plenty of paper and coloured pencils and I asked her to begin to draw her garden of peace. First I asked her to draw the 10 steps down into the garden that we had used in the trance deepening of the previous visit. Then I encouraged her to draw a fountain and pool with goldfish, some lawn, flowers, and a tree. She did so and spontaneously added a bird in the tree, and a plot with carrots and cabbages.

Following a brief induction, I asked her to descend into her garden and enjoy some minutes of really nice peace. In the deepening I referred to some of the features of her drawing and I asked her to look and listen and feel. I had the impression that she was quickly deeply relaxed and the amount of eye movement behind her eyelids suggested very active visualisation. Later, during debriefing,

she said that she had heard the bird singing and that her vegetables were growing beautifully. She also heard the tinkling of the fountain as it sprayed over the fish and rippled the water in the pool.

She then announced bluntly that she was really afraid of her father and mother getting a divorce like the parents of Michael, one of her friends. The mother was visibly shaken by this announcement. I asked whether Margaret sometimes worried about this when she was away from home, and she nodded.

I then offered Mrs Brown some instruction. I said that Margaret is going to practise her garden of peace so that she can be full of peace without much room for worry, but that mother has to help by providing details of what will be going on at home during any time that Margaret spends away. We discussed the need for knowledge of mundane issues such as who would be bathing the infant brother, who would be doing the helping tasks in food preparation ordinarily undertaken by Margaret, whether the family would be watching TV, what time they would go to bed and get up, and what the arrangements would be for picking up Margaret the next morning. Margaret's goblet could be filled up with the peace of her garden and the information about the family activities. There would be little space for fears about parental stability to expand. I encouraged Mrs Brown to consider discussing the events of our two sessions with her regular therapist.

FOLLOW-UP

Mrs Brown telephoned me after the following weekend to say that she had encouraged Margaret to practise being in her peaceful garden. She said that Margaret had slept over at her friend's without any cajoling, tears, or phone calls. Three weeks later she thankfully informed me that Margaret had been away to a very successful school camp.

Three months later, Mrs Brown called to make another appointment for Margaret. The problem was that, although Margaret was not anxious, she sometimes decided that she did not want to go and stay overnight with friends. I said that I would certainly be available if necessary, though it sounded as if Margaret was exercising a growing independence and that I was keen to avoid our identifying her as a problem child. I discussed some parenting issues with Mrs Brown and said that I would be available to meet with her to elaborate on these, but that I thought it would be better if she discussed them with her regular therapist.

DISCUSSION

I am reasonably satisfied with the outcome of this case but not entirely. Margaret was helped to enjoy overnight stays at friends' homes and was able to participate in the school camp. Her satisfactory negotiation of these normal milestones will contribute to her personal and social development more positively than the

alternatives of anxiety and humiliation. Perhaps the skills of relaxation in her peaceful garden will have a longer life and wider application than as a device in this particular crisis, though I suspect that without more thorough practice and continued encouragement the use of these skills will be more likely ephemeral.

The case was complicated by Mrs Brown's concurrent participation in psychotherapy with a therapist with whom I had no liaison. I did consider asking permission to consult with the other therapist, but Mrs Brown did not identify her therapist, and though on two occasions I had suggested that she might discuss some of the issues that had arisen with her therapist, she offered no follow-up. I concluded, perhaps on too little evidence and perhaps because I did not want to engage in poaching Mrs Brown as a client, that she did not want inter-therapist communication.

The therapy seemed to work efficiently and effectively in overcoming the presenting problem, but I do not know which elements were efficacious. The relatively long-standing nature of the condition followed by its swift resolution after intervention suggest that it was the therapy that was beneficial rather than merely a child's natural growth and development, but evidence-based practice this was not! The use of hypnosis probably contributed to the mother's satisfaction that something special had happened, and my personal impression was that the drawings of the goblets and garden followed by trance and relaxation had been efficacious, but the outcome may equally be due to the non-specific effects of a couple of fun sessions with a kindly grey-haired therapist.

I am convinced, however, that in this case, as in some cases of school refusal or school phobia, the child was more concerned about the possibility of adverse events occurring at home than about the stresses of the away-from-home situation.

REFERENCE

Gardner, G. G. (1980). Hypnosis with children. *International Journal of Clinical and Experimental Hypnosis*, 28, 289-293.

HYPNOSIS FOR PERFORMANCE ANXIETY

Sandra Lorensini

Psychologist

This case report describes the use of hypnosis in the treatment of performance anxiety.

