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## **HYPNOSIS IN AUSTRALIA 40 YEARS AGO: RECOLLECTIONS OF GORDON HAMMER, MARTIN ORNE, AND PHILIP SUTCLIFFE**

Campbell Perry  
*Professor Emeritus of Psychology*  
Concordia University, Montréal

*Between December 1999 and August 2000, Australian hypnosis lost three of its major contributors — A. Gordon Hammer, Martin T. Orne and J. Philip Sutcliffe. I knew all of them well, and was deeply influenced by their thinking from the time that I began as a research student at the University of Sydney Psychology Department in 1960. This article seeks to describe their contributions to the field, and to share with readers some of their personal qualities that made knowing them such a delight.*

In the space of less than eight months, the field of hypnosis in Australia lost three of its most incisive contributors. A. Gordon Hammer died in December 1999, followed by Martin T. Orne in February 2000, and early last August, there was the added loss of J. Philip Sutcliffe. From the beginning of my life as a research student at the University of Sydney in 1960, all three had a significant effect upon my outlook and thinking about hypnosis.

Much of this had to do with Gordon Hammer, who at the time ran a weekly hypnosis seminar on Thursday mornings which was the highlight of just about every week. For the winter term, we had a visitor; Gordon handed over the running of the seminar to Martin Orne, then visiting for three months as a Fulbright Scholar. As well as Gordon, Martin and Phil, the other participants, all then research students, included Fred Evans, Wendy-Louise Walker, George Singer, Wendy Fairfax Thorne, Jean Jones, and Margaret

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Austin. Peter Sheehan became Phil's third research student the following year (along with Jean and myself). As it turned out, this was good company to be in once a week.

To add additional spice and substance, Gordon had established links with the then newly formed Stanford Laboratory, which consisted of Ernest and Josie Hilgard, André Weitzenhoffer and some graduate students. Every few months a package of preprints would arrive to be devoured at the seminar. Of course, as a bumptious 22-year-old, I took these riches for granted; I had yet to realise that such an education was the exception, rather than the rule. Fortunately, Jack Hilgard was, already, an internationalist, and by sharing the ideas that were floating around Stanford at the time, he reduced the timewarp that thousands of miles between Sydney and Stanford necessarily impose.

The Sydney Psychology Department of the late 1950s was a remarkable one; you were accepted into the honours programme on the basis of your performance in first-year Psychology; from that time onwards, you were in a special honours class, and on a first-name basis with the entire department from Bill O'Neil, the chairman, downwards. You also got to drink at the Forest Lodge Hotel with your teachers. But Sydney was a tough love department; the price of this perceived privilege was to accept the life of a workhorse. The underlying departmental philosophy appears to have been that we were all good enough to be in the honours class, but could we handle intense stress? The department went about finding an answer to this question, and although I did not appreciate its interest in it at the time, I will always be indebted to the Sydney department for its hard-nosed approach.

In particular, fourth year honours was something akin to Chinese water torture. You were required to write two theses — one empirical and one theoretical. If you survived all of this, you entered directly into the PhD programme, bypassing the MA. Ultimately I got to know Gordon, Martin, and Phil very well, since my first year as a research student was the beginning of three enduring friendships. This paper seeks to share some memories of these three first-rate colleagues, their ideas, and their intensely human qualities.

### **A. Gordon Hammer (1914–1999)**

Gordon was responsible for Phil's entry into the field of hypnosis. Phil was already a lecturer in psychology at Sydney, having completed a masters' degree on level of aspiration. His further progress to a doctoral degree was blocked, temporarily, by the lack of a supervisor. Fortunately, Gordon, in a typical act

of generosity, elected to be Phil's supervisor. (His human decency did not fare as well some years later when, as Chair of Applied Psychology at the University of New South Wales, he responded to the plight of a colleague at another Australian university whose progress in the ranks was impeded by the perception that he was a card-carrying communist. "He might be a bloody commo, but he's a bloody good psychologist," snarled Gordon, and made sure that this colleague was appointed. He later repaid Gordon's generosity of spirit; they had a major falling out, during which he denounced him as a drunk and a womaniser.)

It is unfortunate that Gordon's ideas never travelled very far beyond the walls of his office in which the weekly hypnosis seminar was held. He still remains in my mind, one of the most fertile and fluent generators of ideas that I have encountered. Unfortunately, he published very little, and it was only by being present when he spoke that one had any inkling of the depth and clarity of his thought.

What impressed me most about Gordon was that at this hypnosis seminar (and at an honours seminar on psychotherapy the year before), he talked to students about his failures with patients as well as his successes. Indeed, my memory is that he discussed his failures more often. I think there was a reason for this; Gordon had an almost visceral distaste for anything that smacked of gimmickry (what he called formula thinking), and I suspect that he wanted students to understand that clinical success with hypnosis is not automatic (as some authors of clinical texts still maintain).

Interestingly, it was not until 1975, at the 27th Annual Meeting of the Society for Clinical and Experimental Hypnosis, held at Chicago, that a paper session was first presented on clinical failures. This was at the instigation of Erika Fromm, who managed to persuade some very reluctant clinicians to broach this taboo topic. It may say something about just how taboo a topic this is — there has not been a repeat performance since then.

One person who recognised Gordon's excellence as a thinker was Martin Orne. During the 1960s and 1970s, Gordon spent two sabbaticals at Martin's laboratory in Philadelphia. From this period, the Orne and Hammer (1974) entry on hypnosis in the *Encyclopaedia Britannica* evolved. While it is not possible to determine what came from Gordon, and what came from Martin, it is very likely that Gordon wrote the various drafts. This was not merely because Gordon, being on sabbatical, had more time to write. In addition, he had graduated from the University of Sydney in 1935 with a BA and first class honours in both English and Psychology. This is all the more reason why his

limited scholarly output is such a loss. Nevertheless, he left more than enough behind to confirm the high esteem in which he was held by his colleagues and students. Further, when he retired in 1979 he was made a member of the Order of Australia for his services to education in psychology.

