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Australian Journal of Clinical and Experimental Hypnosis

May 2000 — Volume 28 Number 1

Editorial iii

Obituaries 1

Memory and False Memory

Vicissitudes of Memory: Falsification and False Memory Syndrome
Cam Perry 4

Remembering Trauma or the Trauma of "Remembering"?
Richard A. Bryant 21

An Alternative View: Recovered Memories and the Australian Courts
Eilis S. Magner 30

Sexual Relationships with Former Patients: Prevalence, Harm, and Professional Issues
Douglas Farnill 42

Hypnosis, Grief, and Mourning
Gary R. Elkins 61

Hypnosis in a Case of Vocational Counselling
Andrea Reupert and Darryl Maybery 74

The Effects of an Educational Lecture About Hypnosis
Russell Hawkins and Joanna Bartsch 82

Case Notes 100

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Editorial

Welcome to the "new look" journal. The *Australian Journal of Clinical and Experimental Hypnosis* has been published in the same format since 1975 and, with the support of the Federal Council of the Australian Society of Hypnosis, it was decided it was an appropriate time to update our format and presentation.

This edition features four special papers, in addition to the regular range of clinical reports on the use of hypnosis. In a special section, there are three papers addressing issues in memory, false memory, and hypnosis, with two of these papers written specifically for this edition of the journal.

In a paper reprinted from *Quadrant,* Cam Perry, PhD, from Concordia University in Canada, discusses a range of issues relating to memory. Two noted Australian academics, one a psychologist and the other a lawyer, have each provided reviews of the Perry paper, providing unique views from a research and Australian perspective. Richard Bryant, PhD, from the School of Psychology at the University of New South Wales, comments on psychological aspects and Eilis Magner, LLB, LLM, Professor of Law at the University of New England, comments on false memory issues in the legal context. Note that the Perry paper was first published in *Quadrant,* formatted as required for that publication. To ensure consistency, I asked Bryant and Magner to submit their reviews in a style similar to that used by Perry. Thus, these papers do not accord to the style normally used in *AJCEH.* Full copies of both papers, showing citations and references, are available from the journal.

This edition also features a paper from Douglas Farnill, formerly of the University of Sydney, addressing issues in relation to sex with former patients/clients. This paper was written for an anthology planned by the journal which did not eventuate.

I recommend these papers and those others in this edition of the journal to you.

Publication of Educational modules

I am delighted to include in this edition of our journal, details of an extensive range of new education modules on *Hypnosis in Clinical Practice* being developed in a collaborative arrangement between the society's Board of Eduction and *AJCEH.* I thank Professor Graham Burrows, AO, KSJ, Chairman of the Board, for his support in this endeavour.

The Education and Publication Office of ASH is publishing a series of educational modules addressing a range of theoretical and clinical issues in hypnosis. The current range of modules is listed later in this edition (see pp. 104–105). Select those which you think will be of interest and value to you. Listed and additional modules will be published over time and will be regularly advertised in the journal.

This activity is one response to the expressed needs of members of ASH and subscribers to *AJCEH* for training and educational materials. I have already thanked Professor Burrows for his support; in addition, I note my considerable appreciation to Dr Wendy-Louise Walker (N.S.W.) and Dr Graham Wicks (S.A.) and other members of the Board of Education for their advice in the preparation of these modules. I invite members of ASH to contribute to the development of this innovative training and educational strategy.

Barry J. Evans
University of Melbourne
May 2000

Australian Journal of Clinical and Experimental Hypnosis
Vol. 28, No. 1, 2000, 1–2

OBITUARIES

GORDON HAMMER

Gordon Hammer passed away on 11 December 1999 in Sydney, Australia, aged 85. Although perhaps not known personally to many in hypnosis currently, Gordon was a major figure in experimental and clinical hypnosis from the 1950s to the 1970s. He retired from academic life in 1979, after holding positions at the University of Sydney, University of New South Wales, and Macquarie University. Gordon remained a true academic to his death and maintained a balance of passionate interests in hypnosis, mathematics, classical music, sport (especially cricket), and his four children and seven grandchildren.

Gordon was one of the founding fathers of hypnosis research in Australia, and his intellectual style and influence can be seen directly in hypnosis researchers and practitioners such as Fred Evans, Campbell Perry, Peter Sheehan, and Wendy-Louise Walker, as well as in various other researchers and practitioners both inside and outside Australia, including myself. Gordon had a Socratic style of teaching and supervising, often in the context of drinks and good times, and he cared deeply about ensuring that students and colleagues argued their position well and defensively — even when the position was one that Gordon disagreed with strongly, he could and would disagree strongly but always with good humour and in the spirit of providing an intellectual challenge.

Much of the intellectual strength of Gordon can be seen in the work of others, as well as in his own writings, which include:

Hammer, A. G. (1961). Reflections on the study of hypnosis. *Australian Journal of Psychology, 13,* 3–22.

Nace, E. P., Orne, M. T., & Hammer A. G. (1974). Posthypnotic amnesia as an active psychic process: The reversibility of amnesia. *Archives of General Psychiatry, 31,* 257–260.

Orne, M. T., & Hammer, A. G. (1974). Hypnosis. *Encyclopaedia Britannica* (pp. 133–140). Chicago, IL: William Benton.

KEVIN M. McCONKEY, University of New South Wales

MARTIN T. ORNE

Psychiatrist, psychologist, and international authority on psychotherapy and the medical use of hypnosis, Martin Theodore Orne, MD, PhD, died on 11 February 2000 of cancer. He was 72.

Born in Vienna, Austria, in 1927, Dr Orne received his MD degree from Tufts University Medical School in 1955, with a Residency in Psychiatry at Massachusetts Mental Health Center, and a PhD in Psychology from Harvard University in 1958. He was Professor of Psychiatry and Psychology at the University of Pennsylvania in Philadelphia for 32 years before becoming Emeritus Professor in 1996.

As teacher, scientist, and practising physician, Dr Orne was widely recognised for his work in hypnosis, memory, biofeedback, pain management, lie detection, sleep, and the roles played by specific and non-specific factors in psychotherapy and behavioural medicine. He also pioneered new therapeutic approaches and perspectives on patients' rights. He published the first of hundreds of scientific papers in 1951. He was editor of the *International Journal of Clinical and Experimental Hypnosis* for 30 years, and the recipient of funding for his research from the National Institutes of Health and many other federal agencies for 40 years. Dr Orne was also the recipient of two honorary doctoral degrees, and awards for lifetime contributions from the American Psychological Association, the American Psychological Society, and the American Academy of Psychiatry and the Law.

Throughout his scientific career, Dr Orne collaborated with his wife, psychologist Emily Carota Orne. Their research on hypnosis and memory distortion was cited in more than 30 legal cases by state supreme courts and the U.S. Supreme Court, and it resulted in widely adopted guidelines restricting the use of hypnosis in forensic cases. Dr Orne chaired a blue-ribbon panel that helped establish the American Medical Association's standards for the forensic use of hypnosis. His work on psychotherapy and memory also helped expose the controversial practice by some psychotherapists of using suggestive techniques that encouraged the creation of false memories of trauma in their patients.

Dr Orne was an expert witness in legal cases involving coercion and memory distortion. He was one of four defence psychiatrists who examined kidnapped heiress Patty Hearst during her trial for bank robbery. He remained convinced of her innocence and more recently urged that she be pardoned. His involvement as an expert for the prosecution of Kenneth Bianchi, who

was convicted in the torture and murder of young women in the hillside strangler serial murders of the 1970s was featured in the Emmy award-winning *Mind of a Murderer* documentary by the British Broadcasting Corporation.

His interest in promoting scientific research on the mind and its role in health, wellbeing, and safety resulted in the establishment in 1961 of the non-profit Institute for Experimental Psychiatry Research Foundation, for which Dr Orne served as executive director until his hospitalisation last year.

Dr Orne is survived by his wife Emily Carota Orne, his two children Franklin and Tracy, and by his brother Peter Orne and family.

DAVID F. DINGES, University of Pennsylvania Medical School

Australian Journal of Clinical and Experimental Hypnosis
Vol. 28, No. 1, 2000, 4–20

Vicissitudes of Memory: Falsification and False Memory Syndrome

Cam Perry
Concordia University, Montreal

When I was asked, in 1993, to join the Scientific Advisory Board of the False Memory Syndrome (FMS) Foundation of Philadelphia, I remember thinking about what I understood about memories of childhood abuse. The best I could manage was that there are true memories of sexual abuse, false memories of it, that sometimes you might be able to distinguish between the two, while at other times you might not. Five years later, given the current state of knowledge on memory, I think it was, and is, as much as can be said.

As a research student at the University of Sydney during the first part of the 1960s, I was trained as a hypnosis researcher. After graduation, I was interested in such hypnosis questions as imagination, absorption, creativity, clinical pain relief, dissociation, the acceptance of suggestions during sleep, the treatment of smoking, and the hypnotic responsivity of phobics — to mention some.

In 1980, I became interested in the effects of hypnosis upon memory; this was at a time when police departments in a number of countries had embraced hypnosis as a means of eliciting additional information from crime victims and witnesses. This situation posed grave threats to the integrity of justice systems, since the chances were that if hypnotically "refreshed" rememberings had been admitted into courts of law (and they were in a few places), there would have been an epidemic of wrongful convictions, since, as will be seen, memories elicited in hypnosis can be highly plausible and highly unreliable.

Fortunately, towards the beginning of this decade, police departments began to discard hypnosis as a means of obtaining novel information. DNA analysis ("genetic fingerprinting") offered a far more reliable alternative.

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Requests for reprints should be sent to Barry Evans, PO Box 592, Heidelberg, Victoria 3084.

But then False Memory Syndrome began to percolate into public awareness and I felt obliged to put my newly acquired training in the hypnosis/memory issue to use. For once again, hypnosis was being used to elicit memories — this time of having been sexually abused during childhood by a parent. In approximately 85% of cases, these were memories of father/daughter incest, which had become, allegedly, repressed decades earlier, only to be "recovered" in a therapy that, quite often, resorted to hypnosis. Once again, wrongful imprisonment was all too possible, this time for a crime that elicits widespread visceral repugnance.

In what follows, I will be concentrating on the current situation in the United States. I do this deliberately; what happens in America tends to be exported to other countries. I emphasise that I speak only for myself; my views are not necessarily those of the FMS Foundation or of the 50 members of its Scientific Advisory Board. Further, although my focus is on FMS, I do not wish in any way to trivialise the effects of actual child sexual abuse. My views on this are very similar to those expressed in Justice Wood's 1997 Royal Commission report on the N.S.W. Police, in a chapter on paedophilia.

SCRIPTED MEMORIES

After five years on the FMS Foundation's Scientific Advisory Board, I am still surprised that many of our critics believe that there is no such thing as False Memory Syndrome. They give various reasons for this. Some believe that a charge of sexually abusing an offspring is too serious a matter to have been fabricated; others that FMS does not fit the conventional definition of a syndrome; still others maintain that it is not a syndrome because it has not found its way into the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

I have presented detailed arguments about the syndrome issue elsewhere; for present purposes, it is sufficient to say that even if FMS does not measure up to syndrome criteria (although I believe that it does), it certainly can be viewed as involving manufactured memories that follow a script. The script can be found in *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse*, a book written by Ellen Bass and Laura Davis, two self-described lesbian feminists. It was published in 1988. It has been touted as the bible of the recovery movement and has sold at least three-quarters of a million copies.

The book has had a corrosive effect in Australia, Canada, Israel, the Netherlands, New Zealand, Sweden, the United Kingdom, and the United

States. Wherever it has gone, its arrival has been marked shortly afterwards by a rash of accusations of incest directed against parents, many of which have been shown to be patently false. The accusations show an uncanny resemblance to the script Bass and Davis have proposed for guiding the "recovery" of "repressed" incest memories.

In a typical case, a woman becomes, as Frank and Frank in their 1991 book *Persuasion and Healing* put it, demoralised. I think that this particular term is highly apposite; entering therapy means that a person has reached a point where she has little morale, and no longer feels able to cope with her psychological problems. Accordingly, she places the resolution of these problems into the hands of a therapist. She may have the misfortune to choose, unwittingly, a "recovered memory" therapist; one who believes that all human distempers, from abulia (chronic procrastination) to zoophilia (sexual interest in animals) are based upon repressed memories of incest that occurred during childhood. In addition, the therapist is likely to be a social worker, simply because, in North America, there are more of them, and they cost less. But psychiatrists, clinical psychologists, and self-styled "hypnotists" who have no credentials in any of the healing professions, have all been influenced by the flawed psychologising of Bass and Davis.

At this point, the person, now in the role of patient, is told by the therapist that she harbours repressed memories of incest. If patients do not accept this "diagnosis," and initially most of them do not, they are informed that they are "in denial." This places patients in a very subtle bind; either they tell the therapist where to go, or they embark on a gruelling odyssey for memories of sexual abuse that may not have happened.

A number of adjunctive procedures are then employed to reinforce the belief that the therapist's "diagnosis" is correct. Patients are given *The Courage to Heal,* or some other incest "recovery" self-help manual to read as bibliotherapy and are encouraged to stage an angry confrontation with the alleged abuser, not permitting him to refute the accusations. They are urged, also, to break off all relations with the family, and with anyone else who questions the abuse narrative.

In effect, this places the patient in a cult-like atmosphere, since following the therapist's instructions guarantees that the patient will be surrounded only by like-thinking others, and will not be exposed to a demurring voice. This effect may be magnified if the person follows another piece of advice — to become involved in an incest survivors' group. For people who have yet to "recover" a memory of sexual abuse during childhood, this can increase the

pressure to conform with group mores, and "remember" something which justifies their presence in the survivors' group.

The patient's belief that her childhood was a happy time is questioned, and refuted; she is admonished to grieve for a happy childhood that did not actually occur, even though she may think that it did. Additionally, hatred is advocated as a healing method, contrary to all reputable clinical belief and practice, and fantasies of murder and castration of the alleged abuser are encouraged. After all of these, failure to "recover" the sought-after memory of abuse is brushed aside with such reassurances as:

> If you are unable to remember any specific instances . . . but still have the feeling something abusive happened to you, it probably did. (Bass & Davis, 1988, p.21)
>
> If you think you were abused and your life shows the symptoms, then you were. (p. 22)
>
> If you don't remember your abuse you are not alone. Many women don't have memories, and some never get memories. This doesn't mean they weren't abused. (p. 81)

The person is advised to "get strong by suing," even though she is informed, also, that "you are not responsible for proving that you were abused" (p. 137). This may well be the legal advice of the century.

Certain techniques are advocated for circumventing the alleged repression of abuse memories. The main one involved what is called "writing exercises," in which the person is urged to write non-stop, without regard for syntax or punctuation, on such topics as how the abuse occurred, and of factors in the father's childhood that may have predisposed him to paedophilia. In the cosy environment of an approving "recovered memory" therapist, or a survivors' group, such a hastily written account of a father's past may become highly plausible to the patient.

Such "recovered memory" therapy may be unique: most therapies result in remission of symptoms, improvement, or no change. This is the only one I know of that makes troubled people feel worse.

HYPNOSIS DURING THE 1980s

The FMS debacle is best seen from the perspective of the main social issue facing professional hypnosis societies beginning in the latter part of the 1970s. This involved the police utilisation of hypnosis. In 1976, Dr Martin Reiser, a psychologist with the Los Angeles Police Department, began training police officers in hypnotic induction procedures. Reiser believed that memory is

reproductive; that everything that we experience is stored accurately at the level of what he called the "subconscious." He believed that the memory remains pristine and intact, impervious to such things as decay and to subsequent modification by new information, and that it can be retrieved accurately by hypnosis.

We know from the outstanding work of Sir Fred Bartlett in the 1930s, and more recently of Elizabeth Loftus, that memory is reconstructive, that it is subject to alteration as a result of fresh sensory inputs. It is also subject to reinterpretation of past events. For instance, I know some clinicians who claim considerable success with traumatised rape victims who did not resist the sexual assault; they emphasise to these women how brave and wise they were not to resist, thus sparing themselves from serious injury.

Reiser constructed a set of procedures whereby victims and witnesses could "age regress" to the occasion of a crime, and relive its events as if witnessing it on a videotape in the mind. He believed that one could rewind, fast forward, "zoom in" on a detail of police interest, and "freeze" the enlarged frame. Unfortunately, this created immense police enthusiasm and soon there were what *Time* magazine called "Svengali squads" in a number of countries, including Australia.

In 1980, there was a major case, *State v. Mack*, which was heard before the Minnesota State Supreme Court. This case was to have a major impact upon how American courts were to handle the admissibility of recall elicited in hypnosis, and later, in the 1990s, how they would rule on the admissibility of putatively repressed memories. The case involved a man and a woman who met in a bar, rode on his motorcycle to a motel, checked in, and proceeded to engage in some motel-related behaviour, while continuing to consume more alcohol. They fell asleep, but a few hours later the woman woke to find a puddle of blood between her legs. Mack called an ambulance and waited for it to arrive, but being married he then returned home.

At the hospital, an intern found a lesion inside her vagina and asked her how this had been incurred. She said intercourse; he suggested that it must have been done with a sharp instrument such as a knife. She was stitched and sent home. She awoke the next morning hopelessly confused. Two days later, she contacted the police, who checked her story, and told her that they did not have sufficient information to proceed further. The matter should have ended there, but six weeks later the police recontacted her and referred her to a lay hypnotist who advertised in anatomically explicit magazines for heterosexual men.

In hypnosis, a remarkable story emerged, which was clearly linked to the intern's remark. She now "remembered" that Mack was very gentlemanly until they entered the motel room, whereupon he locked the door, pulled out a knife, ordered her to strip, pushed her onto the bed, and knifed her, repeatedly, in the vagina. The case was thrown out of court, since she had only one vaginal lesion, which was not consistent with repeated stabbing, although consonant with her gynaecological history.

In dismissing the case, the judge placed a *per se* (that is, automatic) exclusion on hypnotically elicited recall, but he stopped short of prohibiting police from employing hypnosis altogether. His ruling was that the testimony of hypnotised witnesses in Minnesota is excluded, but police can employ hypnosis to construct an independently verified case. This means that the person who has been hypnotised would not need to testify about what he or she recalled in hypnosis, since police had the independent evidence to convict. But the judge did not specify the legal mechanics of what has turned out to be a fairly rare situation, since *Mack* is an atypical case. Most of the time, hypnosis elicits a plausible filling in of memory gaps with fantasised material.

I believe that this decision is the best of all the approaches to admitting hypnotically elicited testimony into courts. After all, if police obtain additional information from a witness or victim, and check it, only to find that it is useless, what value can it have in a court of law? It can surely be no better than hearsay.

At the time of the *Mack* decision, there were approximately 500 other cases on the books in Minnesota — the Svengali squad had, quite clearly, been active. These cases lapsed following this decision. The most recent figures on this issue of admissibility, which were presented in *State v. McClure* in 1993, indicate that of 30 state Supreme Courts that have heard cases involving hypnosis, 25 of them ruled that such evidence was inadmissible *per se* in their jurisdictions.

As well as these developments in American law courts during the 1980s, a number of hypnosis researchers began experimental programmes to further explore the effects of hypnosis on memory. There have been three consistent findings. First of all, hypnosis increases productivity (it leads the person to talk more), but most of this new information is error. Secondly, hypnosis increases the subject's confidence in both correct and incorrect information, thus creating in legal terms an unshakable witness who is impervious to cross-examination. Finally, people of all levels of hypnotic responsivity are prone to confident errors. People who are highly responsive, however, make the most

errors when they are hypnotised, as compared to when they are asked to imagine what happened, or merely to recall certain events repeatedly.

HYPNOTICALLY ELICITED "RECALL"

This leads me into why hypnosis can be dangerous in a forensic situation. It does not have to be; for any additional information elicited by hypnosis (and other means, for that matter), it is imperative that it not be taken at face value. It must be corroborated independently. This is standard legal procedure for evaluating testimony in general; unfortunately, belief in the hypnotic hyperamnesia effect — that is, the belief that hypnosis increases accurate memory — dies hard.

At a descriptive level, hypnosis involves asking a person to set aside critical judgment, without relinquishing it completely, and asking that person to engage in make-believe and fantasy. There are individual differences in the degree to which people can do this. Between 10 and 15% of people are highly responsive, and capable of experiencing such difficult items as age regression and post-hypnotic amnesia; another 10–15% are minimally responsive or unresponsive; while the remaining majority experience some, but not all, hypnotic items.

In recent years, there have been renewed claims that techniques such as regression "work," past-life regression, guided imagery, dream interpretation, and sodium amytal represented as "truth serum" lead to veridical recall, and are not hypnosis. All of these techniques, like hypnosis, tap into a person's ability to become involved in imagination, and to accept fantasy as reality. They can be thought of as hypnosis by another name — as "disguised" hypnosis.

It is perhaps ironic that Bass and Davis mentioned hypnosis in their book only once — and that this reference was both brief and unfavourable. Somehow, their doctrine that repressed memories of sexual abuse during childhood underlie all human psychic distresses became grafted to the mistaken societal belief in the hypnotic hyperamnesia effect. The effect of this combustible concoction has been felt throughout the 1990s; even now, it does not appear to have run its course.

REPRESSED MEMORIES

I should state at the outset here that I believe that something like repression is possible. I suspect, though, that it may differ from the repression that Freud

talked about a century ago and the *déségration* (translated into English as dissociation) that his French contemporary, Pierre Janet, emphasised. Although there are some subtle differences in the theorising of these two investigators, they are, to all intents and purposes, discussing a similar mechanism. Indeed, many people these days use the terms "repression" and "dissociation" interchangeably.