Jenny was a 32-year-old woman who referred herself after she and her daughter had fled from her violent husband on Christmas morning several months earlier. She had experienced extreme emotional and physical abuse from her husband. Her daughter had been emotionally abused but the father did not get the chance to physically harm her because Jenny “took whatever was coming for her.” However, the child was forced to watch his acts of cruelty to her animals. After spending time in a women’s refuge, she moved to another city so that her ex-husband would not find her and started a course at university with the hope that she would gain employment in the tourist industry, but considered that she would be “too stupid to get the degree.”

Jenny presented as a quiet and rather timid person who lacked self-esteem and confidence. After months of supportive psychological counselling, she became aware of her many strengths and became more assertive. A shift in her psychological well-being occurred with the realisation that what she had experienced throughout her marriage was different from most women: she had worked at three part-time jobs, maintained her home, and cared for her child except when she was at work (when she paid her unemployed husband to babysit for her). Throughout the marriage she learnt to be subservient to her husband, and found the punishment was less if she stood still and “copped it” rather than trying to get away or fight back.

Jenny’s ex-husband wanted custody of their child and used every legal avenue toward that objective. Her child had clearly stated that she did not want contact with her father. For Jenny and her child, this initially meant family law counselling in her town of origin, and having to meet with her ex-husband. When threatened by her ex-husband, the counsellor was “taken off her case” and given 24-hour protection. Jenny retreated to her home in fear.

She then had to take her child from school one day each week to attend mandatory counselling in Melbourne. The counsellors insisted that the child meet with the father, but when they saw the child’s reaction they noted that this was not of benefit. This is what Jenny had told them during the preceding months. Throughout the conciliation process, Jenny attended court on a few occasions and any decision was appealed by her husband. Upset and crying, she

told me the legal process made her feel stupid and useless. She felt powerless because she felt she could not protect her child, and asked, “Why is it that no-one ever listens to me?”

Jenny was finally granted full custody of her child, and was told no paternal access visits would be allowed. She felt that, finally, the court had listened to what she had to say. The cost to her was half of the proceeds of the sale of the family home (everything she owned). Eventually, she began feeling positive about herself and wanted to help others. She joined a support group for women who each were in, or had left, a violent relationship. She saw herself as a role-model with experience, who could encourage other abused women to lead a normal life. She laughingly said “After all I have been through, I will never be frightened of anything again.”

PRESENTATION FOR HYPNOTHERAPY

When Jenny presented months later, at a time when I was studying hypnosis, she told me she had become so anxious that she “wanted to be swallowed up by the floor.” She had made her first presentation to her class at university and “bombed.” She described how she had thought she was well prepared and expected to be a little nervous, but she was devastated by her performance. Throughout the presentation, her heart pounded, she felt as though her body was shaking, she had difficulty speaking, and had to read her notes because she could not remember any of what she planned to say.

When I suggested that people often think they present more poorly than they have actually done, she reported she received a low mark and her lecturer asked her what had gone wrong. It was important for her to overcome her extreme performance anxiety as class presentations contributed to a large percentage of overall marks for each subject she was studying.

In the past, when Jenny was going to be beaten by her husband or when she had to stand by while her child was abused, she would hold her breath, look away, and “go somewhere else” in her mind; otherwise she would have “gone completely mad.” She also practised this coping mechanism when she was legally forced to meet with her husband and at times during court proceedings. When placed in the potentially anxiety-provoking situation of making a class presentation, Jenny’s learned coping mechanisms were inappropriate. She had a long history of seeing herself as never being listened to, and was a timid but clever student who saw her lecturer as a powerful person about to negatively judge her. It was considered that hypnosis would be of benefit to her as, according to Waxman (1989) the restoration of self-confidence is one of the easiest and most rapid results that can be achieved by hypnotherapy.

Jenny had not experienced hypnosis before. She did not have a history of psychiatric illness, nor did she present with any symptom which could have been a contraindication for hypnosis, such as a psychotic illness or depression with a suicidal component. She was very keen to try hypnosis, desperately

wanted the treatment to be a success, and she was prepared to work hard towards that goal.

GOALS OF THERAPEUTIC MANAGEMENT

Jenny's main aim was to be relaxed enough to be able to present her paper, and to do it well, so that she would not be embarrassed in front of the other students or her lecturer. We worked through what Jenny hoped to achieve through using hypnosis:

1. To feel confident, relaxed, and in control.
2. To be free of symptoms of anxiety (heart pounding sweating, difficulty in speaking).
3. To remember her speech, rather than read from her notes.
4. To speak slowly and clearly.
5. To not fear her lecturer.
6. To feel afterwards as if she had achieved her goal.
7. Her talk to reflect the many hours of preparation and effort that it had taken.
8. To enjoy the task.

TREATMENT PLAN

Jenny's next presentation was in six weeks, so during that time the following was planned:

1. Progressive relaxation to reduce her autonomic arousal.
2. Diminishing the perceived power of her lecturer.
3. Ego-strengthening to build self-esteem and confidence.
4. Visualisation of a safe place, being in control.
5. Suggestions that would speak clearly and slowly.
6. Suggestions that class members and the lecturer would be interested in what she was presenting.
7. Mental rehearsal of making the presentation.
8. Listening to a tape every night for one week prior to the presentation.

SESSIONS 1 AND 2

Hypnosis was carefully explained to Jenny, and myths — such as that hypnosis is caused by the power of the hypnotist, that she could be hypnotised to say or do something against her will, or that she would be asleep or unconscious when in hypnosis (Yapko, 1995) — were discussed. She was given a general overview of hypnosis as an altered state of consciousness which paralleled other spontaneous changes in normal consciousness such as going off into a daydream while listening to a boring sermon, or becoming immersed in reading a good book.

Practical suggestions for making a good presentation were also discussed. These included fully researching the topic, timing her speech, using handouts and overheads, using humour, practising her speech while speaking out loud, and looking her best on the day of the presentation. Jenny's hypnotisability was determined considering three factors: (a) her attitude and perception of hypnosis; (b) hypnotisability, as measured by the Stanford Hypnotic Clinical Scale for Adults (SHCSA; Morgan & Hilgard, 1979); and (c) contraindications. Assessment of her hypnotisability indicated she scored in the high range on the SHCSA (4/5).

SESSION 3

Trance was induced by using progressive relaxation technique, and deepening occurred through a 1–20 count in which suggestions promoting relaxation and feelings of calmness were used while focusing on evoking a safe positive place. Jenny's preferred imagery of a beautiful room was used and during debriefing she told that she experienced the suggested images: textures, perfumes, noises, music, warmth of the sun streaming into the room, and feeling safe, calm, peaceful and relaxed. An adaptation of Torem's (1990) ego-strengthening script was used with emphasis, for example, on viewing herself positively, developing greater confidence, appreciating her talents, gifts, skills, attitudes and abilities. Dehypnotising constituted a reversal of the deepening process (a 20–1 count) with eyes open at 5. The session had met its goals: Jenny had shown a positive response and reported being very relaxed, calm and feeling good about herself in general.

SESSION 4

Following progressive relaxation and deepening, Jenny was asked to think of a code word that she could use in the future when she wanted to feel as calm and relaxed as she was presently feeling. Jenny again used the imagery of a beautiful room, but on this occasion she allowed her lecturer to enter. However, by using any method she wished, she could diminish him in size. She was asked to imagine what it was like for her talking to him as a tiny person and she could place him anywhere she wished. During debriefing, Jenny appeared to have enjoyed this session. Using her index finger that had "ET-type powers," she was able to reduce and expand the size of her lecturer at will by pointing to him. She told him she was not going to be daunted by him in the future, and laughed as she said that with reduced stature he looked rather like the cartoon character Bart Simpson. She had considered putting him into a large vase until after her next public speaking event, but felt sorry for him and expanded him to normal size before he left the room. When asked about her feeling sorry for him, she replied, "He is quite a likeable man, and pretty harmless really."

SESSION 5

At the beginning of this session, Jenny seemed very positive, saying she thought she was really getting somewhere. When she saw her lecturer at university, she thought of him as an understanding Bart Simpson character. In trance, she was asked to imagine herself in front of her class, looking at the friendly faces of her fellow students. They were looking at her in anticipation, waiting to hear what she had to say. She had done her research, had a sound knowledge of her topic, and she felt confident. Her lecturer was present, but he was not a problem as she could mentally diminish him to any size she wanted if that was what she wanted. She was asked to imagine watching herself, as if she was on television, making the presentation. She could see herself speaking slowly, looking good, smiling, calm, and confident. I suggested she might feel a little nervy in the stomach at the beginning of her talk, but not to worry as that was excitement and was normal, and something she would overcome. A tape of the session was given to her and I recommended she listen to it daily. In the debriefing session that followed, Jenny was reassured that she would be surprised at how well her presentation would go, and that she would in fact enjoy the experience. She assured me she had put into practice the suggestions that were discussed in Session 1. She planned a visit to the room where she was to make her presentation following classes that week, to desensitise herself by standing at the front of the room and imagining herself talking to friendly faces and “Bart.”