At any rate, a number of alternatives need to be ruled out before repression or dissociation can be concluded. To begin with, there is a considerable difference in sexual climate between now and the late nineteenth century of Freud and Janet. There may be just as much sexual misery around now as there was then, but talking explicitly about sexual matters in the late nineteenth century was not encouraged. Indeed, it is possible that what Freud saw as repression, and Janet saw as *déségration,* was really a reluctance of patients to talk about their sexuality. They may have been aware of the sexual component of their miseries, but kept it compartmentalised until trust in the therapist had been established. In which case, this aspect of their lives may have been suppressed, rather than repressed.

Further, Janet's celebrated case report of one of his patients, Marie, suggests other possibilities. One of the symptoms he treated successfully was a uniocular blindness which she believed was congenital. Using hypnosis, Janet established, at least to his own satisfaction, that this symptom was linked to the experience she had at approximately six years old, of having to share a bed with a little boy who had an impetigo on one side of his face. She developed an identical impetigo, which was treated successfully by the dermatological procedures of the day. The uniocular blindness, which appears also to have stemmed from this experience, persisted into young adulthood. Janet modified the memory of this event by suggesting in hypnosis that the boy was impetigo-free. The blindness abated.

This case has long been taken as evidence of unconscious mental processing. In the sceptical climate of recent years, however, it is argued, correctly, that the alleviation of symptoms does not verify Janet's account of what gave rise to them. In similar vein, Franz Anton Mesmer, in the eighteenth century, was able to obtain improvements, and possibly some cures, of various conditions for which orthodox medicine had been ineffective. Yet his theory of therapeutics was in error: he believed that there was an invisible animal magnetic fluid in the atmosphere which he could harness, accumulate in his body, and transfer to sick people, with beneficial effects.

Matthew Erdelyi, a much respected cognitive psychologist, has suggested another possibility — that Marie's memories of these events were, in fact, reminiscences. These are memories that are recalled sporadically, much as, in experiments requiring repeated recall of previously learned material, some items are recalled correctly on some trials and not others. While the reminiscence hypothesis cannot ever be verified, or refuted, Erdelyi presents a highly plausible case for such a possibility; Marie was in treatment for some months before these memories surfaced.

Thus it can be said that Marie's recalls behaved like reminiscences, but this does not establish that they were, or even that they were accurate. Notwithstanding, Erdelyi's analysis of this case serves as a very useful reminder that there are reasons, other than repression, for memories being inaccessible, often for extended periods of time, before surfacing in a manner that resembles the lifting of a repression.

In addition to case history data, there exists a body of experimental research that has addressed this question of repression and its existence. Three papers in particular are usually cited as providing positive evidence that repression exists. I will not discuss two of them; their flaws have been aptly critiqued elsewhere. There is a third study by Linda Williams, published in 1994, which is still cited regularly by believers in repressed memory as definitive scientific proof of its existence.

She took a sample of 129 women who had been hospitalised between 1973 and 1975 for sexual abuse, and thus had documented medical records. They had been from 10 months to 12 years old at the time of the abuse, and Williams found that 49 of them (38%) had no memory of the abuse which had been recorded in their medical records. The big problem with this finding concerns the hippocampus and its connecting areas where, according to physiologists, long-term memory is most likely stored. It does not begin to function until roughly between the ages of three and four; hence, some of the 38% who had no adult memories of abuse most likely had not been old enough to remember. In addition, in approximately a third of the cases, the abuse was described as "touching and fondling," and no genital trauma was recorded. While such touching and fondling might be obvious evidence of sexual abuse to an adult, it might not be to a child, and hence would not be memorable.

In a recent critique of the Williams study, Harrison Pope estimated that there were approximately 14 women in Williams' sample who: (a) had medically documented genital trauma; (b) were old enough at the time to

remember an experience of incest; and (c) did not report the experience at the follow-up interview 17 years later. Unfortunately, none of the 14 who fulfilled Pope's criteria for repressed memories were later given a "clarification interview" in which they were asked specifically about the event that had led them to being taken to the hospital. Pope cited a 1990 study by some other investigators, to indicate the importance of such an interview; during an initial interview, 38% of their subjects did not, initially, disclose their history of abuse. When given clarification interviews, however, all of them revealed that they remembered the abuse; for whatever reason, they did not want to talk about it.

In all, the empirical data on repression leaves this hypothesis in an uncomfortable limbo. Failure to document the existence of a phenomenon means either that a hypothesis or theory is mistaken, or else that it has not been possible to contrive the experimental conditions conducive to its appropriate testing. At this point, it is not clear which of these alternatives is the correct one.

ADMISSIBILITY OF TESTIMONY

For most of this century, American courts have been guided by *Frye v. United States* in determining the admissibility of scientific evidence. This 1923 ruling held that a scientific technique or procedure must have "general acceptability" within the "relevant scientific community" to which it belongs. There was always a problem with this approach; in particular, defining the "relevant" scientific community is not always as easy as it would appear.

Frye held sway for 70 years, until 1993, when *Daubert v. Merrell Dow Pharmaceuticals, Inc* reached the United States Supreme Court. The drug company marketed Bendectin, which was prescribed for nausea and vomiting during pregnancy. The Daubert child, and the children of four other mothers who had been prescribed Bendectin during pregnancy, were born with limb reductions, and the question was whether Bendectin was responsible.

The *Daubert* court broadened the criteria of admissibility of scientific evidence. The *Frye* requirement still stands, but it now becomes but one of several criteria for determining admissibility. As well, American courts are now asked to weigh such considerations as: (a) the verifiability of the scientific theory or technique under review; (b) the scientific soundness of the technique or theory; and (c) whether a study introduced as evidence has a known or potential error rate.

Daubert was an attempt to exclude from American courts what has become known as "junk science," and for this alone deserves commendation. One of its most horrifying instances concerns what is known as the "anal wink." In 1984, two husbands and two wives were convicted of sexually abusing their children, partly on the basis of testimony by a self-described "sex abuse expert." He testified that he examined two of the children involved. Although he reported that he found no scars, fissures, or other marks, he found that when he stroked their anuses with the Q-tip, the anuses gaped open — hence the term, "anal wink." He testified that this was the body's effort to accommodate to repeated anal penetration, and that the boys had been chronically sodomised.

In 1988, however, a professor of paediatrics reported that he had examined some hundreds of children with no history of abuse, and found that the "anal wink" occurred spontaneously in approximately half of them when they sat naked on his examination table with their knees on their chest. Notwithstanding, the four people convicted in 1984 were not released from prison until 1997. Viewed in light such as this, the Supreme Court's concern to exclude "junk science" testimony is of major importance.

TRAUMATIC MEMORY

North America looks to be on the edge of a major controversy about traumatic memories. The debate has been gathering steam for some years, but the publication of a book at the start of this year [1998] may bring it to a head. It is *Memory, Trauma Treatment, and the Law*, by Daniel Brown, Alan Scheflin, and Corydon Hammond. Brown and Hammond are clinicians of hypnosis, while Scheflin is a professor of law. The book seeks to cover the many vicissitudes of memory, in and out of hypnosis. Its agenda is explicit: its authors call for the lifting of *per se* exclusions of memories elicited in hypnosis, and of memories that are characterised as "repressed" or traumatic.

It is premised on the belief that traumatic memories are processed and stored in a manner that is different from what occurs for everyday memory. The authors accept current formulations that normal memory is stored at the level of the hippocampus and surrounding areas, and is subject to modification by such factors as decay and new inputs of information. But following a hypothesis of Bessel van der Kolk, a psychiatrist at Boston University, they argue that traumatic memory is stored in the limbic system, most likely the amygdala, and is more likely to be accurate, because it is more "indelible." At

the same time, these authors concede that a traumatised person preserves the gist of the trauma in memory, but may reconstruct and hence distort some of the details. This may just be having it both ways.

At present, the research data in support of this bold hypothesis are sparse, and even supposing that limbic system storage is ultimately verified, courts could become involved in some interesting intellectual gymnastics in differentiating true "gist" from reconstructed details. The limbic storage hypothesis may be true, according to some recent research data. This does not mean, though, that traumatic memory is necessarily more accurate.

For instance, if a person is pointing a gun at a crime witness, chances are that the witness is not thinking: "He is a white male six feet one inch tall, weight 190 pounds, is wearing an Arrow shirt, Levi jeans, and Nike running shoes." In the eyewitness research literature, this is known as a "weapon focus." It is based on the observation that, in such a situation, crime victims and witnesses tend to furnish inaccurate descriptions of their assailants, because they are more focused on the gun than on the gun holder.

Given these considerations, it remains to be seen whether courts will embrace the belief that a traumatic memory is more trustworthy. In particular, there is the question of how Brown et al. conceptualise the issue — in terms of a greater *likelihood* of accuracy. In actual legal cases, the issue may become couched in terms of whether greater likelihood of accuracy can be translated into accuracy beyond a reasonable doubt.

MULTIPLE PERSONALITY DISORDER

The history of Multiple Personality Disorder (MPD) is a long one. The first two recorded cases were between 1800 and 1820, and by 1980 the scientific literature contained slightly fewer than 200 such cases. Then between 1980 and 1985, almost 900 new MPD cases were reported. The greater bulk of this increase involved American diagnosed cases — MPD is rarely diagnosed in Europe.

What appears to have been a major factor in this increase was that in 1980 MPD was officially elevated to the status of a diagnosable disorder. Accordingly, American clinicians proceeded to diagnose it — although August Piper recently conducted a survey which found that 58% of 221 diagnoses of MPD had been made by three psychiatrists. This suggests that over-diagnosis or vague diagnostic criteria have been at play in a large number of cases.

Throughout the 1980s, much of the debate focused on whether MPD was a common or rare condition. Interestingly enough, Corbett Thigpen and

Hervey Cleckley (of *Three Faces of Eve* fame) argued in 1984 in favour of MPD being a rare condition — they stated that, subsequent to *Eve,* some several thousand patients had been referred to them with psychiatric diagnoses of MPD. In their view, only one of these diagnoses was valid.

The reports of "retractors" (women who accused their fathers of sexual abuse during childhood, only to realise that their allegations were false, leading them to withdraw their charges) sometimes reveal evidence that "recovered memory" therapists go to great lengths in seeking out confirmation of their pre-existing beliefs in the ubiquity of repressed incest memories. In one case, a therapist interpreted a patient's numbness in the hand as resulting from holding her father's penis. A more likely explanation offered by this "retractor" was that she had been taking 900 mg of lithium, and a large dose of Xanax and Mellaril — this overdose also causes numbness.

Herbert Spiegel reported last year on the case of Sybil, one of the high-profile MPD patients of the 1980s, who received book and movie treatment. While Sybil was in treatment with Cornelia Wilbur, displaying what appeared to be an array of alter personalities, she was also seeing Spiegel. Early in this encounter, she asked him if he wanted her to be Helen, which she explained was who Dr Wilbur wanted her to be in therapy sessions. He indicated that it would be acceptable for her to be who she wanted to be; she settled for being herself with Spiegel.

In recent years, some therapists of MPD have become progressively more esoteric. One manifestation of this is that it became de rigueur to search for, and find, an "animal" personality. Dog, cat, bear, and duck "personalities" have all been recorded in the scientific literature of MPD with all solemnity. Another arcane direction that has been charted by these clinicians is Satanic Ritual Abuse (SRA), in which satanic cults are alleged to be sexually abusing, barbecuing, and eating young children. There is no evidence for such lurid charges; nevertheless the diagnosis of MPD with SRA has continued.

It is often overlooked that many individuals who are diagnosed as multiples are suffering from symptoms that may be severely debilitating. Some of them may be hysterics who have been misdiagnosed, and their multiplicity may result from a *folie à deux* between therapist and patient, and they may accept fanciful notions of animal "personalities" and of SRA. Despite this, it is possible that some cases of MPD are accurate diagnosis; the sheer longevity of the diagnosis, dating from the early 1800s when there was little if any likelihood of media taint, suggests this possibility may exist.

FMS IN COURTS OF LAW

Thus far, experience with *Daubert* has been mixed, and currently it is up for a five-year review. The main problem with it is that some judges have had difficulties in making the type of analysis that *Daubert* stipulates. For instance, *Shahzade v. Gregory* involved memories, "recovered" in therapy, of non-consensual sexual touching 47 years earlier. In this case, the judge defined the "relevant scientific community" as consisting entirely of clinicians. He cited the testimony of Bessel van der Kolk that the majority of clinicians recognised the theory of repressed memories, and that they do not find it controversial (which is probably true).

In addition, the judge in *Shahzade* dismissed the testimony of one psychiatrist for the defence on the grounds that he was not an expert on memory, and that his credentials and expertise on memory were less than those of van der Kolk. This particular expert had testified that all 52 studies of repressed memory that he had reviewed contained methodological errors. The judge somehow managed to interpret this to mean that the theory for repressed memories was not invalid; only that no study had yet validated it.

Since May 1995, 16 American state Supreme Courts have ruled that expert testimony on repressed memories is inadmissible *per se*. To illustrate what has been involved, I will focus on one of the earliest rulings: a decision of the New Hampshire Superior Court in *State v. Hungerford, and v. Morahan* (1995), which appears to have been highly influential on subsequent rulings. It was upheld in the New Hampshire Supreme Court in 1997. To simplify matters, I will concentrate on the *Hungerford* part of the ruling.

Hungerford was accused of sexually abusing his daughter Laura from the age of 5 to 23. At the time of the trial, she was 27. In 1989, her sister had told her that she had "recovered" memories of her father abusing her sexually, and Laura entered therapy with a social worker, in order to determine whether she had also been abused. In the course of approximately 100 therapy sessions, many involving hypnosis, Laura "recovered" memories of four episodes of alleged abuse by her father. Each of these episodes of abuse began as dreams in which somebody walked into the bedroom which she occupied. The therapist then instructed her to visualise the situation; in each case, the "somebody" turned out to be her father.

The ruling in *Hungerford* emphasised that there is a "raging or robust debate in the field of psychology" about whether repressed memories exist. On this point, the judge cited the 1993 *Daubert* ruling which had argued that a court

must assess: "whether the reasoning or methodology underlying the testimony is scientifically valid and whether the reasoning or methodology can be applied to the facts at issue." He added, still citing *Daubert,* that science is predicated upon formulating hypotheses that can be falsified, and that this is what differentiates science from other disciplines. Based upon these considerations, he concluded that repressed memory had not been established as a phenomenon.

By contrast to the criminal courts, American civil courts have witnessed the more spectacular side of the FMS drama, with three former patients receiving almost $US19 million from their treating psychiatrists during 1997. The three cases have a number of common elements. All involved psychiatrists who diagnosed the patients as suffering from MPD, and in two of the cases, SRA was added on. In two of them, their children were also given the same diagnosis as their mothers and they were hospitalised. In addition, the compensation amounts steadily increased over the year. In April, Nadean Cool was awarded $2.4 million; in August, Lynne Carl received $5.8 million; in November, Patricia Burgus was compensated to the extent of a staggering $10.6 million.

Since the money was paid by companies offering malpractice insurance, I have a hunch that the diagnosis of MPD is going to decline in frequency. Few insurers are likely to offer their services to clinicians who, on a regular basis, diagnose MPD and, quite often, SRA.

SOME CLOSING THOUGHTS

Until quite recently, clinicians tended to take patients' memories at face value and they rarely sought to corroborate them. They argued, soundly in my opinion, that the truth or falsity of the memories did not matter. They believed that even if the memories were false, they represented the patient's current perceptions of the past, and could provide valuable insights into what afflicted them. In the light of recent court settlements, clinicians may be less prone to press the MPD/SRA diagnosis button.

Last December, the FMS Foundation's *Newsletter* reported the results of a survey of 105 malpractice suits against therapists, filed by former patients between 1994 and 1997. Of these, one case was dropped, 42 were settled out of court, and 53 are still pending. Of the nine cases which went to trial, all resulted in a decision in favour of the former patient. In addition, a number of the relevant professional societies in the United States, Canada, Australia, and

the United Kingdom have issued statements or guidelines for professional practice in cases in which repressed memories may be involved. Some of the committees that drafted these documents were irreparably divided; for instance the American Psychological Association's committee revealed a polarisation between clinical and experimental investigators — it finished up issuing separate reports. Despite such problems, all of these statements reflect recognition among professionals (though it is not universal) that both true and false memories of sexual abuse during childhood exist. Further, they emphasise the need for caution in probing patients' recollections of the past, and they advocate scrupulousness in evaluating new memories that emerge in therapy.

In recent years, the number of FMS cases has been declining steadily. In 1992, it had peaked, with 482 families being accused of former incest; by 1996, this had declined to 60. This could be interpreted to mean that the FMS controversy is winding down. There are, however, indications that "recovered memory" therapists are still very active, only now they advise their patients not to call for police intervention, and not to get strong by suing.

Recently I have learned also that women who have "recovered" incest memories during therapy are now being advised to testify in court that they always remembered the sexual abuse. Until recently, the change in testimony could easily be documented; in their police statements, the women involved indicated that their memories were repressed. Some research data suggest that the women may come to believe that a pseudomemory suggested in therapy is really a "true" memory that was always available to them. By contrast, those who know that they are perjuring themselves pose other severe threats to the implementation of justice.

I see no immediate end to the conflicts that FMS has spawned. The good news is that the FMS Foundation, despite a shoestring annual budget, has had a significant impact. It has shaped public and professional awareness of sexual abuse during childhood (both true and false). Further, it has provided help to falsely accused parents. The bad news is that the problem may soon become more acute, despite surface signs to the contrary. The next wave of "retractors," advised not to seek police or legal assistance, and with some of them believing that memories "recovered" in therapy were, in fact, always available to them, may bear even more harrowing signs of a period of cult-like isolation from social reality than those thus far witnessed.

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REMEMBERING TRAUMA OR THE TRAUMA OF "REMEMBERING"?

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Perry's review of the interrelated issues of hypnosis, memory, and repression raises issues that practitioners and researchers in Australia and elsewhere need to take seriously. Many people who read Perry's review will respond with either joyous agreement or vehement anger. This response will depend in part on the reader's "established position" concerning the repressed memory debate. Adopting a polarised response to this issue, and to Perry's appraisal of memory and hypnosis, will result in the most critical issues raised by Perry being overlooked. This is unfortunate because his overview provides an important perspective on clinical, forensic, and social developments that have occurred over the last 20 years. Whether one agrees with Perry's conclusions or not, it is essential that we all learn the important lessons from these developments because they extend beyond the domains of memory and hypnosis, and are fundamental to scientific and ethical practice.

DEFINING "REPRESSION"

I suspect that some readers may be surprised at Perry's comment "that something like repression is possible." If people have read Perry's work on hypnosis and amnesia, one would expect Perry to recognise that people can manage their memories in ways that minimise awareness of certain things under certain conditions. Perry correctly notes that the phenomenon that typically is called repression may reflect numerous cognitive mechanisms that at this stage are poorly understood. In the context of the recovered memory issue, repression is little more than a general descriptive term that has minimal

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explanatory power. There is a need to understand the specific mechanisms that mediate both minimising awareness of memories and also enhancing retrieval of these memories. Further, we need to understand under what conditions these mechanisms operate, and the role of social influences on these mechanisms.

A polarisation of views on repression has resulted in most contributors to this area either accepting or rejecting the notion of repression. The focus on this issue leads many people to overlook the various processes that may mediate forgetting and subsequent remembering of a traumatic (or a benign) experience. Repression involves one extreme explanation that involves impared retrieval of information that has been encoded sufficiently. It is important to distinguish, however, between automatic repression (what Freud called "primary repression") and intentional cognitive avoidance that is initiated by the individual and subsequently becomes habitual. This distinction is important: whereas the former implies that the initial event was not afforded adequate encoding, the latter suggests fuller encoding that may lead to established memories.

A second possibility is normal forgetting, which involves the natural decay of memory as a result of time and interference from subsequent events. Perry alludes to this possibility when referring to reminiscences, wherein people can have partial recall of events or a sense of familiarity about past experiences. This mechanism is more likely under conditions in which the material has not been rehearsed in memory for lengthy periods; this is common in many "repressed memory" cases. This process, however, does not involve repression because there is no inhibitory function occurring. Whereas this mechanism is likely to occur in cases of single trauma, it is more difficult to explain multiple traumas by ordinary forgetting.

A third possibility is that events are not encoded adequately at the time of the trauma. This relates to the phenomenon often called "peri-traumatic dissociation," which refers to alterations in awareness during the trauma usually as a result of heightened arousal or attentional focus on specific aspects of a trauma. There is evidence that during stressful situations people will not encode optimal amounts of information. For example, "weapon focus" studies indicate that under conditions of significant threat, people tend to focus attention on the most threatening aspects of the scene and there is a neglect of other information. This pattern has been observed repeatedly in non-clinical populations under conditions of simulated stress, and there are adaptive reasons why people encode selective information during a traumatic event.

Similarly, there is evidence that under conditions of high arousal there can be impaired encoding because of the load placed on cognitive processing at the time. Also, the encoding of traumatic experiences can be influenced by the subsequent elaboration of the event that may occur. For example, post-trauma elaboration can increase the amount of detail that is stored in memory if there is processing of that material. In contrast, if the post-trauma elaboration is focused on emotional, rather than factual, aspects of the experience there may be reduced elaboration of factual events. Each of these processes may result in impaired encoding of a trauma. If the event is not adequately encoded, it cannot be retrieved subsequently by "recovery" techniques.

Of course, a fourth possibility is that the reported memories are reconstructed beliefs that are inaccurate and are the result of therapist-inspired suggestions of traumatic events that did not occur in fact. It is important to note that these explanations are not mutually exclusive. It is very possible that some or all of these mechanisms may be functioning in cases of reported childhood abuse that allegedly involve "repression."

DEFINITIONS OF TRAUMA MEMORIES

Perry points to the popular notion that traumatic memories are inherently unique and indelible. The phrase that "emotional memories are forever" is often used by those who hold a particular ideology, and is based, in part, on evidence that fear conditioning in animals can be associated over prolonged periods and following cortical lesions. These animal studies have resulted in theories that fear conditioning occurs in the limbic regions, particularly in the amygdala. Some consider that the noradrenergic-mediated arousal that occurs at the time of trauma can result in permanent associations that may be observed in subsequent conditioned responses. Although there is an empirical base for these notions, the extrapolation of this evidence to discursive memories of trauma is unjustified. Although some appear to use the term "memory" to describe both fear conditioned responses and verbal or visual memories of actual events, it is essential that the distinction between conditioned responses and discursive memories is maintained. Without this distinction, one can make the mistaken claim that a person can reconstruct an historically accurate memory from biologically mediated arousal triggered by an internal or external cue. This inference is clearly contrary to what we know about memory. It is also using biological models of learning in ways that were not intended. This development highlights the tendency for some to claim

credibility for a point of view by linking their view to a relevant, but conceptually distinct, scientific finding.

TRAUMA AND MEMORY

Although Perry refers to the possibility that other mechanisms may mediate impaired memory for trauma, he does not delineate these specific processes. This omission is important to consider because there are recent findings that inform us about how people manage memories for trauma. In contrast to some popular views, evidence suggests that memory for trauma is much more complex than the global notion of repression conveys. Put simply, there is no uniform manner in which we remember and/or forget traumatic experiences. In fact, there is increasing disconfirming evidence of the proposition that traumatised people are characterised by tendencies to suppress or dissociate distressing memories. For example, studies that have employed the directed forgetting paradigm require subjects to read lists of trauma-related or neutral words that are to be either remembered or forgotten. According to the repression perspective, we should see survivors of childhood abuse being particularly adept at avoidant encoding styles and at intentional forgetting. On the contrary, studies of survivors of abuse, including those who have allegedly repressed memories, do not demonstrate this avoidant encoding style. In terms of autobiographical memory studies, acutely traumatised people have deficits in recalling positive rather than negative memories. Whereas this finding is contrary to the repression account of memory, it is consistent with established findings of mood congruent memory biases.

There is evidence that traumatic memories may not be organised in a manner that facilitates retrieval. Survivors of rape and serious motor vehicle accidents, for example, display memories that are fragmented and unstructured. In contrast, following therapy and resolution of post-traumatic stress disorder, these individuals display coherent and well-organised memory structures (but not necessarily accurate memories within these structures). When one considers that accessing a specific memory involves a lengthy sequence of retrieval attempts until the desired memory is found, it is conceivable that poorly structured memories may impede retrieval processes when people are attempting to access particular trauma memories. Again, this feature may lead to impaired recall of a trauma but does not require a notion of repression, or a particular assumption about the relationship between trauma and memory.

DEVELOPMENTAL FACTORS

In his review of the problems with the notions of "recovered memory," Perry gives little attention to developmental reasons that may influence memory for memory of childhood trauma. This neglect of the potentially important influence of developmental factors on the encoding and storage of traumatic events is commonplace in this debate. Many instances of "repressed memory" involve events that reportedly occurred to children before the age of 6 or 7 years of age. Much attention has been given to the limiting effects of infantile amnesia, which refers to neurological immaturity preventing memories from being adequately stored prior to the age of two or three years. There are other critical features associated with the developmental milestone that can influence the encoding and appraisal of trauma. For instance, there is robust evidence that younger children have limited capacities in (a) emotion regulation, (b) pre-trauma knowledge base, (c) meta-cognition skills, and (d) linguistic development. Each of these maturational factors can have significant impact on the extent to which an event will be encoded, appraised as traumatic, and elaborated in a way that will increase the likelihood of adequate storage. Much of the discussion about repression ignores the probability that the way in which young children encode, appraise, and manage distressing experiences depends heavily on developmental factors. For example, a child with limited knowledge about inappropriate sexual behaviour, who does not perceive sexual abuse as threatening, and who is strongly persuaded by a perpetrator that the activity is wholesome may not encode the event as traumatic. In contrast, the same child may interpret a similar experience five years later in a much more distressing light. The assumption that all abusive events that occur in childhood can be fully "recovered" in adult years incorrectly assumes that children encode and perceive events in a way that is uniform and that permits retrieval. Researchers need to delineate the cognitive mechanisms that mediate encoding, appraisal and retrieval of traumatic experiences at different developmental stages, and index the relationship between the management of these memories and subsequent retrieval in adult years.

THE ROLE OF SCIENCE

One striking feature of Perry's review is the stark contrast he describes between available empirical evidence concerning memory and the flourishing practices of recovered memory therapies that ignore this overwhelming evidence. As Perry notes, there was strong evidence indicating the capacity for distorted memories before the recent explosion of recovered memory therapies. In more recent times, there has been a surge of rigorous research further attesting to the mechanisms of memory distortion. Despite the quality and quantity of this evidence, significant proportions of the academic, professional, and lay communities have persisted in ideologies and practices associated with recovered memory therapies. This disturbing pattern raises questions concerning the role that science and evidence plays in guiding the daily actions of practitioners who are dealing with potentially disturbed populations.

Perry notes that in recent years the North American courts have moved towards the *Daubert* ruling by favouring science-based opinion rather than the rule of general acceptance. This trend has resulted in a shift, albeit a slow one, to legal decisions that are based on sound evidence. Quite astonishingly, however, we continue to see influential works ignoring, or at times distorting, current evidence to perpetuate policies and practice which assume the pristine nature of trauma memories. Indeed, we see books and articles published that clearly favour approaches that are inconsistent with most of what we know about memory and trauma. This raises the question: What role does science play in our understanding and management of trauma memories? For many people it does not seem to play any role. As Perry notes, there are significant dangers in adopting that position.

Perry points to some of the dangers that exist if the assumptions and practices of recovered memory approaches are unconditionally accepted. Assuming that recovered memories reflect historical truth may have disastrous influences on legal decisions concerning alleged abuse. This possibility, which was one of the major incentives behind the U.S.-based False Memory Syndrome Foundation and the Australian False Memory Association, has received considerable attention. Unfortunately, this danger has been illustrated by numerous cases of personal, financial, and social upheaval that have occurred as a result of alleged abuses. There are other dangers, however, which have received less attention. Encouraging vulnerable clients to believe that they have been the victim, or even participant, in torture, satanic rituals, and other

horrific activities as a child confronts the client with a "believed-in" past that can have damaging consequences for both their present and future. It can be difficult enough for a client to deal with an eating disorder or depression when they initially consult a therapist. To then "recover" memories that he or she has been abused can make the individual feel overwhelmed and powerless. It is curious that although society disdains childhood abuse, there is often a lenient attitude to practices that teach people that they have been the victims of the most horrendous childhood abuse. Today there are many people who are struggling with the compelling belief that they were tortured and abused, and these beliefs dominate their daily lives. To hear people describe the distress that they experience as they deal with these "memories" highlights perhaps the damaging effects of recovered memory therapy. I am not suggesting that it is better to not know about a traumatic history. Rather I am proposing that it is harmful to "know" about traumatic "histories" that did not occur.

In addition to Perry's criticisms of the rationale for recovered memory, there are other unsubstantiated underpinnings of recovered memory therapy. For example, it is curious that there is such common acceptance of the notion that "recovering" memories of abuse will lead to a therapeutic outcome. In fact, to my knowledge there are no treatment outcome studies that indicate that this approach leads to improved mental health. There is a wealth of empirical support for the range of interventions of psychological problems that many people who received recovered memory therapy actually present with (e.g., eating disorders, anxiety, depression). Despite this evidence, recovered memory therapists often prefer to focus on alleged childhood abuse rather than provide clients with techniques that have proven efficacy to manage their current problems. Further, there is an assumption that childhood abuse, often sexual abuse, is the fundamental cause of many current psychological problems. Although we know that there are a range of psychological disorders that can arise following childhood abuse, there is no linear relationship between childhood abuse and adult mental disorder. Indeed, recent evidence suggests that a significant proportion of people who survive childhood sexual abuse are able to function without psychological disorder in their adult years. Moreover, there is evidence that one's family environment may be a more important predictor of adult mental health than childhood sexual abuse *per se*. These findings question the fundamental premise upon which recovered memory therapy is based.

REPRESSED MEMORIES IN AUSTRALIA

Although Perry refers primarily to cases of repressed memory in North America, his comments are directly relevant to developments in Australia. There is a steady stream of allegations of childhood abuse arising from recovered memories in Australia. A noticeable change in recent years has been the increasing scepticism of prosecuting agencies of matters that rely on recovered memories of abuse. Whereas Directors of Public Prosecutions previously adopted an accepting stance with respect to such allegations, there is now increasing caution about prosecuting these cases. This change of attitude can probably be attributed to awareness that court decisions have recognised that there is more than "reasonable doubt" about the accuracy of memories that have been recovered after many years. Perry's comment that there is a trend for future allegations to disguise the recovered nature of memories of abuse is particularly worrisome. There are certainly indications in Australia that people who allege abuse following recovery of memories are likely to omit those aspects about the "recovery process" that may make them vulnerable to claims of being contaminated by external influences. Indeed, some groups actively advise people to not volunteer such information.

In recent years Australia has benefited from empirically based guidelines on recovered memories. The Australian Psychological Society, the Royal Australian and New Zealand College of Psychiatry, and the Wood Royal Commission in New South Wales have explicitly cautioned against accepting reports of recovered memories as historically accurate accounts. In doing so, these agencies have adopted a stance that is consistent with prevailing research on memory for trauma. There is a persistent challenge to these guidelines, however, by groups that desire an acceptance of "recovered memories" or "body memories" as acceptable evidence of recalled trauma. In this sense, Australia is following the unfortunate trend that Perry has observed in North America. There are attempts to dilute the rigour of existing policies concerning repressed memories by suggesting that some forms of "repressed" or "somatic" or "metaphorical" memories are genuine reflections of childhood trauma. In both Australia and North America these suggestions are attempting to obtain credibility by linking their claims to "science" via reference to biological models of trauma. Despite the claims of these groups, the prevailing evidence is unequivocally telling us that "repressed memories" cannot be relied on as accurate recollections. Considering the serious adverse effects of recovered memory practices, I hope that Australian organisations maintain their

commitment to the wellbeing of people seeking therapy by ensuring that recovered memory procedures are explicitly and strongly discouraged.

FUTURE DIRECTION OF REPRESSION

Perhaps one of the most unfortunate aspects of the repressed memory debate is that the polarised positions that have been taken have precluded effective dialogue about the mechanisms of managing trauma memories. There is convergent evidence that resolution of a traumatic experience is, in part, dependent on how an individual deals with the memory of the experience. Whereas there have been important developments in recent years in terms of memory for adult trauma, this pattern has not been so evident in the field of childhood trauma. Constructive advances in how children and adults deal with memories of childhood trauma will be made when researchers, practitioners, and survivors of abuse can collaborate in ways that facilitate progress in this critical area. Adopting positions that simply defend one's own perspective does not lead to an environment in which the processes that mediate memory of trauma can be fully understood.

Perry recognises the dangers of childhood abuse and the need to help those who suffer its consequences. At the same time, he highlights the risks that recovered memory therapy poses for both recipients of this therapy and those who are falsely accused. People who seek out therapists should be able to expect ethical and evidence-based behaviour that, at the very least, does not exacerbate whatever the problems faced by the individual. In the context of recovered memory therapy, this is a false expectation.

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AN ALTERNATIVE VIEW: RECOVERED MEMORIES AND THE AUSTRALIAN COURTS

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My first reading of Cam Perry's paper "Vicissitudes of Memory: Falsification and False Memory Syndrome" served to remind me of the breadth of his knowledge of the field. I was also impressed by his command of the language. I say to remind me because I was present when Professor Perry presented a staff seminar at the University of Sydney's Faculty of Law almost a decade ago and have been aware of his work in the field since that date.

On a second reading I focused on his themes, his context, and an undertone which I detected. The themes are the ethics of memory therapy, and the proper interaction between this therapy and the legal system. His context is the cultural history of sexual assault over the last century. His undertone is, unfortunately, misogynistic. The themes are important. The context is of interest and the undertone should be addressed. My conclusions differ from those that the author has drawn and I welcome the opportunity to discuss the issues.

THE CONTEXT: THE LAW AND SEXUAL ABUSE

At the outset Perry indicates that he does not wish in any way to trivialise the effects of actual child sexual abuse. He states that his views on paedophilia are very similar to those expressed in the Wood Royal Commission Report in 1997. Australian readers do not need to be told that that report condemned paedophilia in no uncertain terms. This indeed is the position taken by the False Memory Syndrome Foundation, which is now quite clear in its condemnation of child sexual abuse. Dr Underwager, who told a magazine reporter that sex with a child can be a responsible choice for an adult, is no longer a member of the Foundation.

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It is worth remembering, however, that this position has not always and everywhere been the accepted view. Richard Posner in his book *Sex and Reason* discusses the history and rationale of attempts to regulate sexual practices. He concludes that whether or not childhood sexual encounters would damage the child in another society, there is sufficient evidence that a child subjected to sexual advances in modern American society does suffer long-lasting harm to justify the law's condemnation of such behaviour. Where such abuse is perpetrated by a member of the child's family, the harm that is done is multiplied and accordingly incest is more universally condemned and, Posner suggests, should be punished more severely. Child sexual abuse is a crime. If the charges can be proved the defendant will be punished, most probably by a term of imprisonment.

Survivors of childhood sexual abuse can also choose to seek compensation for the harm they sustained. Such compensation may be obtained from a civil action for damages or, possibly, depending on the circumstances from other forms of action. Perry refers in passing to Bass and Davis' suggestion that survivors should get strong by suing. Judith Herman in her book *Trauma and Recovery* identifies three stages of healing through which survivors of trauma pass. Very briefly these are: establishment of safety; remembrance and mourning; and reconnection with ordinary life. It has been suggested that civil action may contribute to the reconnection process. Feldthusen, Hankivsky, and Grimes recently completed a comparative study of the reactions of Canadian survivors of sexual abuse to their experiences in seeking compensation through a number of pathways. As part of that study they sought an account from the participants of their reasons for taking civil action. Survivors reported that they had initiated their claims to obtain public affirmation that they had been wronged, to seek justice, to obtain closure, to secure an apology, to prevent the perpetrator from harming others, and to take revenge. These motivations are clearly consistent with those of well persons seeking appropriate social responses to injustice. They are the purposes that our civil action systems were designed to serve.

MEMORY, SUPPRESSION, REPRESSION, AND DISSOCIATION

Over the past twenty years the general understanding of the way in which memory operates has evolved radically. Perry describes the beliefs of Reiser, a psychologist employed by the Los Angeles Police Department in 1976. These

beliefs, though formed by ignoring some important work on memory, were typical of the time. In 1980 Elizabeth and Geoffrey Loftus published the results of a survey in which they asked psychologists about their concepts of memory. They reported that a large number of psychologists believed that memory was a permanent record. It was to be another three years before it was generally acknowledged that the misleading information effect, whatever its causes, was a durable phenomenon.

Due in large part to the work on the misinformation effect carried out by Elizabeth Loftus and her colleagues, it is now generally recognised that, in Perry's words, "memory is reconstructive, that it is subject to alteration as a result of fresh sensory inputs." This means, among other things, that memories can be suppressed and suggests that repression and dissociation are also possible. I assume that this work is familiar to all my readers and needs no further comment from me. I cannot, however, let pass without comment Perry's remark in this context on the reinterpretation of memories. The equation of the reinterpretation of traumatic memories of not resisting sexual assault with the sort of reconstruction obtained as a result of the misleading information effect may have been unintentional but it is strongly objectionable nevertheless.

Perry refers to the early work of Freud and Janet. He suggests that although these pioneers believed that they had identified cases of repression and dissociation the possibility that what they had identified were cases of suppression cannot be eliminated. Suppression then is considered to be a voluntary process, the person who possesses the memory chooses whether to advert to it or not. Repression is, on the other hand, an involuntary process. The memory is unavailable because it is so traumatic that the subconscious has intervened to protect the individual who has undergone a traumatic experience.

Perry has not explored the relationship between repression and dissociative identity at this stage in his account of the phenomenon. Although Perry's position is that neither phenomenon has been demonstrated, the explanation of the terms need not imply an acceptance of their reality. This treatment of the concepts has the effect of isolating his subsequent discussion of multiple personality disorder. This disorder, now formally called Dissociative Identity Disorder, is vividly described in Cameron West's book *First Person Plural*. The suggestion is that dissociative identities are established to protect the personality by preventing it from experiencing the traumatic incident, by creating a different personality to suffer the trauma. Repression, on the other hand, is a

form of dissociation that operates after the trauma has been experienced to prevent it from being re-experienced in memory.

It is beyond question that suppression can and does occur. It is widely recognised that the standard tactic of perpetrators of child sexual abuse is to attempt to persuade their target to suppress any report of the incident. The Bass and Davis book with its cursory dismissal of hypnosis appears to have been aimed primarily at survivors experiencing difficulties because of suppressed memories.

Perry states that he believes that "something like repression is possible" but that it has not yet been demonstrated. He canvasses the psychological studies cited to prove the fact. Specifically he adopts Harrison Pope's criticism of the Linda Williams study published in 1994. He concludes "the empirical data on repression leaves this hypothesis in an uncomfortable limbo." He suggests that "failure to document the existence of a phenomenon means either that a hypothesis or theory is mistaken, or else that it has not been possible to contrive the experimental conditions conducive to its appropriate testing. At this point, it is not clear which of these alternatives is the correct one." The conclusion is unwarranted, given that Pope's criticism indicated the one missing step in Williams' procedure. If Williams had conducted a clarification interview and received negative responses Pope would have accepted that repression had been demonstrated. The only warranted conclusion on the authorities cited by Perry was that the phenomenon had not yet been scientifically demonstrated. There is a difficulty of which any researcher who contemplates conducting a clarification interview would be conscious. Perry does not acknowledge it. The difficulty comes from the ethical limitations on human research. There could be little or nothing more destructive than to confront a person who is functioning well but repressing memories of sexual assault with the fact that they had been sexually assaulted. It might be possible, however, to discover whether the participant remembers the medical treatment in question and what cause is assigned for that medical treatment. The existence of this problem does not justify Perry's conclusion.

Be that as it may, it is clear that a substantial number of psychiatrists and psychologists accept that memories can be repressed. Perry refers to one such authority, the book by Brown, Scheflin, and Hammond. This book presents an argument against automatic exclusion of testimony based on recovered memories and a new theory of how traumatic memories may be stored. A recent article by Richard Reagan reviews position papers issued by seven national scientific societies in four English-speaking countries and concludes

that these papers demonstrate considerable scientific controversy as to whether the repression principle can be accepted. Reagan states that two of these reports accepted the existence of repressed memories. He characterises two reports as sceptical about the existence of such memories, but the only statement that clearly takes the position that repression of memories is not possible is the product of half of a working group composed only of research psychologists. The clinical psychologists in the group produced a conflicting report. *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) acknowledges some degree of general acceptance of the existence of repressed memories when it lists "Dissociative Amnesia" as a diagnostic category "characterised by an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness."

THE ETHICS OF THERAPY

Perry is strongly critical of therapists who adopt a suggestive approach. I cannot conceive of any counter-argument that could be presented against this position. Perry suggests that therapists who adopt this approach are likely to be social workers but states that "psychiatrists, clinical psychologists, and self-styled 'hypnotists' who have no credentials in any of the healing professions, have all been influenced by the flawed psychologising of Bass and Davis." The 1991 study by Frank and Frank supports this proposition. A more interesting question is whether this influence still persists. There are grounds for hoping that this influence has now been countered, at least where the therapist is a health professional. It is clear, for instance, that all of the position papers that Reagan describes have been concerned to counter this influence and to establish guidelines for responsible and ethical therapy.

There may be questions as to whether or not the descriptor "False Memory Syndrome" should be accepted, and as to whether or not such therapy is still being administered. I do not question the proposition that such therapy does grievous damage both to the person who is its subject and to their family and friends. Perry's criticisms here are well warranted.

LEGAL QUESTIONS

There are a number of complex legal questions that arise when a court is asked to deal with recovered memories. Perry touches upon each of these and refers to some of the relevant American authorities. For a more thorough

treatment of the authorities — American, Australian, and otherwise — I refer readers to a chapter that I wrote with Patrick Parkinson. This chapter appears in a forthcoming book, *Recovered Memories, Capturing the Middle Ground*, edited by Davies and Dalgleish. My treatment here is limited to a description of the problems and a discussion of Perry's preferred approach.