SESSION 6

Jenny called on the morning of the day she was to make her class presentation and told me she was well prepared and rehearsed. She had listened to the tape each day, as recommended, and through practising self-hypnosis was able to control her autonomic arousal system to bring about feelings of calmness and relaxation. It appeared Jenny needed to be further reassured that she would do well.

OUTCOME

Flushed with success, a very excited Jenny telephoned shortly after her class to tell me her talk went as planned. She had felt a little nervy in the stomach at the beginning, but knew this was normal and it would pass. Many questions followed her talk, reassuring her that the students and lecturer were interested in what she was saying, and she gained further confidence by her ability to answer questions while standing in front of the class. She reported experiencing a tremendous sense of relief knowing that she had accomplished, and actually enjoyed, the event.

Two weeks before her next class talk was due, Jenny presented again and asked for a “top-up” hypnosis session to reinforce what she had achieved during

the previous sessions. A tape, similar to the first one, was recorded during the hypnosis session. Jenny did not want to revert to the anxious person she had been, and found having the tape was the reassurance she needed during the days leading up to her next talk. She contacted me to say that she was again successful.

DISCUSSION

The success of this case was probably due to Jenny's motivation. If she had not been able to overcome her performance anxiety, she would have given up her course. She saw a university degree as giving her a great sense of accomplishment as well as leading her out of poverty through employment opportunities. Along with her motivation, she had a high score of hypnotisability, and also had previous experience of a type of self-hypnosis where she would "go somewhere else in her mind" to cope with stressful situations. These features made Jenny an ideal patient to be successfully treated by hypnosis. When asked what she found particularly useful during trance, she told me that it was helpful when she gained control over her feelings toward the lecturer. She was able to reduce him from an object of fear to a likeable character. She reported that watching herself give the talk, as if seeing herself on television, was also of great benefit. Having made one successful presentation, Jenny was psychologically spurred on to further success.

REFERENCES

- Morgan, A. H., & Hilgard, J. R. (1979). The Stanford Hypnotic Clinical Scale for Adults. *American Journal of Clinical Hypnosis*, 2, 134–147.
- Torem, M. S. (1990). Ego-strengthening. In C. Hammond (Ed.), *Handbook of hypnotic suggestions and metaphors* (pp. 110). London: W. W. Norton & Company.
- Waxman, D. (1989). *Hartland's medical and dental hypnosis* (3rd ed.). London: Baillière Tindall.
- Yapko, M. D. (1995). *Essentials of hypnosis*. New York: Brunner/Mazel.

BOOK REVIEWS

Hypnosis and Hypnotherapy with Children. Karen Olness and Daniel Kohen. New York: Guilford Press. 1996. xv + 457; hardcover.

The first edition of this book was published in 1981 and immediately became the “gold standard” by which books on children and hypnotherapy were judged. Sadly, one of its co-authors, Gail Gardner, has since died. For this new edition, Dr Daniel Kohen has taken her place as co-author. Both Karen Olness and Daniel Kohen are extraordinarily skilled, creative, and astute clinicians and these qualities shimmer through the text. They bring to this book a wealth of experience with patients as well as a keen awareness of current research in the field.

Part I covers some of the basic developmental aspects of children’s emotional growth as well as an account of early uses of hypnosis with children. The correlates and norms of childhood hypnotic responsiveness are discussed, followed by an extremely useful and practical chapter detailing many hypnotic techniques and strategies for use with children. These techniques are clearly described and the authors have included a table setting out which strategies are most appropriate for particular age groups. They include modifications for children with special disabilities, such as physical or learning disabilities. Throughout this description of techniques, however, the authors emphasise that a hypnotherapist is first of all a “therapist” and must not use hypnosis in a simple “cook book” way without a thorough understanding of the child’s social and emotional issues. In the numerous case studies they describe, they make clear that each child is an individual and is treated as such. The impact of parents is also highlighted as well as the complexities of the child’s unconscious wishes and fears.