Statutes of Limitation

The first problem arises from statutes of limitation. If applicable, these statutes would bar any action in which allegations are made that an adult suffered sexual abuse as a child because of the lapse of time involved. In some jurisdictions the only way to overcome these limitations may be to establish that the survivor could not have accessed the memory of the abuse in the interim. This is the reason for Perry's emphasis on the question of whether memories can be repressed. Perry's implicit argument is that as there is no effective proof that memories can be repressed, all such actions should be statute barred. A preferable approach, given that the fact that memories can be suppressed is beyond challenge, would be to allow the limitation period to be avoided in a much wider range of circumstances. In fact, the New South Wales statute of limitation and many American statutes of limitation allow this. Limitation periods can be avoided whenever it can be shown that the plaintiff did not know that the injury had been sustained, or was unaware of the nature or extent of personal injury suffered, or was unaware of the connection between the personal injury and the defendant's act or omission. Where the approach to avoiding the statute of limitations is less rigid, the problem of whether it can be established that memories can be repressed becomes less crucial.

Admitting Testimony after Therapy

The second problem is whether or not the testimony of the survivor should be admitted. Perry expresses a strong preference for the approach, adopted by the Minnesota Supreme Court in *State v. Mack*. This approach is an automatic exclusion of all testimony about an incident from someone who has recalled that incident under hypnosis. This approach can be extended to an exclusion of all testimony about an incident from someone who has recalled the incident under therapy that is potentially memory altering.

Other courts in the United States of America have adopted the approach

that the testimony is automatically admitted. This approach is in line with the principle of free proof. This principle does not strictly apply in any common law country, being characteristic instead of civil law systems. Theorists of the law of evidence suggest, however, that the principle also provides the starting point for our evidentiary system. Evidence is admissible unless it is caught by an exclusionary rule. The evidence legislation adopted in 1995 to apply in the federal and New South Wales jurisdictions, states that all evidence is admissible unless it is caught by a rule articulated in the Act. There is no specific mention in the legislation of an exclusionary rule that would catch testimony that potentially was affected by therapy.

Another approach is to allow the testimony in if it can be shown that the therapy was administered in circumstances in which safeguards were taken against the dangers of suggestion. This is the approach taken by the California legislation and it is the approach that was preferred by the New South Wales Court of Criminal Appeal in 1995. The case in question, *R v. Tillott,* concerned memory apparently recovered after EMDR. It decided that a similar approach should be taken to EMDR as to hypnosis and suggested that this approach was correct whenever similar dangers of the effect of suggestion arose.

As an Australian resident in Canada, Perry should appreciate that the effect of the guarantee of equality regardless of disability in the Canadian Charter of Rights and Freedoms would support an argument that no person should be barred from testifying because they have felt the need for therapy to face a traumatic memory. There is no similar provision in the Australian constitution but our courts sometimes suggest that they honour the same principles anyway. An automatic exclusion would not be consistent with this presumption. It has yet to be seen how Australian courts bound by the 1995 legislation will resolve the question of whether testimony that might have been affected by potentially memory altering therapy should be admitted.

Admitting Expert Testimony

The third problem arises in the context of trials in which testimony from someone who has recalled the incident under therapy is accepted. The question then is whether expert witnesses should be allowed to testify about repression and recovery of memory. In *Shahzade v. Gregory* the assumption was that if such expert opinion was not admissible then the accusing witness's testimony itself would not be admissible. The defence asked for a ruling at the outset that the expert testimony was not admissible. A request for such a ruling

asks the court to rule on the question without considering the facts of the individual case. In refusing to make the ruling the court ruled that on the evidence presented it had not been established that the theory of repressed memories was not invalid; only that no study had yet validated it. Perry ridicules this ruling. I have suggested above that on the evidence Perry presents it was the correct ruling. I would also suggest that it is inappropriate to ask the courts to resolve a scientific question in this way. Scientific questions should be resolved by bodies of scientists on the basis of scientific results and not by any Orwellian Ministry of Truth on the basis of assessments of credibility. Given that the seven scientific societies in four English-speaking countries have failed to resolve that repressed memory theories must be rejected, I suggest that no court should adopt that position.

A decision such as that reached in *Shahzade v. Gregory* does not preclude challenge to the admissibility of expert opinion evidence from any specific witness. The court might still exclude such testimony on the basis that the preconditions for its admissibility have not been established. At the stage when the court considers the qualifications of the witness, the relevance and the particular basis for the witness' opinion may also be explored. These are questions which may arise whenever expert opinion testimony is offered.

Incidence of Burden of Proof

The fourth legal problem is the incidence of the burden of proof. This is a question peculiarly within the province of the law and the courts. In a criminal trial the burden is on the prosecution. It is not on the accusing witness. In a civil trial, the burden of proof is on the plaintiff but where the plaintiff is represented by counsel the carriage of the case will not rest directly on the individual plaintiff. Perry chose to make an issue of this in commenting on Bass and Davis' suggestion about the burden of proof. Unless Bass and Davis were confining their comment to criminal proceedings there is some justice in Perry's comment but it should not be overstated.

Warnings Required

In the past, corroboration was required by the law in certain types of case and corroboration warnings were required in others. More recently the approach has been to avoid the term corroboration and to remove formal requirements for corroboration or corroboration warnings. Instead more emphasis has been put on warnings that, where dubious evidence is presented, independent

support should be sought. The 1995 evidence legislation imposes a duty on the judge to warn the jury about the danger of acting on any evidence that appears for any reason to be unreliable. It is clear that this description would apply to any case where testimony is based on a recovered memory.

The nature of the independent support, or corroboration, that is required must be correctly understood. It is incorrect to suggest, as Reagan does in his article in the *Rutgers Law Journal,* that if corroboration is available the unreliable evidence need not be presented. Corroborative evidence does not need to be capable of sustaining a conviction when standing alone. Justice McHugh makes this clear in his judgment in *Pfennig.* An example to illustrate this point can be taken from an old sexual assault case even though this case does not involve recovered memories. In *Lindsay* the accusing witness testified that she had been forced to submit to intercourse by the accused, in the back of a panel van. She stated that she had been held down, that another man held her arms above her head. The account given by the accused was that the sexual intercourse was consensual; his testimony, however, confirmed that her arms had been held. The judge instructed the jury that this admission was capable of confirming her story if the jury found her explanation more credible than that of the accused. It is very clear that the admission would not have been sufficient to ground a conviction by itself, even though it confirmed the identity of the accused and could be interpreted to confirm that a crime (sexual intercourse without consent) was committed.

Appellate and Prosecutorial Powers

Prosecutorial authorities have the power to decide that in the absence of sufficient independent evidence a prosecution should not be commenced. Appellate courts have the power to set aside a conviction if it appears that the evidence cannot sustain it. In a 1997 decision, the New South Wales Court of Criminal Appeal set aside a conviction based on testimony reliant on recovered memory because it was not satisfied that the evidence could sustain it. This decision was reached in the face of some independent proof. The court explicitly stopped short of holding that a conviction could never be supported on the basis of such testimony. The practical effect of the decision has been to encourage the Director of Public Prosecutions to decide not to pursue convictions where the history of the principal witness's memory of the assault is in question.

DISCLOSURE OBLIGATIONS

Whenever a witness comes forward to give information about a crime after a delay, questions will be asked about the cause of the delay. These questions will include questions about the history of the memory. These questions will be asked repeatedly. The police will ask them when taking the initial report. The prosecution will ask them while deciding whether to bring the case to court. Almost invariably the defence will ask them in court.

Such questions must be answered honestly. The primary source of the obligation to answer these questions honestly is ethical. An obligation to tell the truth in any and all circumstances is a prime ethical imperative. This obligation may be seen as even more weighty when the consequences flowing from the answer will be so grave. In the circumstances envisaged the decision whether to prosecute will hinge on the answer to the question. In addition to the ethical obligations, dishonest answers to these questions may attract legal liability. When given in court, a dishonest answer will constitute perjury.

A therapist dealing with a patient who is exploring such memories should be aware of the disclosure obligations that would be entailed if legal proceedings were contemplated. I suggest that the information that a therapy, which may alter memory, might prevent any legal action from succeeding should be conveyed in the course of obtaining informed consent to the therapy.

Where a patient who has undergone such therapy does become involved in legal action the therapist will also face disclosure requirements. The therapist is liable to be called as a witness and may be asked for any records of the case that they have kept. Again, both ethics and law require that any questions be answered honestly. In some Australian jurisdictions information possessed by the therapist may be protected by privilege conferred by statute. In New South Wales, under amendments to the legislation enacted in 1997, information confided to a health professional must not be divulged in court unless the court decides that the interest in protecting the confidentiality is outweighed by the necessities of the court. In making this decision the judge must take certain factors into account. Prominent among these factors is the harm that might be done to the confider. These provisions go further than giving the health professional the right to object to being asked to divulge the information. It is, however, inconceivable that the judge would uphold the objection where the information relates to the effect of therapy which had the potential to alter memory of the central incident.

Where the information is in the possession of the prosecution, as in the Canadian case of *R v. Taylor,* the obligation of disclosure on the prosecution may require that the information be disclosed to the defence even in advance of the trial. It follows that if there is an intention to claim that confidentiality protects the records or information, this claim should be asserted when the first inquiry is received. In these circumstances the correct answer to such inquiries is: "Yes, I have information. It is confidential and I refuse to disclose it on that basis."

Perry states that: "Recently I have learned also that women who have 'recovered' incest memories during therapy are now being advised to testify in court that they always remembered the sexual abuse." This is the most serious and the most damaging allegation that Perry makes. If true, a serious abuse of the trial system is being perpetrated. I would like to believe that no such advice is really being given. I admit however that I have heard clinical psychologists speculating about responding to a subpoena asking them to produce client records by destroying the records. This was in advance of the amendment of the legislation to provide protection for confidential information in the possession of health professionals. The conduct contemplated there was much less heinous than the conduct that Perry is suggesting.

Apart from the ethical problems that should concern those giving such advice, three potential consequences of such a course of action should be of concern to those counselling survivors of sexual assault. The first is the anti-therapeutic consequences for the survivor who follows such advice. Even where a conviction is obtained the conviction will be overturned when the facts come to light. This happened in the New South Wales case of *R v. CPK.* In that case the accusing witness had misled the court as to the circumstances in which the memory was recovered. The true history involved some time spent in an Indian temple.

It was pointed out above that anyone who deliberately misleads the court could be legally liable in a number of ways. Therapists contemplating giving the advice in question should note that anyone giving the advice that Perry refers to could also be held liable. As a reasonable person contemplating giving such advice would realise the effect of such advice on the person to be accused, there is a basis for an action for negligence. Such an action would allow the individual who is accused of perpetrating the abuse to recover civil damages. The basis for such liability would be much clearer than the basis for the liability of the therapists in the *Ramona* case. There is also a common law offence of suborning perjury to be considered.

Finally, any professional contemplating giving such advice should realise the effect that such conduct will have on all delayed prosecutions for sexual assault. The currency of suggestions such as that Perry has made will already present fuel to defence attorneys. Any proof that such advice is actually being given will only exacerbate the problem.

CONCLUSION

Perry's article identifies some real problems but is based exclusively on a very limited view of American law. Australian courts have taken a different and in my view a preferable approach to that which Perry advocates. Perry has taken the view that there are absolutely no circumstances in which recovered memories of child sexual abuse can be relied upon. The legal positions he advocates would result in the conclusion that there are no circumstances in which either a criminal prosecution or a civil action should succeed where a delay has occurred before an allegation of sexual assault is made. In adopting this position Perry is taking as one-eyed a view as that which Bass and Davis presented.

The position adopted by Cameron West speaking about Dissociative Identity Disorder is much more to be preferred. "It is possible," he suggests, "to induce the symptoms . . . and, sadly, some people have experienced this at the hands of inept and untrained therapists. It is also possible to mimic the symptoms . . . and a few have done so to seek some personal gain." On the other hand, some people experience a cluster of recognisable symptoms that are not better accounted for by any other diagnosis.

This is most likely also the situation with respect to repressed and recovered memories of childhood sexual abuse. The law in Australia has properly approached such cases with extreme caution, but if it were possible to overcome the difficulties and present a case which, considering all the factors, established that such abuse had taken place the law should not refuse a remedy.

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Sexual Relationships with Former Patients: Prevalence, Harm, and Professional Issues

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Although there is strong consensus proscribing therapists' sexual relationships with current patients, sexual relationships with former patients fall within a grey area of professional ethics. There is nothing to suggest that this is a more serious issue for professionals who use hypnosis than for doctors, dentists, and psychologists in general, but it could be useful for societies of hypnosis to provide more explicit guidelines for the benefit of their members and the protection of the public. Research literature surveying the prevalence of sexual involvement with former patients and the ethical attitudes of members of professional societies is reviewed. Despite the methodological limitations of this survey research it seems clear that some sexual involvement with former patients occurs, and that the members of the helping professions have not yet arrived at full consensus about the ethical propriety of such behaviour. Clinical reports of harm to patients are reviewed and the characteristics of therapists who engage in sexual relationships with patients are discussed. Over the last decade, several major professional societies have debated the issues and revised their codes of professional conduct. The American Psychiatric Association has recently declared an absolute ban on sexual relationships with former patients, whereas the American Psychological Association has specified a two-year period from the termination of therapy before a sexual relationship might be considered subject to other conditions and constraints. The ethical and practical issues are complex and there is need for other societies to discuss and clarify their positions.

Sexual exploitation of patients has been condemned from earliest times. As long ago as the fourth century BC, Hippocrates stated: "Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption and further from the seduction of females or males, of freemen and slaves" (Hippocratic Oath, Edelstein,

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1943). Some time later Freud, alarmed by the practices of some of his followers who engaged in erotic physical contacts with their patients, warned of the temptations and destructiveness of sexual relationships with patients (Freud, 1958; Jones, 1953). Since then, although a few have argued that sexual contact might have a positive role in psychotherapy (e.g., McCartney, 1966; Shepard, 1971), there is nowadays firm consensus among the helping professions that sexual activity between therapists and patients is unacceptable. Accordingly, the ethical codes of most professional societies and licensing and registration boards include explicit prohibition of sexual relationships with current patients (e.g., American Psychiatric Association, 1989; American Psychological Association, 1992; Australian Psychological Society, 1986; National Association of Social Workers, 1993; New South Wales Psychologists Registration Board, 1990; Royal Australian and New Zealand College of Psychiatrists, 1992).

Sexual activity with *former* patients, however, falls into a grey zone of professional ethics. For example, Schoener (1989, p. 287) laments: "The psychotherapy field must define the parameters of sexual relations between therapists and patients after therapy for both practitioners and consumers of the services. The current lack of clarity is appalling. Ignorance is not bliss. It is the breeding ground for disaster for the therapist, the patient, and the field itself." Gonsiorek and Brown (1989) reinforced this with an exhortation that ethical and regulatory bodies should develop a clear written standard to govern post-therapy sexual or romantic relationships: "Case by case determinations in the absence of written standards or the application of unwritten rules are unethical and unacceptable" (p. 301).

Some professional societies have responded to this need over the last few years through modifications of their ethical codes, but the issues are enormously complex and the desired clarity and full consensus have not yet been achieved. It is the aim of this paper to encourage discussion by presenting some important features of the debate. Empirical studies of the attitudes and behaviours of members of helping professions in respect to post-termination sexual relationships will be presented, the effects of post-termination sex on patients, the circumstances under which therapists discover themselves vulnerable to unethical behaviour, and the improvement of basic and continuing education in ethical issues and self-awareness will be discussed.

There is little evidence to suggest that the special phenomena of hypnosis have been used by therapists to enhance the sexual exploitation of their patients. Moreover, there is not a scrap of evidence that the incidence and problems of post-termination sexual activity are greater for hypnosis than for

any other form of therapy. However, in view of community perceptions about the coercive power of hypnosis, and especially in the context of hypnosis in the treatment of sexual dysfunction, it is important to include consideration of the ethics of post-termination sexual relationships. High ethical standards are essential for those practising hypnosis for, as Wall (1991, p. 76) declared, "the acceptance of hypnosis as a legitimate tool in health care delivery requires careful adherence to appropriate ethical principles."

In order to accommodate the multidisciplinary nature of its membership, the ethical code of the International Society of Hypnosis refers members to the standards of ethics that apply in their various professional fields, typically those of medicine, dentistry, and psychology. In addition the code contains injunctions specific to hypnosis relating to the use of hypnosis in public entertainment and the training of lay persons in the use of hypnotic techniques. In view of the current lack of clarity and consensus about post-termination sexual relationships within the various professional fields that comprise the membership of hypnosis societies, and of the importance of sexual ethics to the perceived legitimacy of hypnosis, the International Society might consider adding relevant guidelines to its ethical code.

THE PREVALENCE OF SEXUAL RELATIONSHIPS WITH FORMER PATIENTS

There is a dearth of reliable data on the prevalence of sexual relationships with former patients. Surveys of practitioners in Europe and the U.S.A. have focused on sexual attitudes and behaviours in respect to current patients (e.g., Borys & Pope, 1989; Gartrell, Herman, Olarte, Feldstein, & Localio, 1987; Kardener, Fuller, & Mensh, 1973; Lamont & Woodward, 1994; Pope, Tabachnick, & Keith-Spiegel, 1987; Rodolfa et al., 1994; Wilbers, Veenstra, van de Wiel, & Weijmar-Schultz, 1992). Different definitions and interpretation of what constitutes inappropriate sexual activity, modest response rates with the attendant possibility of bias, and reliance upon respondents to honestly report their sexual interactions with patients have resulted in reports suggesting that between 1% and 9% of professionals acknowledge that at some time they have engaged in sexual activity with current patients.

The prevalence of self-reported sexual activity with patients appears to be declining over the two decades spanned by these research surveys. For example, Borys and Pope (1989), found a prevalence of only 1% of mental health professionals who reported having engaged in sexual intimacies with a current patient. This was considerably lower than prevalences reported in the

previously published national studies. Rodolfa et al. (1994) in a survey of a randomly drawn sample of 908 psychologists of the American Psychological Association, albeit with only a 43% response rate, found a higher prevalence than Borys and Pope, namely 5.5% of male and 2.2% of female psychologists, but even these rates were lower than those typically reported from the earlier studies. The lower rates may possibly be explained by psychologists exercising greater self-control, increased awareness of the negative consequences for patients, the increased publicity given to malpractice suits, or perhaps a greater reluctance to report sexual interactions even anonymously. Williams (1992) offers a very careful methodological critique of these prevalence studies and of some of the problems of generalisation from them to the overall professional population. However, despite their methodological limitations, the studies indicate that sexual relationships between therapists and patients have been and probably continue to be a problem.

There do not appear to be any published data on the attitudes and practices of Australian doctors, dentists, psychologists or other health workers regarding sexual contact with patients or former patients. However, recent reports in the media have certainly publicised the fact that such cases do occur (Galletly, 1993), and they are likely to become more prominent because of the raised awareness of sexual abuse and harassment in general, the growing consumer rights movement with its more active and critical stance towards service providers, and the interests of the mass media in sensational material (Searight & Campbell, 1993).

Studies of sexual involvement with former patients suffer similar methodological problems to the surveys of attitudes and behaviour with current patients. Nonetheless they are valuable in their broad indications of the prevalence of the behaviour and the range of attitudes that are expressed by professionals. Borys and Pope (1989) randomly selected 800 male and 800 female clinicians from the membership directories of each of the three mental health professional organisations in psychiatry, psychology, and social work, to constitute a total sample of 4,800. Half of the sample were asked to express their attitudes to a range of issues about dual relationships, and the other half were asked to report the frequencies of their personal involvements. This half and half procedure was adopted to protect against the potential contamination of responses across the two domains of ethical beliefs and enacted behaviours. The overall response rate was 49%, comprised of 904 psychologists, 570 psychiatrists, and 658 social workers. There were no significant differences among the professions in terms of sexual intimacies with patients before or

after termination of therapy. Sixty-eight per cent of respondents in one half of the sample asserted that sexual relationships with a former patient were never ethical, 23% said that they were ethical under some conditions, 5% that they were ethical under most or all conditions, and 3% were unsure. In the other half of the sample, who were asked about their actual behaviours, 95% said that they had never engaged in sexual activity with a patient after termination, but 4% reported that they had at some time.

Conte, Plutchik, Picard, and Karasu (1989) surveyed 203 practising psychotherapists in the department of psychiatry of a large metropolitan medical school. Seventy-five psychiatrists, 22 psychologists, and 4 social workers responded, for an overall response of 50%. The respondents were asked to rate various behaviours according to whether they were grounds for malpractice, or whether they were unethical, inappropriate, or acceptable. Included were items about sexual activity with former patients. One hundred per cent of respondents judged that having sex with a patient while still in treatment was either grounds for malpractice (80%) or unethical (20%). Terminating treatment for the purpose of having sexual contact with a patient was judged to be malpractice by 37%, unethical by 52%, and 10% thought it inappropriate though not necessarily grounds for malpractice or unethical practice. One respondent believed that such termination would be acceptable. Schoener (1989) reports further details of the Conte et al. study, having obtained them through personal communication. Having sexual contact with a patient after proper termination of only a brief therapy was judged to be grounds for malpractice by 14%, as unethical by 53%, as merely inappropriate by 27%, and as acceptable by 6%. Marrying a patient after proper termination of long-term therapy was viewed as grounds for malpractice by 2%, as unethical by 28%, as inappropriate by 41%, and as acceptable behaviour by 30%. Unfortunately these data sample the ethos of only one department of psychiatry and while they contribute to the fund of information they cannot be taken as representative of the field.

In an attempt to systematically gather data about psychologists' beliefs about and compliance with ethical principles, Pope et al. (1987) surveyed 500 women and 500 men randomly selected from the 4,684 members of the psychotherapy division of the American Psychological Association (APA). The overall response rate was 46%. Of the respondents, 33% described themselves as psychodynamic in orientation, 26% as eclectic, and the remainder were spread over cognitive, gestalt, humanistic, existential and behavioural orientations. Several survey items pertained to sexual ethics. The survey items

"engaging in erotic activity with a patient" and "engaging in sexual contact with a patient" produced very similar profiles of response. Ninety-five per cent of respondents said that such behaviour was unquestionably unethical, but 3% were willing to entertain the possibility under rare circumstances, and 1% asserted that it was unquestionably ethical or appropriate under many circumstances. Two per cent acknowledged that such sexual behaviour sometimes occurred in their practice.

Fifty per cent of their respondents believed that becoming sexually involved with a former patient was unquestionably unethical, 34% believed that it could be ethical under rare circumstances, 7% declared that they did not know, and 7% thought that it was ethical or could be under many circumstances. Reported behaviour was somewhat more conservative: 88% of respondents said that they had never been sexually involved with a former patient, but 10.9% reported that sexual involvement had occurred sometimes in their practice, even though rarely.

About one year later, Akamatsu (1988) also surveyed 500 women and 500 men from the psychotherapy division of the APA. He asked questions in a very similar format to Pope et al. (1987) and obtained a response rate of 39%. It is not clear whether his random sample partly overlapped with that of Pope et al. because they were drawn from the same constituency. Overall, 11% of respondents acknowledged that they had at some time had sex with former patients (14% of male and 5% of female respondents). Akamatsu's attitude scales were slightly different from those used by Pope et al., but he obtained fairly similar results. Forty-five per cent believed that sex with former patients was very unethical, 24% that it was somewhat unethical, 23% that it was neither ethical nor unethical, and 8% that it was somewhat ethical or very ethical.

Akamatsu also asked respondents to suggest what factors should be taken into account when making ethical judgements about sex with former patients. The suggestions offered may illuminate the response of the 23% who declared that the behaviour was neither ethical nor unethical. The length of time that had elapsed since termination was the most frequently suggested factor, followed by transference issues, length and nature of therapy, nature of termination, freedom of choice and mental health of the patient, whether therapy would ever need to be reactivated, and whether there was any harm to patient welfare. Akamatsu asked specifically about the length of an appropriate moratorium between the termination of therapy and the commencement of an intimate relationship. Thirty-eight per cent of the

respondents answered that no duration of time could make the behaviour appropriate, 19%, many of whom had said that time should be considered, refrained from nominating a specific length of time, and 43% advanced suggestions ranging from "immediately after termination" (1%) to "after 3 years" (6%). The modal length of moratorium was "after one year" which was advocated by 16% of respondents.

We should be cautious about generalising too confidently from the data of these research reports because of specialised samples, typical response rates of only 30% to 50%, and the rapid changes in community awareness and increasing professional accountability. What can be said is that while most mental health professionals do not engage in sex with former patients, between 4% and 11% of those surveyed have acknowledged that they have done so. About a half to two-thirds of respondents have declared that sex with former patients is always unethical, small minorities declare that there is nothing at all unethical about the behaviour, while the remainder, about 30%, say that it depends on the factors involved in the situation. As reported above, Conte et al. (1989) listed some of the factors that affect these judgments. It is clear that professionals have not yet reached full consensus about the ethics of sex with former patients and the pleas for more explicit guidelines by Schoener (1989) and Gonsiorek and Brown (1989) appear to be justified.

THE HARMFUL EFFECTS OF SEXUAL INVOLVEMENT ON THE PATIENT

It is widely accepted that sexual activity between therapist and patients is harmful. Here I shall focus on the effects upon the patient, although there may also be harm to the therapist, significant others of both parties, and the profession at large. In addition to the transitory harms to dignity and autonomy that may occur through sexual exploitation stemming from transference and the differential power of the therapist, the surveys and case reports document more lasting negative psychological and interpersonal effects on patients. Pope and Bouhoutsos (1986), following a review of research in the period 1966–85, go so far as to suggest that the sequelae of therapist–patient sexual involvement form a distinct clinical syndrome for the patient (pp. 57–64). This therapist–patient sex syndrome includes: ambivalence, guilt, feelings of isolation and emptiness, cognitive dysfunction such as reduced concentration, flashbacks and nightmares, inability to trust, sexual confusion, lability of mood, suppressed rage, and increased suicidal risk. They comment that the syndrome bears

similarities to aspects of borderline and histrionic personality disorders and that the appearance of some of these symptoms may be considerably delayed. However, Gonsiorek and Brown (1989), out of extensive experience in the rehabilitation of sexually abused victims, reject the value of the proposed syndrome, arguing that there is no clear pattern that can be found across the board.

Systematic and reliable information about the incidence of harm that arises from sexual relationships with former patients is simply not available. Anecdotes about successful marriages between therapists and their ex-patients are not uncommon. One difficulty in distinguishing between the effects of sexual involvement within therapy and relationships that commence after therapy is the possibility that therapies are terminated prematurely in order to begin a sexual relationship. However, cases of harm are documented even when therapy has been completed and terminated to the satisfaction of both patient and therapist. Spindler (1992), for example, reports a disastrous instance in which the sexual relationship began a full 15 years after termination. Such case reports, and generalisations from groups of distressed ex-patients, do provide clinically important data about the reality of harm and the potential for harm but, as Williams (1992) has pointed out, these data, obtained primarily from those who have suffered ill effects, do not allow confident extrapolation to all situations of post-termination sexual involvement. Those ex-patients on whom the effects were neutral or even positive may not be strongly motivated to respond to invitations to participate in research. Consequently, conclusions about the prevalence of ill effects derived from samples of volunteers or from samples who request therapy or legal redress may be biased. The matter is further complicated by the problem of retrospective attribution. Many relationships, not just those with a former therapist, end up in grave distress for one or more of the parties. When there is deterioration or breakdown of a relationship that had been established between a therapist and a former patient, how confidently may it be assumed that the nexus of harm is in the former therapeutic relationship rather than in the vicissitudes of ordinary sexual relationships? In the struggle for power, and the potential gains of assuming a role as victim, there may be temptation to attribute responsibility to the unequal power of the previous therapeutic phase of the relationship. Ethics committees and licensing boards are often faced with such complexities.

Sell, Gottlieb, and Schoenfeld (1986) conducted a survey of the outcomes of complaints of sexual impropriety that had been brought before ethics

committees and licensing boards in the period 1982–83. Twenty cases involved allegations of sexual relationships commencing after the termination of therapy and, in 70% of these, the therapist was found to be in violation. There was little consistency between the criteria used by the various sanctioning bodies, and most responded that the issues were decided on a case-to-case basis. Sell et al. commented that the public and the professions would be better served if there were more explicit guidelines.

Although we cannot be sure of the proportions of individuals for whom post-termination sexual involvement with their former therapist is a negative, neutral, or even positive experience, it seems clear from the available case research and outcomes of malpractice hearings that sexual involvement with former patients has potential in some cases, and perhaps in most, to result in serious harm.

THERAPISTS INVOLVED IN SEXUAL BEHAVIOUR WITH THEIR PATIENTS

Again there is a dearth of systematic research on the characteristics and dynamics of therapists who engage in sexual behaviours with patients and none that is specifically focused on those who have sex with former patients. Of crucial importance to this discussion is the distinction that must be made between sexual attraction to patients and sexual involvement with patients.

As shown by the research of Pope, Keith-Spiegel, and Tabachnick (1986), in their national survey of 1,000 psychologists in APA Division 42 (Psychologists in Independent Practice), the majority (95% of male and 76% of female respondents) acknowledged having experienced sexual attraction to patients during therapy. Unfortunately there are no data on attraction that might develop after therapy has been terminated. A half of the respondents reported that their training had not included any guidance on these matters, and only 9% judged that their training and supervision had been adequate. However, only 7% reported having acted on their feelings by becoming sexually involved. The respondents provided many reasons why they had refrained from sexual contacts with their patients, but the survey did not shed any light on the motivations of those who had become involved. More recently, Rodolfa et al. (1994), in a careful survey of therapists who work in university counselling centres, have reported similar findings.

Both Pope and Bouhoutsos (1986) and Schoener and Gonsiorek (1989) have reviewed the literature on the characteristics of those who become

sexually involved with their patients and have found it lacking in comprehensiveness. Motivated by their desire to determine rehabilitation potential, they have offered broad typologies based upon their own, not inconsiderable, clinical experience with therapists who have transgressed. Pope and Bouhoutsos suggest three main clusters: the poorly trained psychotherapist, the distressed psychotherapist, and the therapist with characterological problems.

A most frequent explanation offered for sexual involvement on the part of a therapist is naivety, lack of knowledge about the standards of care in mental health, and inadequate understanding of professional boundaries. Schoener and Gonsiorek remark that many paraprofessionals as well as some professionals who received substandard training are included in this cluster. Some common misperceptions, or rationalisations generated after the event, are that sexual involvement with a patient is acceptable if it occurs outside the therapeutic situation, or if it is initiated by the patient. The fact that some therapists may have been led into sexual situations by ignorance rather than a propensity to exploit does not reduce the harm that might be done to patients or former patients.

Many reports documenting the occurrence of unethical sexual behaviour advocate improved training in the management of sexual feelings in therapy as means of preventing infringements (e.g., Carr & Robinson, 1990; Fisher & Fahy, 1990; Rodolfa et al., 1994; Shaw, 1994). Others urge clarification of the ethics of dual relationships and a more pronounced emphasis on education in sexual ethics (e.g., Borys & Pope, 1989; Sonne, 1994). Gottlieb (1993) has proposed a decision-making model to assist therapists in avoiding exploitative dual relationships, and a new scale, the Exploitation Index, is being developed to alert practitioners to their tendencies to boundary violations (Epstein, Simon, & Kay 1992). The need for improved training is seen as especially strong by some who note a reduced emphasis on psychodynamic theory and the less frequent requirement of undergoing one's own therapy in preparation for practice (Kagle & Giebelhausen, 1994).

A second cluster described by Pope and Bouhoutsos (1986) and Schoener and Gonsiorek (1989) is that of the distressed psychotherapist. This is a reasonably large cluster of healthy or mildly neurotic therapists whose sexual involvement with patients tends to be limited or represents an isolated circumstance. Such therapists typically acknowledge the unethical nature of their conduct, and become remorseful, anxious, and depressed when the sexually exploitative nature of their behaviour becomes apparent to them.

Situational stressors, such as marital difficulties, separation loss, and "burn out" are often in evidence. Schoener and Gonsiorek believe that for many of this group the prognosis for rehabilitation is good, but Pope and Bouhoutsos assert that major obstacles to rehabilitation are the reluctance of mental health professionals to view themselves as troubled human beings, and, when they do recognise themselves to be needy, they may perceive their professional societies as punitive and adversarial rather than rehabilitative.

A third cluster of sexually exploitative therapists is a mixed bag of persons with characterological problems who tend toward repetition of sexual involvement. Schoener and Gonsiorek (1989) indicate that some have long-standing emotional problems, especially depression, feelings of inadequacy, and low self-esteem. Others have histories of problems with impulse control sometimes associated with narcissism, and others appear to be psychotic or borderline personalities. Schoener and Gonsiorek and Pope and Bouhoutsos believe that effective rehabilitation is less likely with these groups. They point out that it is incumbent on institutions to have adequate staff selection procedures, and for licensing bodies to have procedures that screen effectively against therapists with a propensity toward sexual involvement with their patients.

SEX WITH FORMER PATIENTS AND PROFESSIONAL CODES OF CONDUCT

Sell et al. (1986) reported the results of a 1982–83 survey about the ethics of sex with former patients which was directed to the 114 chairs of psychology ethics committees and the executive secretaries of licensing boards in 50 states of the U.S.A., the District of Columbia, Puerto Rico, and the Canadian Provinces of British Columbia and Nova Scotia. The overall response was 75%. The results indicated that only 9% of professional ethics committees and 6% of state boards had formal guidelines. However, in response to the question of whether the development of guidelines would be helpful, 91% replied that they would. However, even with the provision of guidelines, most believed that decisions should continue to be made on a case-by-case basis because of the complexity of the issues. Since that time, several major professional organisations have developed their codes of conduct to provide more explicit guidance.

In California, Florida, and Minnesota, a case of sexual malpractice against a psychotherapist is not mitigated by formal termination of the therapy,

especially if termination was in order to begin the relationship (Kagle & Giebelhausen, 1994). Following considerable debate, an absolute ban on sex with former patients has recently become an official part of the American Psychiatric Association ethics code (Gabbard, 1994). However, the new code of conduct of the American Psychological Association (1992) has adopted a less absolute position stating that "Psychologists do not engage in sexual intimacies with a former therapy patient or patient for at least two years after cessation or termination of professional services" (p. 1605). The code goes on to stipulate that the psychologist who engages in such activity after two years following termination of treatment bears the burden of demonstrating that there has been no exploitation. This decision by the American Psychological Association not to bar sexual relations in perpetuity has been strongly criticised by Gabbard (1994), but has been just as strongly defended by Bersoff (1994), invoking principles of autonomy and sexual equality. Bersoff argues that an absolute ban would be tantamount to implying that "women who were once in therapy will not be able to make an informed, voluntary, and intelligent decision about their sexual partners" (p. 385).

Other professional bodies are also engaged in clarifying their stances. The ethical guidelines of the Royal Australian and New Zealand College of Psychiatrists (1990, 1992) state that sexual relationships with former patients are generally improper, adding that a mutually acceptable termination of therapy does not necessarily mean re-establishment of equal relationships and that advice from a body of colleagues should be sought. The code of conduct of the New South Wales Psychologists Registration Board (1990) addresses the issue of post-termination relationships by stipulating that the advice of senior colleagues should be sought before beginning any other sort of relationship. These prescriptions imply that post-termination relationships may possibly be contemplated, subject to careful consideration. But there are few guidelines to assist the senior colleagues who might be consulted, nor specifications of the length of a suitable moratorium between termination and commencement of another relationship.

It seems imperative for the sake of professionals and for the protection of the public that professional codes of conduct should include more explicit statements about the proprieties and improprieties of sexual involvements with former patients. Appelbaum and Jorgenson (1991) have most helpfully reviewed the areas of concern and the current approaches to regulation of post-termination sexual contact. They begin by identifying four main areas of concern about therapist–patient sexual relationships in general, and then

consider how these are reduced as result of the completion and termination of therapy.

1. Patients may have significantly impaired ability to make decisions about sex with their therapist because their judgement may be clouded by distressing issues that brought them to therapy and by the development of transference often characterised by an idealisation of the therapist.
2. There may be an element of coercion in the relationship because an implicit threat exists that a patient who refuses sexual contact may be abandoned. Moreover, the privileged knowledge obtained by therapists about their patients may add to their power to exploit.
3. There may be deceit if the therapist claims that sexual contact is an appropriate part of the treatment, or offers a false reassurance that a dual relationship will not reduce the effectiveness of therapy.
4. Therapists enter into fiduciary relationships in which they assume responsibility to act in their patients' best interests rather than their own. In entering sexual relationships with patients, therapists may satisfy their own needs, but the available data suggest that many patients suffer harm as result.

Similar analyses have been provided by Baylis (1993) and Carr and Robinson (1990). Appelbaum and Jorgenson proceed to acknowledge that these four concerns may not be a feature of every therapist–patient sexual relationship. Indeed, some patients are able to make unimpaired decisions, free from coercion, and without subsequent ill effects. But such a benign and non-maleficent combination of circumstances is so unlikely that the absolute ban on sex with current patients is entirely warranted. However, they argue that the concerns that justify this absolute proscription are generally reduced in the post-termination context.

They conclude that the most serious harms and dangers of allowing patients and their former therapists to enter into sexual relationships can be addressed by proscribing sexual contact for a mandatory period of one year after the end of treatment during which all significant social contact would be precluded. After this waiting period, social and sexual relationships could be permitted because the specified moratorium would minimise problems in the chief areas of concern. This policy would balance the competing goals of protecting former patients and of avoiding excessive interference with consensual relationships. These recommendations provoked immediate vigorous criticism but also found significant support.

Three main types of criticism were advanced by opponents to the proposal of a one-year moratorium: its promulgation would corrupt the process of therapy, it underestimates the persistence of transference with its impairment of former patients' autonomy, and it underestimates the potential severity and prevalence of harm that would ensue if it were to be adopted. The chairman of the ethics committee of the American Psychiatric Association strongly disagreed with the concept of a moratorium of set length, arguing that important ethical issues such as balancing patient autonomy against potential or actual harm is not a simple function of time (Lazarus, 1992). Brown, Borys, and Brodsky (1992) responded that they did not believe that it is justified clinically or ethically for a therapist to engage in sexual intimacy with a former patient regardless of the time that has elapsed between terminating and the sexual intimacy. They argued that when "the possibility of sexual relationship exists in the mind of either party, but particularly that of the therapist, psychotherapy can and all too often does become a courtship, a process of grooming in which a vulnerable individual is shaped to meet the sexual and narcissistic needs of the therapist" (p. 979). A number of other respondents echoed these views and asserted that Appelbaum and Jorgenson had significantly underestimated the endurance of transference and the intensity of its grip (Burnham, 1992; Drummond, 1992; Friedman, 1992; Gabbard, 1994; Hersen, 1992; Sapir, 1992; Sonnenberg, 1992). Hersen added that sexual intimacy between therapist and patient is tantamount to a breach of the incest taboo which is not time limited, and Sapir forecast nightmares for committees who would have to decide whether a year had in fact elapsed since the end of treatment and whether any significant social contact had occurred during that year.

The proposal did find some support. Ritchie and Hays (1992) pointed out that an absolute lifetime prohibition is hard to reconcile with the primary ethical mandate of respect for patients' autonomy. They argue that a one-year prohibition after termination is reasonable, justifiable, and enforceable. Aronson (1992), who declared herself a victim of sexual misconduct, argued pragmatically in favour of the policy because, while "It's never okay" is a terrific bumper-sticker slogan, the principle of absolute prohibition fails to deal with the real situation and does not provide useful guidelines. The response of Schoener (1992) is particularly interesting because, over two decades, he and his colleagues have been consulted about many allegations and cases of therapist–patient sex. Schoener congratulated Appelbaum and Jorgenson on stimulating the vigorous debate, adding that in his experience

the only wide consensus is agreement that terminating a therapy in order to have sex is unethical. He observed that the vast majority of cases of post-termination exploitation involve situations where there has been no clear termination or where there was a premature termination in order to have sex. Schoener argues that we obviously need more clearly articulated standards which should include a clear definition of termination, a two-year moratorium, an absolute prohibition of sexual contact with patients of long-term transference-laden therapies, and a prohibition against sex with former patients who have suffered past victimisation.

CONCLUSION

It appears that while a majority of professionals favour a complete proscription of sexual relationships with former patients there are many who recognise circumstances under which they might be acceptable. The complexity of issues involved makes it difficult to formalise rules that are able to cover all situations and contingencies. There is need to promote discussion and debate within professional societies. There are many grounds for concluding that it would be best if helping professionals did not form sexual relationships with former patients. These include the danger of compromising the therapeutic process, the sacrifice of future therapeutic support should it be indicated, and the contamination of the ensuing relationship by the privileged knowledge and power of the therapeutic relationship.

It seems that Chan (1992) had tongue in cheek when he proposed that some problems would be solved if single physicians in remote areas should be required to make a vow of chastity before they were allowed to practise. But there are many genuine ethical and practical arguments against an absolute proscription in perpetuity against sexual involvement with former patients. As Gonsiorek and Brown (1989, p. 301) have said: "It is important that professional ethics codes maintain a delicate balance between the protection of vulnerable patients and the civil and legal rights of both patients and therapists. A simple 'Thou shalt not' does not suffice for a problem that is so complex in nature." More explicit guidelines are needed and those who serve on ethics committees and licensing boards need ample measures of experience, wisdom, and compassion in their applications of the guidelines in their case-by-case decisions.

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HYPNOSIS, GRIEF, AND MOURNING

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Grief and mourning are associated with emotional distress and a process of psychological adjustment. Current models of grieving and mourning provide some understanding of effective psychotherapy work but largely neglect the integration of hypnotherapeutic interventions. In this paper, a theoretical model for hypnotherapeutic intervention is presented and illustrated via a case study. The clinical case study is of a woman whose husband had died, which led her to enter hypnotically oriented psychotherapy. Clinical hypnosis may provide a powerful adjunct therapy for the treatment of grieving and facilitate resolution of mourning.

Grief and mourning may be thought of as two closely related, overlapping, and to some degree separate processes (Rando, 1993). Grief may be conceptualised as the initial period of emotional response to recognising the death and loss of a loved one and is characterised by a mixture of acute emotions such as intense sadness, depression, guilt, and anger.

Some individuals may also experience a transient dissociative state characterised by a feeling of unreality or detachment from the environment. Thus, the period of grieving may be described by some individuals as "being in a state of shock" or an emotional "numbness." Individual responses vary and this period may last for days or months. Eventually, however, this gives way to a larger process of mourning the loss.

Mourning, in contrast, may be conceptualised as the larger process of "working through" the loss and moving toward acceptance and adjustment. Mourning, like grief, is also associated with depression, psychological distress, and a variety of emotions (Kübler-Ross, 1969).