Part II deals with the practical application of hypnotherapy in a wide variety of disorders. The chapters are divided into such topics as psychological disorders, habit disorders, problems in learning and performance, pain control, paediatric medical problems, paediatric surgery and emergencies, hypnotherapy for grief and mourning in the terminally ill child, biofeedback and child hypnotherapy, self-hypnosis, psychoneuroimmunology, and teaching child hypnotherapy. There is an extensive use of case studies, including detailed transcripts of interviews, which highlight the ways in which the clinician can approach particular problems. At the same time, there is a review of the current

state of hypnosis research in the particular clinical area being addressed. The range of clinical topics addressed is vast. Among the more unusual of these are the use of hypnosis with Tourette's syndrome, seizures, and haemophilia.

The authors state that they hope this volume will "provide our colleagues with new ideas and will stimulate creative approaches to understanding children and adolescents and helping them develop their potential to the fullest extent. In the final analysis, we see ourselves as guides, coaches, and teachers. It is the children who bring healing to themselves." Olness and Kohen are superb guides, coaches and teachers. We are lucky to have them and to be able to share their knowledge and wisdom through this book.

DORIS BRETT, Clinical Psychologist, Melbourne

Stretching the Imagination: Representation and Transformation in Mental Imagery. Cesare Cornoldie, Robert. H. Logie, Maria. A. Brandimonte, Geir Kaufman, and Daniel Reisberg. Oxford: Oxford University Press. 1996. 197.

Many years ago, well maybe not that many, I made a decision to pursue clinical psychology as a career rather than remaining in the academic stream. The main reason that I decided to go in this direction was because I found the pursuit of academic psychological research disappointing. I felt that the research was largely trivial, generally derivative, and ultimately did not lead me to a better understanding of human behaviour.

The reason that I open this review with this statement is because *Stretching the Imagination* is basically a summary and explication of academic research into mental imagery and particularly focusing on where the field is now in the 1990s. I found this book extremely difficult as I was challenged to try and make sense of this material in terms of practical applications in clinical practice and especially with regard to hypnosis. I have to admit at this point that I have failed in that particular endeavour.

Stretching the Imagination is made up of five chapters written by the various authors. The first chapter gives a history of the research into mental imagery and summarises the key points of the research material that is presented in the later chapters. I have to say that I found this chapter to be the only one that really held my attention, as it did not explore the minutiae of the research questions too much. That is, it was sufficiently shallow to allow me to get a grasp on the general issues in the field. The following chapters then basically go on to present the evidence in relation to current theories about mental imagery and its relationship to visual perception. It was at this point that I found the book really hard going.

I really cannot give a summary of the main points in the current debate about mental imagery after reading this book, mainly because I didn't understand them. Apparently the debate as to whether mental imagery is "imagery" per se

has been abandoned as empirically meaningless and has shifted on to issues about how mental images are and are not like visual percepts and the extent to which language mediates the acquisition and analysis of mental images. Further than this I really cannot say.

On the whole I have to say that I think that this is an excellent book. It is, however, aimed at a very particular audience. If the reader is involved in research in this area it provides an admirable discussion of up to date research and clearly examines the “cutting edge” issues in the theoretical and empirical debate. But if you are interested in the clinical implications of research into mental imagery then this is really not the right book. It is clearly quite bound to its own field and there are few, if any, attempts to move beyond into the broader areas of cognitivist models of psychology and implications for working with people’s experience of their own imagery as a resource in personal development.

In closing I would have to say, at a personal level, that I have been confirmed in my decision to follow the clinical field. I cannot say that I saw the research that is being done on mental imagery as meaningless but I was left with the feeling that it really was not going anywhere that I wanted to follow. No doubt it is important to sort out the specific issues that are covered in this book. Nevertheless, I cannot help feeling that these particular approaches lose sight of the woods and, to some extent, diminish some of the experiential wonder and magic that is involved in the experience of imagery.

ALISTAIR CAMPBELL, Senior Clinical Psychologist, Launceston, Tasmania

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

Martin A. Conway *Recovered Memories and False Memories*. Oxford:
Oxford University Press, 1997.

Robert G. Kunzendorf, *Hypnosis and Imagination*. Amityville, NY:
Nicholas P. Spanos, & Baywood Publishing, 1996.
Benjamin Wallace (eds)

Björn Enqvist *Pre-Surgical Hypnosis and Suggestions in
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