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People experiencing grief and mourning present unique challenges to psychotherapeutic interventions. On the one hand the painful emotions will be seen as a necessary part of moving toward an eventual healthy adjustment. At the same time, there is a desire for relief and ability to experience positive emotions and interactions. Patients may wonder how they "should" feel and have difficulty thinking of the future without the loved one. Some individuals might feel a need to "let go" of the relationship while others are horrified at the thought of thinking of themselves totally detached from the deceased (Unruh, 1983). This paper discusses the current theories of grief and mourning. Following this, the role of hypnosis in grief and mourning is considered and a hypnotherapeutic model is presented. This is illustrated via a case example and discussion.

THEORIES OF GRIEF AND MOURNING

The process of grief and mourning is most often described as involving three or more stages toward adjustment. Some theories emphasise more of a goal of detachment or severing the emotional ties with the deceased while others have emphasised more of a process of redefining the "metaphysical" relationship with the deceased. In the first theoretical view, adjustment may be conceptualised as more of a task in involving "letting go" or a "detachment" from the deceased and then forming new relationships.

For example, Freud (1917) described mourning as the search for attachment that has been lost and then the need for the ego to reorganise and "detach." First, there is a denial of the loss. This is followed by a hypercathexis and a clinging to the lost object and finally detachment (i.e., decathesis).

Other researchers have echoed similar stages toward detachment that include: (a) denial; (b) despair; and (c) reorganisation and detachment. Similarly, successful mourning is seen as involving detachment from the deceased, readjustment, and establishment of new attachments and relationships.

More recently, Rando (1993) has proposed her conception of the "Six R's of Mourning." These processes are divided into three stages. The first involves an attempt to avoid reality as the person recognises the loss. This is followed by the confrontation stage in which there is an acute reaction, the process of recollection and reviewing memories, emotional relocation of the decedent, and relinquishment of the attachment. The final stage of accommodation involves readjustment and reinvestment in new relationships.

Most theories have a common theme of emphasising mourning as a process

which involves a degree of eventual severing of the emotional ties with the deceased and reinvestment in new relationships.

Other theorists' views have tended to emphasise an alternative view in which the mourning process is conceptualised as more of a process of "relationship redefinition" in which a variety of possible changes in the relationship with the deceased occur without necessarily a detachment. Within this alternative theoretical orientation, mourning is emphasised as being a very individualised process.

When mourning is conceptualised as a process of "redefinition of the relationship," it is recognised that when death occurs, the physical relationship with the deceased is ended. This recognition of the physical loss contributes to the pain and grief. However, for many individuals there continues to be an ongoing emotional and psychological or "metaphysical" relationship with the deceased. This involvement comes through a necessary process of relationship redefinition and a preservation of the deceased identity in a way that gives meaning to both the deceased and the survivor. For example, Parks and Weiss (1983) found that a desired continued psychological involvement with the deceased may be found among some widows and widowers.

Also, Stroebe, Gergen, Gergen, and Stroebe (1992) suggest that "continuing bonds" may be a desirable outcome for some individuals. Attig (1991) conceptualises grief and mourning as an active process and involving a "relearning" of the world without a physical relationship with the deceased but with a transformed psychological relationship with the deceased.

Thus, the transformed relationship with the deceased may accommodate new relationships as well. Worden (1991) states that one "task" in the process of mourning is to "reinvest emotions into new relationships." This may be accomplished as a relationship with the deceased actively continued at a psychological level.

Unruh (1983) also suggests that attachments to the deceased may change but may never be completely severed. The emotional relationship may continue through memories, symbolism, recurring images, dreams, and internal conversations. For some individuals this continued attachment may give added meaning to their existence and may be reinforced by the belief in an eventual reunion after death.

In this regard, the goal of mourning is to redefine the relationship with the deceased and to achieve a revised sense of identity following the loss: This redefinition of the relationship may begin to occur in the interactions with the

dying. It continues through eulogies, rituals, dreams, and images. Most grief work is primarily relational in nature.

HYPNOSIS AND IMAGERY IN GRIEF AND MOURNING

When conceptualised as relationship redefinition, hypnosis and mental imagery methods may have particular relevance to grief and mourning work. The emotional relationship with the deceased is altered in regard to the survivor's internal representation of the deceased. The survivor maintains a relationship with the deceased that is represented at both conscious and unconscious levels of awareness. Also the relationship is "metaphysical" as it exists beyond physical boundaries. Hypnotherapeutic intervention may be especially useful in accessing the internally represented metaphysical relationship with the deceased, and, facilitating imagery, dreams, symbolism, rituals, and decision making. Several authors have previously identified hypnosis as an important method in grief and mourning psychotherapy.

Vijselaar and Van der Hart (1992) presented a report of hypnosis to facilitate treatment of traumatic grief. A case study was discussed that demonstrated that hypnosis enabled individuals to move from symptoms and experiential recollection of traumas to conscious processing of grief. Kleber and Brom (1987) conducted a study of comparative methods of treating pathological grief that included hypnotherapy, desensitisation, psychodynamic therapy, and a control group. Considerable improvement, pre- and pro-treatment, was found for loss-related intrusive thoughts, anxiety, and avoidance in all treatment groups, in comparison with the control condition.

Fromm and Eisen (1982) demonstrated the use of self-hypnosis as a therapeutic aid in the mourning process. A clinical case report demonstrated, through excerpts from diaries, how self-hypnosis was used by a woman who lost her husband to achieve a sense of liberation from the deep grief and to develop a future orientation. Self-hypnosis was used to review memories and to facilitate productive mental imagery.

Van der Hart (1988a) discussed one form of mourning therapy that involved a "therapeutic leave-taking ritual" and a parting with symbols associated with the deceased. Also Van der Hart, Brown and Turco (1990) discussed the integration of hypnosis and Janetian theory (Janet, 1889) in treatment of traumatic grief. Spiegel (1981) reported on the use of hypnosis to facilitate grief work amongst Vietnam veterans who were experiencing grief and post-traumatic stress symptoms.

Handelsman (1984) presented a 4-session intervention using self-hypnosis to facilitate the mourning process in a 20-year-old woman who had experienced her father's death. Self-hypnosis was used to develop a greater sense of self-efficacy (Bandura, 1977) and a sense of mastery and coping skills. Additionally, a number of case studies (Brown, 1990; Levitan, 1985; Manthorpe, 1987, 1990; Turco, 1981; Wadsworth, 1990) have demonstrated the use of hypnotically oriented interventions in the treatment of unresolved grief and mourning.

ELKINS' HYPNOTHERAPEUTIC MODEL OF GRIEF AND MOURNING

The author presents a hypnotherapeutic model of grief and mourning that is based upon four primary assumptions: (a) relationships exist at both physical and internally represented or "metaphysical" levels; (b) the physical relationship ends with death. However, the internal or "metaphysical" relationship may continue (Attig, 1991). The acceptance of the end of the physical relationship and the transformed internal "metaphysical" relationship is the focus of subsequent therapeutic intervention; (c) the goal of mourning then becomes "relationship redefinition" (that may or may not involve detachment); and (d) hypnosis may be effective in facilitating access to the internal representation of the deceased and the metaphysical relationship.

This model is illustrated in Table 1. Three phases of adjustment and hypnotherapeutic intervention are presented.

The author's conceptualisation of a hypnotherapeutic model proposes that the process of grief and mourning is understood as dealing with one's individualised and internally represented metaphysical relationship with the deceased. In this regard, the process of mourning begins with acute grief. The relationship with the deceased is both physical and metaphysical with the internal, metaphysical processes being characterised primarily by imagery, emotion, thoughts, and memories. While, with death, the physical relationship ends, the internal metaphysical relationship with the deceased continues. This involves a period of acute grief and recognition of the loss as previously identified by Rando (1990).

Hypnotherapeutic methods utilised at this phase include the use of relaxation induction to facilitate a greater degree of control and calmness. Mental imagery may be used to facilitate a review of memories and catharsis is allowed in a supportive environment. Ego strengthening suggestions may be used toward recognising the loss without becoming overwhelmed.

Table 1: Elkins' Hypnotherapeutic Model of Grief and Mourning

Phase	Hypnotic interventions
Phase I – grief work	
• Recognise the loss (physical/metaphysical) • Expression of feelings • Recollection • Facilitate coping	• Hypnotic relaxation inductions • Ego strengthening suggestion • Control facilitated by hypnotic suggestion • Emotional expression • Hypnotic mental imagery and memory review
Phase II – redefinition of the relationship	
• Redefine the metaphysical, internal permission relationship with deceased (which may or may not involve detachment)	• Post hypnotic suggestion for to alter the metaphysical relationship (may or may not involve detachment) • Post hypnotic dreams • Symbolism and ritual • Supportive hypnotic suggestions • Metaphysical relationship experienced via internal hypnotic imagery.
Phase III – readjustment	
• Adjustment to either detachment or the redefined metaphysical, internal relationship with the deceased in the future • Forming a new identity	• Ego strengthening and self-efficacy suggestions • Hypnotic suggestion for experiencing the metaphysical relationship or for detachment • Hypnotic suggestion for age progression and identity change • Acceptance of detachment or the redefined relationship (internal and metaphysical) via self-hypnosis

The second phase, redefinition of the relationship, focuses upon the internal representation of the deceased and the imagery related metaphysical relationship. With acceptance of the physical loss comes a need to redefine the metaphysical relationship. This may involve detachment, or a continuing experience and a renewed identity that maintains an internal and metaphysical relationship with the deceased. Hypnotic interventions may include supportive hypnotic suggestions. Post-hypnotic suggestions for dreams or symbolism may be utilised to characterise the redefined relationship or the relationship may

be experienced via mental imagery. For example, Van der Hart (1983, 1988b) has written extensively on the use of symbolism and ceremony to develop and facilitate the mourning process. This includes the collection of materials that have been symbolic of the relationship with the deceased, a burying or interring ceremony, and then a ceremonial dinner as a "parting ritual." Within the present model, this may occur in vivo or through hypnotic imagery. Likewise, these methods also may be used to facilitate detachment, if appropriate.

The third phase is a readjustment in identity and may or may not include a continuing metaphysical experience of relationship with the deceased in the future. Detachment may or may not be a goal. Adjustment may be facilitated by age progression, symbolic dreams, and imagery.

CASE ILLUSTRATION

A client treated by the author illustrated the above-described hypnotherapeutic model. The client was seen for 12 sessions and achieved a positive outcome in self-report of adjustment.

Linda was a 63-year-old woman who was referred to counselling due to depression and unresolved mourning following the death of her husband. Stanley and Linda had been married for 42 years until Stanley's death at age 68, eight months earlier. Linda related that Stanley had retired, at age 65, from his work as a petroleum engineer. They had planned to travel and spend more time with family. This has been somewhat limited due to Stanley's health problems that included hypertension and a history of "heart problems."

She related that they had what she felt was an especially close marital relationship. Throughout their marriage she had been a homemaker, while Stanley worked outside the home. They raised their two sons, ages 38 and 34, and a daughter, age 37. Linda continued to live alone following the death of her husband. However, she had several friends who lived nearby as well as her adult children.

She described the events on the day of Stanley's death. Linda related that she was in one part of the house and Stanley in another. She recalled hearing his footsteps as he walked down a hallway. She recalled hearing the sound of Stanley falling against the wall. She went into the hallway to find him lying on the floor. She realised he was having a heart attack and rushed to call the hospital emergency room. He was unable to speak, but she remained near his side until medical personnel arrived. He was pronounced dead at the hospital.

When asked to describe the following months, she responded that she felt she was in the midst of dealing with the loss of her husband. She stated she had difficulty sleeping, felt a pervasive sense of sadness and "emptiness." Following Stanley's death and funeral, she engaged for several months in a frenzy of activity that included cleaning the house and redecorating. She felt she had been "in a fog" and "going through the motions" of everyday activity. She said she felt emotionally "numb" and had in her words, at times, "a hard time believing that he was gone."

Linda went on to relate that she now felt that "the fog was lifting" and that she was dealing more with her emotions. She described an intense longing and a mixture of sadness and anxiety. She described frequent dreams about Stanley and that, at times, she could "feel his presence" near her. She was fearful and emotionally distraught in her expression of grief and mourning. She stated that she had a difficult time imagining a life without Stanley. The use of hypnosis was discussed with her as an adjunct to psychotherapy. The goals of psychotherapy included: gaining greater control of her emotional wellbeing, expression of feelings, redefinition of her internal metaphysical relationship with Stanley, forming a new identity, and adjustment.

Phase I — Grief Work

As Linda appeared to be experiencing intense symptoms of grief, including insomnia, anxiety and intrusive thoughts, hypnotherapy was first utilised for increased symptom management. She was instructed in self-hypnosis by completing a hypnotic induction emphasising relaxation and comfort. A tape recording was made during the second session and given to her to help with sleep and to achieve greater emotional comfort. Ego-strengthening suggestions (Hartland, 1971) were included toward developing more of a future orientation and coping skills. An example of this hypnotic intervention is:

> Imagine a wave of relaxation spreading from your forehead to your feet. Each muscle and fibre of your body becoming more and more relaxed. Forehead relaxes, neck, shoulders, arms, back and legs. Positive feeling. The kind of feelings you may have felt before on a warm summer day. Sitting outside and feeling the warm sunshine on your face and hands. And . . . perhaps there is a cool and gentle breeze in the air. And . . . or that cool air blows in and brings even deeper relaxation. And . . . with the relaxation a greater comfort. More emotionally calm, more at ease, more relaxed. And within this relaxation finding a kind of strength. Knowing that there is a

> part of you that understands and has the ability to cope . . . able to imagine feeling happier. More confidence and more of a feeling of control. Giving yourself permission to take care of yourself and to feel more relaxed.

At times during hypnotic induction and during discussion, Linda experienced intense emotions and tearfulness. Expression of such feelings was supported and the hypnotic context provided even greater control for the expression of these emotions. As Linda began to feel more of the sense of control and wellbeing, the true concept of redefining her metaphysical relationship with Stanley was introduced.

Phase II — Redefinition of the Relationship

As Linda felt she was ready, the focus of therapy (sessions 5–9) was shifted to a redefinition of her relationship with Stanley. She indicated that she had no desire to completely detach. Linda related that she found the dreams about Stanley and the sense of his presence very comforting to her.

During hypnotherapeutic sessions supportive suggestion were given to her to allow herself permission for the relationship to be redefined. For example, the hypnotic suggestions included:

> As you become more and more absorbed in the feelings of relaxation, allow yourself to achieve an even greater understanding of your relationship with Stanley. The internal relationship that exists within your thoughts, feelings, memories, and dreams. An understanding that change is necessary, that some relationships that existed in the past can no longer exist exactly as they did in the past . . .Giving yourself permission for the relationship to change. To allow a redefined relationship . . . Giving yourself permission, without guilt or distress, for an alteration and change in internal relationship that exists beyond physical reality.

As Linda progressed, she was able to discuss the loss of Stanley and the concept of the redefinition of the metaphysical relationship without feeling overwhelmed or overtly distressed. The concept of post-hypnotic suggestion for imagery and dreams was introduced. For example:

> And as you begin to allow a redefinition of the internal relationship, this may occur through images, dreams, thoughts, and feelings. Perhaps a particular dream that is especially meaningful to you. Or it may occur in some idea or image that comes to you. Perhaps in your thoughts of some change in feelings that are positive, good, and appropriate for you.

Subsequently, Linda reported a particular experience (she did not know if she was asleep, dreaming, or imagining the experience) in which she intensely felt Stanley's presence at her bedside. She stated that a feeling of peace came over her and she heard his voice say, "It's alright, I'm okay and I want you to be okay too." She stated that she had a feeling of being kissed on the side of her face, and that she felt it was, in her words, "an angel kiss" from Stanley. This was a powerful and symbolic experience for her that allowed for further adjustment.

She felt that her relationship with Stanley would continue, as a metaphysical one, but had become different. This was a welcome change for her. Suggestions were given that the metaphysical relationship would be experienced in imagery, feelings, and inner thoughts, in ways that were acceptable to her. Linda stated that she felt more accepting of Stanley's death and that she was able to think of herself differently and able to think of positive changes that she might further consider.

Phase III — Readjustment

The final three sessions were devoted to a future orientation and adjustment issues. Linda began to discuss forming a new identity for herself and continued adjustment. As she felt more at peace with her internal relationship with Stanley, she discussed the relationship less frequently and with less intensity and emotion. She continued to utilise self-hypnosis. Hypnotherapy sessions integrated suggestions for coping, identity, age progression, and acceptance of the altered metaphysical relationship with Stanley. Suggestions included:

> As each day passes, finding more and more a sense of yourself as a changed person, with a new identity. Perhaps new interests, activities, and relationships. A growing process that occurs with confidence and comfort and acceptance. Able to look forward to the future with a feeling of happiness and enjoyment. Understanding and accepting changes in your internal relationship with Stanley and able to see yourself in the future. Even now, seeing yourself in the future, the things you are doing, people you see, and thoughts. And with this even more of a feeling of confidence and an inner sense of emotional and personal control.

Linda reported that she was able to imagine the future. She became more independent and became more involved with her church and with friends. She reported feeling more optimistic about the future and her ability to cope with change.

DISCUSSION

Hypnotherapeutic interventions appear to be very underutilised in grief and mourning counselling. However, hypnotherapy may be of particular benefit in addressing the experiences and needs of grieving and mourning patients. Hypnosis may be especially beneficial in facilitating emotional comfort and addressing the internal metaphysical relationship with the deceased.

Mourning is very individualised and may or may not involve a complete detachment from the deceased. Thus, the present paper conceptualises that the ending of the physical relationship is accepted by the survivor. A further goal of hypnotherapy is that the internal, metaphysical relationship is redefined. This may or may not involve detachment. This process does necessarily lead to a renewed identity for the survivor.

A permissive and supportive hypnotherapeutic style is recommended. It is understood that the individual responses and preferences of the patient, toward adjustment, may be influenced by many factors including the nature of the relationship in the past, personal religious beliefs, support system, age and future plans related to adjustment (Gamino, Sewele, & Easterling, 1998).

This paper offers a model for conceptualising and utilising hypnotherapeutic interventions. This model integrates hypnotherapy as an adjunctive approach to psychotherapy. Hypnotic methods of relaxation, ego strengthening, post-hypnotic suggestion, imagery for symbolism and ritual, and experience of the internal metaphysical relationship with the deceased are integrated. It is hoped that this paper will serve as a useful hypnotherapeutic model for clinicians and will stimulate further consideration of hypnosis as an intervention in this important area of practice.

Also, much is yet to be done in regard to research to investigate specific hypnotherapeutic interventions in facilitating successful mourning. This may include further study of supportive hypnotic suggestions, ego strengthening, and age progression. For example, it would be of interest to empirically determine whether age progression suggestions are of significant benefit to fostering greater adjustment for the mourning patient. Additional research may address certain aspects, and refine the present model of hypnotic intervention in grief and mourning.

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HYPNOSIS IN A CASE OF VOCATIONAL COUNSELLING

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Hypnosis was used with a client facing a difficult vocational decision. The client was a young woman who had made a series of vocational decisions in the past without fully understanding her own interests and needs. A variety of hypnotic techniques were used, including time projection, going to a special place, and listening to an older and wiser version of herself. Hypnosis was effective in developing self-confidence and relaxation, as well as enhancing self-awareness, enabling the client to make an appropriate vocational decision. Hypnosis is not often reported in the vocational counselling literature, but this case study demonstrates its efficacy.

Vocational counselling has several aims: (a) to enhance a client's self-awareness; (b) increase his or her knowledge of the world of work; and (c), to fit these two objectives together in order to allow the client to make appropriate vocational choices.

A variety of approaches and assessments have been developed to assist clients making career decisions (for a review see McMahon, 1992). Most of these interventions rely on various cognitive and behavioural procedures that examine a client's attitudes, values, problem-solving approaches, and thinking styles, and then matching these to the most pertinent career. Certain behavioural techniques are then prescribed, such as mock interviews, résumé writing, and sampling (Weiler, 1977). Several less conventional approaches have also been used in this area, such as Okiishi's (1987) family of origin work and Berne's (1970) transactional analysis theory. However, there are few, if any,

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references to the use of hypnotic techniques in vocational counselling. The following case study demonstrates one approach.

CASE HISTORY

Kate was a 23-year-old single female who presented to the first author for career counselling in a heightened state of confusion, anxiety, and uncertainty. She had been working as a trainee manager at an entertainment club for the past two years and disliked it intensely. She had recently applied for and been accepted into the police force and needed to reply to a letter of acceptance the day after her session. However, her family was concerned about her "giving up" her traineeship without finishing it and "wasting two years." In addition, friends had expressed much surprise in her applying for the police force, stating that her easy-going manner, love for spontaneity, and hatred of discipline and routine might not suit her to such a position.

A short history of her past education and career was obtained. Kate completed Year 12 with average marks, saying that she "didn't like to study." After school she obtained an apprenticeship as a chef and said that, while she found cooking was "okay," it did not really appeal to her, lacking the social contact she particularly enjoyed. She found the work increasingly boring and mundane, but finished her apprenticeship nevertheless. Following this apprenticeship she obtained the management traineeship. She was disappointed in this position because she found herself doing considerable amounts of paper and computer work. In addition, she found herself the only woman in a team of 12 male trainees and felt that she was not listened to or valued. She had clashed with senior management concerning dress rules and other general decision-making procedures.

Kate was finding it increasingly difficult to work at the club, a situation which had affected her emotionally and physically, with increased health problems in the past 12 months (such as colds and headaches). Kate reported being attracted to the police force because, "the dog squad would be good, or working with the horses." It appeared she had a very vague picture of life as a police officer.

In terms of past vocational decisions, Kate had entered into various careers without having adequately researched the actual position, or having a full understanding of her own desires, strengths, and interests. It also appeared that family pressures had affected her vocational decisions in the past.

Kate lived with two friends in a flat, had a boyfriend and an active social life. Her manner was gregarious and quickly paced; she tended to jump from subject to subject with great energy and enthusiasm. Kate appeared as a friendly, excitable, and interested young woman. She described herself generally as fit and healthy and had never been hospitalised. She had no history of psychiatric illness, nor did she present with any symptom that contraindicated hypnosis (e.g., psychotic illness, depression with suicidal component). Kate had no experience of hypnosis.

On presenting for therapy, Kate was extremely distressed, knowing that she had to make a decision soon, but was very unclear as to what she should do. She felt pulled by her family and friends and did not want to make "another bad decision."

Goals for Therapeutic Management

Kate's main aim was to make a decision regarding her vocational future, in particular to either accept or reject the police force. Together, we worked through what Kate hoped to achieve in this one session:

1. To feel calm and relaxed;
2. To increase self-confidence;
3. To enhance self-awareness about her abilities and likes;
4. To determine what was important to her, without the pressure of family and friends; and
5. To make a decision regarding the police force, and start the process of making long-term vocational decisions.

Treatment Plan

Hypnosis was included as part of the treatment plan for a variety of reasons. It was considered that the initial use of hypnosis would reduce anxiety and promote calm, rational decision making. Additionally, numerous hypnotic techniques have been used to facilitate self-exploration and insight (Wright, 1987) and it was thought that hypnosis would enhance self-awareness. In addition, given the short time frame, it would provide a means of making a vocational decision without the undue influence of others.

As we only had one session, I decided to use a number of techniques to achieve her goals in the hope that one, some, or all would be successful. I planned to use:

1. General information and education regarding the nature of hypnosis;
2. Progressive relaxation to reduce her autonomic arousal and level of anxiety;
3. Ego strengthening to build her self-esteem and confidence; and
4. Various procedures that aimed to enhance self-awareness.

The latter procedures were:

1. Taking her to a "special place" and receiving a "special message";
2. Meeting an older and wiser version of herself; and
3. Projecting herself into the future

TREATMENT

A careful explanation of hypnosis was undertaken. Trance was described as a state between fully awake and fully asleep, a "normal" state of focused attention rather like a daydream, where one is paying attention to what the therapist is saying, rather than to their own thoughts or things around them. It was further described that, when in trance, the conscious or critical mind is being occupied by a certain task, or is relaxed, so that the subconscious mind can be accessed more directly. Kate was happy with this explanation and somewhat relieved, stating "I have been thinking and talking too much about all of this" and was looking forward to exploring the issues in a different way.

Most of the items from the Betts Questionnaire Upon Mental Imagery (Sheehan, 1967) were used (the complete scale was not given because of time constraints) to determine specific imagery sensitivity. Kate had good visual and auditory vividness, but scored less on kinaesthetic items. She was congratulated on doing well on the scale and her ability to imagine the various scenes (increasing her expectancy). She was told the session would use suggestions that she naturally found easy. Consequently, the session concentrated on providing imagery based primarily on visual and auditory cues.

As Kate had presented in a jumpy and quickly paced manner, the induction consisted of a prolonged and explicit progressive relaxation technique. Because of her good imagery skills, Kate was invited to "see" her body become more and more relaxed and to "hear" it slowing down. For example: "See your breath move in and out, in and out, hear it moving slowly in and out, in and out."

Further deepening was then undertaken using a revolving-wheels fantasy (Watkins, 1986). This was chosen because of its strong auditory and visual images:

> You are in the country lying on a grassy slope. You notice in front of you a large old-fashioned wagon wheel. It is so close and so large that it almost fills your field of vision. As you stare at it you are very aware of the huge hub, the thicken oaken spokes and the iron rim around the outside edge. If you look closely at this iron rim you will notice that there are points of light in it embedded as if they were tiny light bulbs. In fact, there are seven such points of light evenly spaced around the rim of the wheel. Look at each one of them: The first. The second. The third. The fourth. The fifth. The sixth. And the seventh. Now focus your eyes on that seventh tiny point of light on the rim of the wheel. As you stare at it the wheel begins to slowly revolve . . . it seems as if there is a voice also coming from the wheel that keeps saying over and over again, "Deeper, deeper, deeper." And as the wheel turns and you follow that seventh point of light with your eyes, it goes around and around and around, and the voice keeps saying "Deeper, deeper, deeper . . . Around and around and around. Deeper, deeper, deeper." (p. 176).

This deepening technique finished with: "all the light is gone and all the voices are gone, and there is nothing left but a great soft warm darkness that fills the entire world, and you feel deeply at peace with the whole universe." (p. 177). It was felt important to have nothing left but a "soft warm darkness," given the range and complexity of the remaining techniques in the session.

Ego-strengthening suggestions, including affirmations and providing a feeling of "rightness," were directly provided, inferring that she did not need others to tell her what to do, with such statements as:

> tell yourself . . . every day I find myself calm, composed and tranquil . . . I am right, just the way I am . . . every day I will become and I will remain more and more completely relaxed . . . I will accept myself as self-confident and self-assured . . . feeling at ease with myself . . . I am right, just the way I am . . .

Various procedures were employed to enhance self-awareness, without the pressure of friends and family. The aim of these procedures was to tap into her unconscious mind so that she could find what she most needed to know at this time. The procedures were deliberately open-ended, without focusing directly on the immediate vocational decision she needed to make, so that she did not feel any overt or covert pressure to come up with an immediate answer. The aim and challenge of this part of the session was to make these various procedures cohesive, integrated, and even-flowing.

The client was directed to go to her "special place," a place of serenity, a place "that you've been to before or some special place that you find yourself in for the first time." I then provided the various sensory stimulatory suggestions that she could see and hear in this special place, so that she experienced it fully. The emphasis was on continued feelings of calmness and peacefulness. Then, using a model modified from Hammond (1990), Kate was told:

> . . . 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. With no effort on your part whatsoever, you will find that you may gain a new perspective, or you just find yourself reacting differently . . . or maybe, before awakening, you'll receive from your unconscious a special gift . . . that gives you the understanding or the perspective or the feelings that you most need right now . . . just let it happen . . .

Some time was spent in this serenity place. Kate was then asked to stay in her special place and for her to meet a special person, a very grand visitor. Working with inner advisers or guides is a popular therapeutic technique used by many therapists (Zilbergeld & Hammond, 1988). While many advisers are usually "a reflection of your inner life" (Bresler, 1990), Maybery (1996) suggested using the adviser as the client "but wiser and older." Again, Kate was asked to visualise and to listen to this visitor, an older and wiser version of herself. Kate was then asked to report to the older version of herself what she had learnt from going into her serenity place. The older, wiser Kate was then asked to tell her what she had learnt about her life and what was important to her. The aim of this part of the session was twofold:

1. To help Kate articulate what she had found in her serenity place; and
2. To provide additional insight into what might be important for Kate to know about herself and her future.

Kate was then asked to leave her special visitor and her special place and to let herself drift across time and space to sometime in the future, "bringing these wonderful feelings, and this sense of perspective with you." She was asked to:

> picture yourself sometime in the future . . . at no specific time . . . but at some time further on from the present . . . it may be in two years time, it may be five, [the implication being that it will be either of these two times], your unconscious mind will let you know . . . and, one morning . . . in the

> future . . . you wake up . . . the ideal, perfect, and happy you . . . at peace with yourself and the world . . . happy with who you are and where you are . . .

The day then progresses with various sensory questions (again, visual and auditory) being asked at different times of the day, for example: "What does it look like, your early morning routine? What are the sights you can see? The colours, the light? What are the early morning sounds that are around you? Are there machines, the sounds of nature, or soft silence?" The day continues with no direct mention of work, but rather of activity, ". . . whatever feels right, proceed to do whatever you most want to do, during the day . . . your perfect day in the future . . ." Throughout the session the tone was highly permissive and indirect and considered total lifestyle perceptions, rather than work issues alone.

Kate was given time to recollect everything that had occurred in the session, and to feel calm and relaxed with the images she had experienced. After bringing her out of hypnosis, we concluded the session, discussing how she felt about the various aspects of the experience.

OUTCOME

At the conclusion of this session, Kate appeared at ease and relaxed, a marked change from her appearance on arrival. She said that she had learnt more about herself and her priorities, namely, that she needed creativity, flexibility, variety, and a sense of purpose in her everyday activities. Working alongside other people was another strong value that she was now able to articulate in terms of work requirements. In terms of the final goal, Kate reported that neither the police force nor the traineeship had featured in any of the processes used. Instead, she had a vague as yet unclear picture of working with lots of people around her, in a relaxed, friendly, and "somehow creative" atmosphere. Kate had a strong picture of herself in the future being outside, surrounded by lots of light and lots of people, having fun and laughing, in a relaxed and casual atmosphere. In the short term, this meant that while she was confident and sure about rejecting the police force she would also be looking for other work besides her current traineeship. Kate recognised that she needed to work further in clarifying and articulating her vocational direction but felt that in the short term at least she was making the right decision.

CONCLUSION

Hypnosis was found to be a useful vocational decision making strategy in this case. It was a useful technique for reducing anxiety, helping the client become more relaxed and self-confident. It then provided a means of exploring the desires of a client within a holistic lifestyle perspective, enhancing self-awareness. Finally it increased knowledge of work and life options through creative visualisation of future possibilities. Applying hypnosis to the field of vocational counselling appeared to have considerable merit.

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The Effects of an Educational Lecture About Hypnosis

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A group of 45 undergraduate students who had been exposed to an educational lecture about hypnosis were compared with a control group of 32 students who did not attend the lecture. Approximately nine months after the lecture, students were given a range of attitude and belief questionnaires together with the Harvard Scale of Hypnotic Susceptibility. The results showed that lecture exposure was associated with significantly higher hypnotisability scores. No similar benefits to hypnotisabiltiy scores were found when previous experience with hypnosis or exposure to stage or television hypnotic performances were considered. The results were considered in terms of the mediating effects of attitudes and beliefs with a special focus on expectancy effects and the theory of reasoned action.

INTRODUCTION

Many theorists have suggested that hypnotisability is a modifiable trait. In 1986 Gorassini and Spanos developed a skills-training programme called the Carleton Skills Training Package (CSTP) to train subjects of a low or medium level of hypnotic susceptibility to respond more fully to hypnotic suggestions. The CSTP is probably the best researched of the packages available (Spanos, Burgess, Roncon, Wallace-Capretta, & Cross, 1993). Spanos suggested that administration of the CSTP results in gains in both behavioural and subjective indexes of hypnotisability (Spanos et al., 1993). Other researchers (Bates & Brigham, 1990; Bates, Miller, Cross, & Brigham, 1988; Gfeller, Lynn, & Pribble,

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1987) strongly disagreed with this claim, showing that while objective hypnotic susceptibility scores increased as a result of administering the CSTP, subjective scores did not, indicating that "behavioral compliance, not hypnotic ability is enhanced by the CSTP" (Bates & Brigham, 1990, p. 193). Gibson and Heap (1991) suggested that the process used in training programmes such as the CSTP could be compared to providing subjects with the correct answers for an intelligence test, then training them to elicit these answers when tested.

Shor, Orne, and O'Connell (1966) introduced the concept of plateau hypnotisability to explain the fact that increased expectancies about hypnotic responsiveness can slightly increase a subject's hypnotisability levels. Plateau hypnotisability is defined as "the maximum hypnotic depth achieved in as many intensive hypnotic training sessions as the experimenter needed in order to feel confident that a stable plateau in the subject's hypnotic performance had been reached" (Shor et al., 1966, p. 82). This indicates that although hypnotisability levels can alter somewhat with experience and demystification, hypnotisability in itself is a relatively stable trait (Bowers, 1976).

Gfeller (1994) suggested that although many still conceptualise hypnotisability as a stable trait, research evidence is leading to the conclusion that hypnotisability might be more usefully viewed as a configuration of attitudes and skills which are not only modifiable, but are "strongly influenced by contextual factors" (Gfeller, 1994, p. 107).

Despite the debate, hypnotisability has been generally shown to be a stable trait over time, with little variation between situations. A correlation of .60 was found by Morgan, Johnson, and Hilgard (1974) when testing the same subjects for hypnotisability over a period of 10 or more years, and with testing carried out by different hypnotists. Piccione, Hilgard, and Zimbardo (1989) carried out a longitudinal study which involved measuring the hypnotisability levels of the same subjects at 10, 15 and 25 year intervals. They found that levels of hypnotisability remained significantly similar at each stage of re-testing.

Self-Predictions of Hypnotisability

Melei and Hilgard (1964) found that when subjects who had not been previously hypnotised were asked to predict their level of hypnotisability, most were uncertain about how they would respond and were also very inaccurate in their predictions about their susceptibility. There was a very small positive correlation between positive attitudes towards hypnosis and the ability to

correctly predict hypnotisability levels. Subjects who had previous experience with hypnosis were more likely to correctly predict their levels of hypnotisability than subjects who had not had any previous hypnotic experience.

Katsanis, Barnard, and Spanos (1988) gave subjects a brief explanation of the suggestions they would be asked to respond to while hypnotised, and then asked them to predict the manner in which they would respond. Subjects tended to overestimate their level of response; however, Spanos, Gabora, and Hyndford (1991) also found a moderate correlation between hypnotisability and subject expectations of susceptibility.

Spanos et al. (1991) found that subjects generally predicted their levels of hypnotisability more accurately post-induction than pre-induction. Subjects who had high expectations about their level of hypnotic responding actually had hypnotic susceptibility levels which varied between low, moderate, and high. Subjects who had expectations that they would only have a low level of hypnotic responding did not attain anything above moderate levels of hypnotisability.

Kirsch (1985) discussed the effect of response expectancy on the modification of hypnotisability. He outlined three types of cognitions, which he believed affect response expectancies in hypnotic situations. These were: (a) perceptions of the situation as more or less appropriate for the occurrence of hypnotic responses; (b) perceptions of the response as being appropriate to the role of a hypnotised subject; and (c) judgments of one's hypnotisability. Kirsch believed that both the effectiveness of hypnosis, and the response of the person being hypnotised, relied first and foremost on the person's expectancies of, and beliefs about hypnosis, including expectancies which they held about how susceptible they would be to hypnosis. He reported findings from a number of studies (Gregory & Diamond, 1973; Saavedra & Miller, 1983; Vickery & Kirsch, 1985) which indicate that altering subject expectancy about level of susceptibility to hypnosis accounted for more of the variance than the concept of "stable trait" hypnotisability. Kirsch (1985) suggested that evidence for the stable trait theory of hypnotisability was based on studies in which the response expectancies of subjects were held relatively stable across test-retest situations. For Kirsch, subjects' expectancies represent the primary determinant of hypnotic responsiveness (De Groh, 1989).

Gearan and Kirsch (1993) concluded that changes in hypnotisability brought about by the administration of the Carleton Skill Training Package (CSTP) were based purely on changes in expectancy which the administration of the CSTP induced. They reported that when changes in expectancy after

the administration of the CSTP were controlled, no significant differences between the trained and control groups were found.

Observations of and Education about Hypnosis

A few studies have focused on the impact which stage hypnosis had on audience members. Generally, audience members in these studies had not been exposed to hypnosis as part of a treatment programme, and had not been given any accurate information about hypnosis (e.g., Echterling & Emmerling, 1987; Meeker & Barber, 1971).

Early studies reported that stage hypnosis had a very negative impact on audience members (Meeker & Barber, 1971). Stage hypnosis was found to be lacking in proper de-briefing of subjects and did not include correct handling of abreactions of participants or audience members (Kleinhauz, Dreyfuss, Beran, Goldberg, & Azikri, 1979).

Large and James (1991) found that none of their subjects was left with a positive attitude towards hypnosis after either observing a live stage hypnosis performance or viewing a stage hypnosis performance on television. The two central areas of concern were loss of control and the potential that the hypnotist might withdraw secrets from the subjects. Echterling (1988), and Echterling and Emmerling (1987), noted that observing stage performances of hypnosis often left an audience believing that the hypnotic subject is completely under the control of the hypnotist.

Echterling and Emmerling (1987) found that although stage hypnosis is presented as entertainment, it does have a therapeutic effect on a number of people present. Most of the audience enjoyed watching the hypnosis performance and most of the people who actually participated in the performance were found to have positive after-effects such as having a good night's sleep, obtaining self-insight, thinking more constructively, and feeling more relaxed. Approximately one-fifth of the subjects had negative experiences both during and after the performance, for example, feeling embarrassed and scared, "spacing out occasionally" for a long time after the performance, to the point where comments were made by others, falling into a "trance" state while listening to the radio days after the performance, being in a manic state which included being unable to sleep or concentrate for hours afterwards, laughing with no reason for a long time after the performance, and remembering memories previously repressed. The authors concluded that despite its entertainment value and the potential positive effects which it may have for

some individuals, the risks stage hypnosis pose for some subjects and audience members may be too great to warrant its use.

Coe, Peterson, and Gwynn (1995) provided one group with no information about the possible negative reactions to hypnosis, a second group received vague warnings about after-effects which might be "mildly unpleasant" but usually are "pleasurable and interesting," and a third group was given specific warnings about a number of possible negative after-effects of being hypnotised. Both the vague and the specific warnings about potential negative effects reduced the subjects' responsiveness to hypnosis. Coe et al. suggested that warnings about negative experiences or reactions during or after hypnosis might decrease the willingness of some subjects to cooperate with the experience. This has implications for the conduct of research studies since this finding conflicts somewhat with the normal requirement to provide fully informed consent to research participants.

In 1995, Echterling and Whalen looked at the influence of a public lecture on hypnosis on the attitudes and beliefs of audience members. They compared attitudes towards hypnosis of subjects who had attended a lecture in hypnosis, and subjects who had attended a stage hypnosis show (Echterling & Whalen, 1995). They assessed their subjects both before and after the hypnosis lecture and stage hypnosis experiences and found that "attitudes, beliefs and motivation regarding hypnosis are malleable" (p. 18).

In summary, the literature review suggested that hypnotisability seems to be at least somewhat modifiable, people are not necessarily good predictors of their own hypnotisabilty, expectancy factors are very important determinants of hypnotisability, observation of stage hypnosis may generate negative after-effects, and very little is known about the potential positive effects of the provision of educational material about hypnosis.

THE PRESENT STUDY

Ajzen and Fishbein (1980) have shown that attitudes and social behaviour can be understood through a theory of "reasoned action." They described how a causal sequence of behaviour, which stems from an individual's beliefs and attitudes, moves on from this to what that individual considers to be the "social norm," then to the intention behind the individual's behaviour, and finally to the individual's behaviour itself (Sarver, 1983). The intention to either perform or not perform a specific behaviour or behavioural sequence is the "immediate determinant" of the final behaviour (Ajzen & Fishbein, 1980).

A combination of the logic behind Ajzen and Fishbein's theory of reasoned action and Kirsch's notion of the central role of expectancy effects suggested a number of experimental hypotheses.

1. An educational lecture in hypnosis might have a variety of positive effects. Lecture-exposed subjects will have more accurate knowledge about hypnosis, as well as more positive attitudes and realistic beliefs towards hypnosis. They will be less likely to subscribe to the myths and misconceptions surrounding hypnosis and, therefore, less likely to be fearful of the possible effects of hypnosis. These subjects would be less likely to inhibit their hypnotic responsiveness and should, therefore, display higher levels of hypnotisability than a non-informed group.
2. Subjects who have had previous clinical experience with hypnosis will be more positive and realistic in their attitudes towards hypnosis. This should result in higher hypnotisability scores than in those subjects without previous clinical experience of hypnosis.
3. Subjects who have at some time in their lives observed or participated in a hypnosis performance will have less accurate knowledge about hypnosis, and will possibly hold less positive attitudes towards hypnosis, than those who have not observed a hypnosis performance. These subjects will be likely to subscribe to certain of the myths regarding hypnosis. This is likely to result in lower hypnotisability scores than for comparable people who have not observed a hypnotic performance.

METHOD

Subjects

The subjects were undergraduate students from the disciplines of psychology, nursing, physiotherapy, and education at the University of South Australia. Subjects were separated into two groups: those who had or had not received accurate information about hypnosis in the form of a lecture in hypnosis. The lecture was given as a routine part of an introductory psychology subject.

There were 77 subjects aged between 17 and 55. The mean age for the subject group was 24 years (*SD* = 9.00). Nine subjects were male (12%) and 68 subjects were female (88%).

Forty-five subjects received the lecture in hypnosis and 32 subjects did not. The lecture group consisted of five males (11%) and 40 females (89%). The mean age of this group was 26 (*SD* = 9.97), with an age range of 17–55. The

group who did not receive a lecture was made up of four males (12.5%) and 28 females (87.5%). The mean age of this group was 22 (*SD* = 6.72), with an age range of 17–43.

Measures

Standardised Scales The Attitudes Towards Hypnosis Scale (ATHS) (Spanos, Brett, Menary, & Cross, 1987) was used. This is a 14-item questionnaire which measures attitudes towards, and beliefs about, hypnosis. Measures are taken along three independent dimensions: (a) positive beliefs about hypnosis; (b) an absence of fear concerning hypnosis; and (c) beliefs about the mental stability of hypnotisable people (Spanos et al., 1987).

Subjects were administered the Harvard Group Scale of Hypnotic Susceptibility, Form A (Shor & Orne, 1962).

Additional Measures A simple, 3-question Hypnosis Beliefs Scale (Appendix) was devised, which asked subjects to use 12-point scales to nominate: (a) their level of interest in trying hypnosis, (b) their prediction about how susceptible they would be to hypnosis; and (c) the degree to which they would like to be susceptible to hypnosis. A 12-point scale was used to allow easy comparison with the 12-point hypnotisability rating of the Harvard Group Scale of Hypnotic Susceptibility.

Subjects were asked seven true/false Hypnosis Questions (Appendix). These questions were based on the hypnosis lecture given to some of the subjects. They were designed to ascertain whether the subjects who attended the hypnosis lecture had retained the information provided and whether there was any difference between the knowledge about hypnosis of those subjects who did receive a lecture in hypnosis and those subjects who did not. An additional question asked whether subjects had seen a stage hypnosis performance either live or on television.

Procedure

Nine months after the hypnosis lecture presentation, volunteer subjects were recruited via very brief presentations given at the beginning of large first-year undergraduate classes.

The university ethics committee required the presence of an independent psychologist to talk with any subjects who might have queries about any aspect of the study and that subjects were provided with an information sheet

which outlined the possible negative after-effects which might occur as a result of induction.

Subjects signed a consent form, completed the series of questionnaires and were then administered the Harvard Group Scale of Hypnotic Susceptibility. This was followed by a general discussion about the subjects' experience of hypnosis.

RESULTS

Influence of Attendance at the Hypnosis Lecture

There were no significant differences between the two groups in terms of age (t (75) = 1.92, p = .06), sex (χ^2 (1) = .03, p = .85), the incidence of previous hypnotic experience (χ^2 (1) = 1.08, p = .30), or the likelihood of having attended a hypnosis performance (χ^2 (2) = .75, p = .69).

Table 1 provides data about the influence of attendance at the hypnosis lecture on a range of dependent variables.

Influence of Previous Experience with Hypnosis

Male and female subjects were found to be equally likely to have previously

Table 1: The Influence of Attendance at the Hypnosis Lecture.

Dependent variables	Lecture *M (SD)*	No lecture *M (SD)*	*t*	*p*
Attitudes Towards Hypnosis Scale				
Positive beliefs about hypnosis	27.98(6.22)	24.75(6.23)	2.23	.05
An absense of fear concerning hypnosis	26.73(7.26)	21.56(5.38)	3.40	.001
Beliefs about the mental stability of hypnotisable people	25.78(2.88)	24.28(3.41)	2.08	.05
Hypnosis Beliefs Scale				
How interested are you to try hypnosis?	9.60(3.63)	8.81(3.46)	.96	.34
How susceptible do you think you will be to hypnosis?	6.87(2.33)	6.03(1.89)	1.67	.10
How susceptible would you like to be to hypnosis?	9.51(2.85)	8.34(2.74)	1.80	.08
Hypnosis Questions total score	6.02(1.18)	3.75(1.59)	7.22	.0001
Harvard Group Scale score	7.82(2.93)	6.50(2.74)	2.01	.05

experienced hypnosis (χ^2 (1) = .08, p = .77). No significant difference in age was found between the group who had been previously hypnotised (M = 27.00, SD = 7.07), and the group who had no prior experience with hypnosis (M = 23.69, SD = 9.24) (t (75) = 1.13, p = .26).

Table 2 provides data about the influence of previous experience of hypnosis on a range of dependent variables.

Influence of Previous Observation of a Hypnosis Performance

Table 2: The Influence of Previous Experience of Hypnosis

Dependent variables	Hypnotised previously *M (SD)*	Not hypnotised previously *M (SD)*	*t*	*p*
Attitudes Towards Hypnosis Scale				
Positive beliefs about hypnosis	28.18(6.13)	26.35(6.44)	.88	.38
An absence of fear concerning hypnosis	30.00(5.22)	23.62(6.85)	2.94	.005
Beliefs about the mental stability of hypnotisable people	25.27(3.20)	25.14(3.20)	.13	.90
Hypnosis Beliefs Scale				
How interested are you to try hypnosis?	8.73(4.61)	9.36(3.39)	–.55	.59
How susceptible do you think you will be to hypnosis	8.00(2.57)	6.27(2.04)	2.51	.05
How susceptible would you like to be to hypnosis?	9.91(1.87)	8.88(2.96)	1.11	.27
Hypnosis Questions total score	6.18(1.17)	4.89(1.78)	2.31	.05
Harvard Group Scale score	7.36(3.04)	7.26(2.91)	.11	.91

Table 3 shows the effect of previous observation of a hypnotic performance on a range of variables.

Harvard Group Scale Relationships

Female subjects scored significantly higher than male subjects in levels of hypnotisability (t (75) = –2.05, p <.05) (male M = 5.44, SD = 3.17; female M = 7.51, SD = 2.81).

Table 4 shows correlations between the Harvard Group Scale and a range of other measures.

Table 3: The Influence of Previous Observation of a Hypnotic Performance

Dependent variables	Hypnotic performance observed *M (SD)*	No Hypnotic performance observed *M (SD)*	*t*	*p*
Attitudes Towards Hypnosis Scale				
Positive beliefs about hypnosis	27.29(6.01)	25.30(7.02)	1.30	.20
An absence of fear concerning hypnosis	23.57(6.90)	26.00(6.81)	-1.45	.15
Beliefs about the mental stability of hypnotisable people	25.18(2.84)	25.04(3.79)	0.19	.85
Hypnosis Beliefs Scale				
How interested are you to try hypnosis?	9.59(3.42)	9.00(3.55)	.71	.48
How susceptible do you think you will be to hypnosis?	6.88(2.04)	5.82(2.34)	2.06	.05
How susceptible would you like to be to hypnosis?	8.80(3.01)	9.41(2.58)	-.89	.38
Hypnosis Questions total score	4.84(1.86)	5.84(1.53)	-1.53	.13
Harvard Group Scale score	7.33(3.02)	7.15(2.80)	.25	.80

Hypnosis Beliefs Scale Relationships

Greater accuracy in responses to the Hypnosis Questions (total score) was

Table 4: Correlations with the Harvard Group Scale

	r	*p*
Attitudes Towards Hypnosis Scale		
Positive beliefs about hypnosis	.38	.001
An absence of fear concerning hypnosis	.33	.005
Beliefs about the mental stability of hypnotisable people	.35	.005
Hypnosis Beliefs Scale		
How interested are you to try hypnosis?	.07	.54
How susceptible do you think you will be to hypnosis?	.39	.0001
How susceptible would you like to be to hypnosis?	.38	.001

associated with higher predictions of hypnotic susceptibility ($r(77)=.28$, $p<.01$).

Interest in hypnosis (item 1 of the Hypnosis Beliefs Scale) did not show any significant relationships with other variables.

Hypnotic susceptibility predictions (item 2) were higher for people who correctly identified the statement: "People can bring themselves out of hypnosis" as true (t (75) = -2.29, p <.05) (correct response M = 6.90, SD = 2.30; incorrect response M = 5.72, SD = 1.70).

Desired level of hypnotisability (item 3) was higher for people who correctly identified the statement: "A person is not conscious when hypnotised" as false (t (75) = -2.04, p <.05) (correct response M = 9.25, SD = 2.50; incorrect response M = 7.13, SD = 4.76), for people who correctly identified the statement: "People of lower intelligence are more easy to hypnotise" as false (t (75) = -3.73, p <.0001) (correct response M = 9.29, SD = 2.51; incorrect response M = 4.25, SD = 4.72) and for people who correctly identified the statement: "People typically forget what they experience in hypnosis" as false (t (75) = -2.64, p <.01) (correct response to M = 9.67, SD = 2.44; incorrect response M = 7.97, SD = 3.19).

DISCUSSION

Influence of the Hypnosis Lecture on Subject Responses

Before assessing differences between lecture-exposed and lecture-naive groups, an initial task was to determine whether the messages contained in the lecture had been retained by the audience who were participants in the present experiment some nine months after the lecture presentation. The evidence for this is that lecture-exposed subjects answered the seven Hypnosis Questions (based on the information provided at that lecture) significantly more accurately than the subjects who had not attended the lecture.

The first important finding from this study is that the provision of accurate information about hypnosis led to a small but significant increase in the hypnotisability scores of subjects. This result can best be explained by the research which indicates that subjects who have been given accurate information about hypnosis will be less likely to subscribe to the myths surrounding hypnosis, less likely to be fearful of the possible affects of hypnosis, less likely to try to block their hypnotic responsiveness (Echterling & Whalen, 1995), and will have an altered perception of hypnotisability and a corresponding willingness to respond to hypnotic suggestions (Echterling, 1988; Saavedra & Miller, 1983). These subjects are more likely to reach their level of plateau hypnotisability than subjects who have not received accurate information about hypnosis, who are therefore more likely to be reticent to respond to hypnotic suggestions to their full potential.

The explanation that improved hypnotisability scores might have been mediated by attitudinal factors is supported by the finding that the lecture-exposed subjects had significantly more positive attitudes towards hypnosis than those subjects who had not been given the lecture. They held more positive beliefs about hypnosis, had less fear of hypnosis, and held fewer stereotypical/negative beliefs about the mental stability of hypnotisable people.

These results complement the findings of Large and James (1991), who found that after being given accurate information about hypnosis, subjects who had previously expressed negative attitudes towards hypnosis stated that they felt more positive about both hypnosis in general and the possibility of trying hypnosis for the relief of pain symptoms. The current finding indicates that accurate information about hypnosis can have a positive effect on potential subjects not only when it is provided in a one-on-one setting as in the Large and James (1991) study, but also when more general information about hypnosis and the common misconceptions about hypnosis is presented in the form of a lecture to a large group of people.

Influence of Previous Experience with Hypnosis on Subject Responses

Self-predicted hypnotisability scores were higher for subjects who had previously been hypnotised than for subjects who had no previous experience with hypnosis. This finding is not unexpected since previous experience should allow confidence about predictions of future experience. However, actual hypnotisability scores did not differ between those subjects who had previously experienced hypnosis and those who had not.

As expected, subjects who had previously experienced hypnosis reported significantly less fear than subjects who had no previous experience with hypnosis (second dimension of the Attitudes Towards Hypnosis Scale).

Subjects who had been previously hypnotised scored significantly higher in the accuracy of their responses to the Hypnosis Questions overall. This finding was anticipated because subjects who have been hypnotised in the past are more likely to have an accurate concept of hypnosis and hypnotisability than naive subjects.

xPrevious Observations of Stage or Television Hypnosis Performance

Viewing a hypnosis performance on stage or on television was found to have a significant impact on subjects in terms of their responses to the item: "How susceptible do you think you will be to hypnosis?" from the Hypnosis Beliefs Scale. Subjects who had seen a hypnosis performance of some kind predicted that their hypnotisability scores would be significantly higher than those subjects who had not attended a hypnosis performance.

Since stage hypnosis incorporates immediate and dramatic demonstrations of high levels of subject hypnotisability (Echterling, 1988), people who view stage or television hypnosis performances may be likely to overestimate the ease with which people tend to respond to hypnotic suggestions, as was found in this study.

Despite expectations about higher hypnotisability levels in subjects who had observed a hypnosis performance, subjects who had viewed a hypnosis performance did not differ in terms of actual hypnotisability scores from subjects who had not viewed a hypnosis performance.

Having previously viewed either a stage or televised hypnosis performance was not found to have a significant influence on the way in which subjects completed the Attitudes Towards Hypnosis Scale.

No significant relationships were found between the viewing of a hypnosis performance and subjects' responses to the Hypnosis Questions. This was not what was anticipated, given the literature which suggested that people who have viewed a hypnosis performance are more likely to subscribe to misconceptions regarding hypnosis (Echterling & Emmerling, 1987).

However, this finding supports the notion that attending a hypnosis performance does not in any way educate subjects about the reality of hypnosis. If hypnosis performances educated people about hypnosis, subjects who had attended hypnosis performances should have responded more accurately to the Hypnosis Questions than subjects who had not attended such performances.

The findings highlight a considerable difference between the hypnosis lecture, which significantly increased the subjects' levels of accurate knowledge about hypnosis, and observation of previous stage hypnosis performances, which resulted in no such increases in knowledge (possibly because the main aim of stage hypnotists is to entertain, rather than educate).

Harvard Group Scale Relationships

There was clear evidence that the attitudes which people hold towards hypnosis impact to some extent upon their hypnotisability levels. Total hypnotisability scores were found to have a significant positive relationship with all three dimensions of the Attitudes Towards Hypnosis Scale. These three dimensions are: (a) positive beliefs about hypnosis, (b) an absence of fear concerning hypnosis, and (c) beliefs about the mental stability of hypnotisable people (Spanos et al., 1987, p. 139). These results can be understood using the concept of plateau hypnotisability where more positive and realistic attitudes towards hypnosis allow people to respond at their optimal level to hypnotic suggestions.

The Hypnosis Beliefs Scale items showed that while interest in trying hypnosis was not associated with actual hypnotisability scores, there were strong positive associations between desired level of hypnotisabiltiy and actual levels, and between predicted levels of hypnotisability and actual levels. These associations were stronger than would have been predicted by the earlier study of Melai and Hilgard (1964).

Female subjects were found to have significantly higher hypnotisability scores than male subjects. Gibson and Heap (1991) have stated that although there is reluctance in the literature to report sex differences in hypnotisability, females do tend to have slightly higher levels of susceptibility to hypnosis than males. They cited a number of studies which found a slight, but significant, tendency for female subjects to score higher on hypnotisability measures than male subjects.

Hypnosis Beliefs Scale Responses and Hypnosis Questions Responses

Hypnotisability levels were positively related to knowledge about hypnosis. Both predicted level of hypnotisability and desired level of hypnotisability were higher for better informed people. These findings underscore the importance of adequate education about hypnosis.

The more knowledge a subject had about hypnosis, and in particular the degree to which they understood that subjects can bring themselves out of hypnosis, the more likely they were to predict that they would respond at a higher level to hypnotic suggestions. These findings support the suggestion that accurate information about hypnosis allows subjects to respond to

hypnotic suggestions at their most optimal level or their level of plateau hypnotisability (Bowers, 1976).

Analysis of particular items which affect desired level of hypnotisability further highlighted the importance of correcting myths and misconceptions prior to any clinical hypnosis intervention. High desired hypnotisability levels were associated with the knowledge that (a) people are not unconscious when hypnotised, (b) easy hypnotisability is not related to low intelligence and (c) people can remember most of what occurs while they are hypnotised (items from the Hypnosis Questions).

Taken together, the findings from the present study provide evidence for the position long taken in good quality training programmes that potential clients should receive adequate information prior to the use of hypnosis since client responsiveness is likely to be affected.

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APPENDIX

Hypnosis Beliefs Scale

Please read the following questions carefully and then circle the most appropriate response for you. Please respond to each question.

How interested are you to try hypnosis?

Very Uninterested			Uninterested			Somewhat Interested			Interested		Very Interested
1	2	3	4	5	6	7	8	9	10	11	12

How susceptible do you think you will be to hypnosis?

Very Low Susceptibility			Low Susceptibility			Susceptible			High Susceptibility		Very High Susceptibility
1	2	3	4	5	6	7	8	9	10	11	12

How susceptible would you like to be to hypnosis?

Very Low Susceptibility	Low Susceptibility	Susceptible	High Susceptibility	Very High Susceptibility

Hypnosis Questions

Below are some statements about hypnosis. Indicate whether you believe each statement is true or false by circling the appropriate response. Please attempt to circle a response for each question. If you are unsure of the answer, make a guess.

1.	A person is unconscious when hypnotised.	TRUE	FALSE
2.	People of lower intelligence are more easy to hypnotise.	TRUE	FALSE
3.	People typically forget what they experience in hypnosis.	TRUE	FALSE
4.	Hypnosis is a form of sleep.	TRUE	FALSE
5.	People can bring themselves out of hypnosis.	TRUE	FALSE
6.	During hypnosis, people surrender all control to the hypnotist.	TRUE	FALSE
7.	In some cases, blood vessels can be controlled under hypnosis so that bleeding can be started or stopped.	TRUE	FALSE
8.	Have you ever seen or participated in a live or televised hyopnosis performance?	YES	NO

If yes, please briefly describe your experience with stage hypnosis

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Case Notes

The aim of Case Notes is to enable readers to contribute brief items and case material drawn from their own experience. These may be case situations in which hypnosis has been used in treatment or a description of specific hypnotherapeutic techniques used within treatment contexts. The contributor is asked to supply as much information as is needed to ensure the reader has an understanding of the situation, the therapeutic aims of the hypnosis, and outcomes. It 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.

Improvised Self-Hypnosis for Childbirth

Wendy-Louise Walker
Psychologist

My clients never cease to surprise and delight me with their inventiveness. The case of Sally's use of self-hypnosis for childbirth is an example.

I had counselled Sally and her family when she was a little girl of 12 years. She was of superior intelligence but suffered cognitive defects of minimal brain dysfunction, probably due to a very difficult birth. Her upper-middle class parents were enmeshed on constant conflict, her little sister played the "good girl," while Sally was the family rebel.

She returned to see me at 28 years of age, having survived all manner of risk-taking in her teens and some periods of stormy romances and ensuing patches of depression in her young adulthood. She was having difficulty concentrating and keeping her temper at work, and her boyfriend had just left

Wendy-Louise Walker, PO Box 262, Croydon, N.S.W. 2132.

her. She remembered me one night and the next day she made an appointment to see me.

I agreed to see Sally once a fortnight, feeling she needed supportive psychotherapy for a while and needed some more effective coping skills. Her strengths were evident as well as her problems: a deep capacity for affection; tolerance and forgiveness; a capacity to laugh at herself; and the courage to engage in self-scrutiny. I pointed these out to her in the first session.

I saw Sally for the next six months, with one-hour appointments every two or three weeks. We dealt with here-and-now issues, discussed relationships, and set plans in the waking state. We used hypnosis every session to learn skills such as coping with anxiety, stopping pointlessly worrying thoughts, and simply feeling serene. Sally was maximally hypnotisable, with a score of 12 on the Stanford Form C. I tape-recorded each hypnotic session for Sally and these tapes eventually provided her with a personal stress management library.

For induction, I mostly used words woven in and above music, the music providing a focus for attention and a pathway into hypnosis in its own right, and the words comprising another pathway, defining the end-state of hypnosis and giving guidance along the way for how to get there. Some of my hypnotic words included suggestions that, as she allowed her moving pathway of music to carry her into hypnosis, into beautiful spaces of her own mind, she would relax as she breathed in . . . relax as she paused . . . and when she breathed out, she would breathe out through her skull and this too would take her further along her pathway. (The notion of "breathing out through your skull" I learned from June Jackson when we ran a joint workshop on music and hypnosis for the ASH Congress at Broadbeach in 1986 and many of my hypnotic subjects find it a very facilitating concept.)

Over the time I was seeing Sally, she was reconciled with her boyfriend, got pregnant, and married him. It was a very complicated pregnancy and the obstetrician told Sally that the baby would be delivered by caesarean. With this firm expectancy, Sally did not even attend childbirth classes, reasoning that it would only make her feel sad.

Sally had great problems with hypertension during the pregnancy, as had her mother and her aunts, but continued to see me and use the audiotapes for general relaxation and coping. Just before the baby was due, Sally phoned me in a panic to say that her specialist was overseas and that a new obstetrician had decided the baby would be born naturally. She had no idea how to cope with this and ultrasound had shown a very big baby.

We talked on the phone for about half an hour and I said that, if she came to see me the next day, we would muddle along and make up some kind of hypnotic childbirth package for her delivery. I told her some facts about childbirth and general ways of coping, gave a sketchy outline of the role of breathing and told her that, with her hypnotic gifts, she had undoubted ability to dissociate from pain but maintain other sensations. Sally felt reassured (though I felt rather stressed) and she ended the conversation happily.

Sally came into labour that night and the baby was born after 14 hours labour, so Sally did not get her session on how to use her hypnotic skills to cope with the delivery of her very large and healthy baby girl. However, when I visited her in hospital, Sally told me that she had not suffered at all during the delivery and that everyone — her fear-ridden husband, the obstetrician, the nurses and, later, her mother and father — had been very surprised at the calm and competent manner of her coping during labour. Sally said her memory of the labour and delivery was rather fuzzy, "just like a dream, but pleasant."

A couple of months later we decided to use hypnosis, as Sally was feeling rather frazzled with the feeding demands of the baby and the effects of her own disrupted sleep. She was floating into hypnosis with a haunting piece of J. S. Bach when I noticed tears running down her face. Without interrupting the music, I asked Sally why there were tears.

She told me they were tears of joy. Back in hypnosis she remembered with great vividness the whole experience of childbirth. She had been very frightened when she arrived at the hospital and, as she walked in, had told herself to "breathe out through her skull" a few times and had apparently spent the ensuing hours in trance, responding to instructions but experiencing no pain. In hypnosis with me, she remembered no pain and I did not try to delve for any "hidden observer" who may have monitored that pain. Before we ended the hypnotic session I bridged that experience across to the waking state, telling Sally that the experience of the birth of her little girl would now definitely be available to conscious memory. I had her recall it all again in the waking state to reinforce this.

Sally had built herself an hypnotic coping package based on her experience of hypnosis with me and the tapes and scraps of information I had given her during our chat on the phone the night before the baby was born.

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