### **Martin T. Orne (1927–1999)**

Martin Orne was not only a fluent and graceful writer, but a prolific one. This was impressive given that his first language was German; his medically trained parents had moved out of Vienna in 1938 for the United States to escape the impending Nazi onslaught. Equally as impressive was that his first two publications (Orne, 1951, 1959), respectively on hypnotic age regression and demand characteristics, are recognised classics. More were to follow, most notably his paper on the placebo effect (McGlashan, Evans, & Orne, 1969) which showed convincingly that response to hypnosis is more than a mere matter of suggestibility.

Martin's 1959 paper made a major methodological contribution by introducing low hypnotisable simulators as a quasi-control for demand characteristics. His argument was that if hypnotised and simulating subjects behaved identically, then demand characteristics could not be ruled out. It meant that the experiment was not a crucial test of an investigator's hypothesis, since it suggested that the simulators had divined the experimenter's intent. A difference between hypnotised and simulating subjects suggested a core or "essence" quality of hypnosis. This is a highly stringent, and conservative strategy, since few real/simulator differences have been found other than for pain and for post-hypnotic amnesia (Sheehan & Perry, 1976). Simulators tend to report no pain, and total amnesia; high hypnotisables in hypnosis tend to report a small amount of pain that does not bother them, and they usually can remember a few fragments of the hypnosis session before amnesia is relieved.

Further, in practical terms, it yielded a major dividend in the forensic setting; in the case of "the Hillside Strangler," Martin was able to show that Kenneth Bianchi, charged with the sexual torture and murder of at least 10 young women, was faking hypnosis, and could be simulating the Multiple Personality Disorder that he claimed as his defence (Orne, Dinges & Orne, 1984). In this case, Martin demonstrated his thoroughness as a forensic psychiatrist; his opinion on Bianchi's guilt was not based exclusively on his performance in hypnosis. Whenever possible, he made a point of obtaining police records of an investigation. In the Bianchi case, these revealed a



longstanding pattern of deceit. He learnt, for instance, that Bianchi had attempted to blackmail a lawyer who had a passion for under-aged prostitutes which he and his cousin, Angelo Buono (the other Hillside Strangler), cheerfully provided. This information buttressed Martin's conclusion that Bianchi's simulation of hypnosis was an index of habitual dishonesty.

Martin is one of the few people who could do it all; not merely was he a major force experimentally and forensically; he was equally as exceptional as a clinician. We are fortunate that a record exists of Martin's clinical skills; Michael Barnes (then of the BBC) wrote and produced a four-part documentary in 1982, and two of them (on pain control and psychosomatic interaction) featured Martin prominently.

Another of the Michael Barnes documentaries captures Martin's mastery of forensic issues (Barnes, 1982). For all of the 1980s, and into the first half of the 1990s, he was the top expert witness on hypnosis in American courts. He made legal history; his guidelines for the forensic use of hypnosis (Orne, 1979) were accepted by 25 of 30 American State Supreme Courts which heard cases that involved a hypnosis component (State v. McClure, 1993).

The guidelines were formulated at a time when the utilisation of hypnosis by police departments was gathering steam. They were predicated on the belief that all interactions between crime witnesses and victims should be videotaped, so that a trier of fact could evaluate the degree to which a witness' memory had been contaminated by cues from the hypnotist, and was artifactual of the hypnosis procedure employed, rather than being a product of "true memory."

For instance, in one case in which Martin participated, a hypnotised female crime witness in a Wisconsin murder investigation was told by a clinical psychologist for the prosecution: "Now somebody did it. I don't know who, and you may not know who. But you know Joe White is a suspect in this case. Do you think there is any reason why Joe White should or should not be a suspect in this case?" Although the witness said nothing at the time, she named Mr White two days later, and he was charged with murder. The judge ruled, on the basis of the video record, that the psychologist's question had altered the woman's memory by leading her inadvertently. Joe White was exonerated.

A reader may wonder how I can remember exactly what a psychologist said to a crime witness in a case that happened almost 20 years ago. In fact, my original memory was that the witness responded affirmatively, and immediately, when she was asked: "Do you see Joe White?" This memory is plausible, and

some would say that it goes to the gist of these events. But it is not what happened, as I discovered to my mild embarrassment when I replayed the video of the Michael Barnes documentary on forensic hypnosis (1985). It included the segment I have just quoted verbatim. In short, the video was instrumental in helping a court reach a decision and in improving the accuracy of my own recall.

Despite considerable sniping from both police (allegedly for an anti-police bias) and from some of his colleagues (for suggesting that clinicians conducting a forensic interview could make egregious procedural errors), Martin won the many battles that followed, and, ultimately, the war. Most courts in America followed the decision in *State v. Mack* (1980), at which Martin testified before the Minnesota State Supreme Court. The Mack court imposed a *per se* (i.e., automatic) exclusion of hypnotically elicited testimony, but allowed prosecutions to utilise evidence gathered in hypnosis in order to construct an independently corroborated case. If such a case could be so constructed, it meant that there was then no need for a court to determine the admissibility of hypnotically elicited testimony — thus saving much valuable court time.

As well as the prosecution of Kenneth Bianchi, Martin played a key role in the defence of Patricia Hearst, who faced charges of armed bank robbery following her abduction by the self-styled Symbionese Liberation Army. Better than anything, these two court appearances illustrated one of his most fundamental beliefs about the role of the expert witness; s/he should be as willing to testify on behalf of the prosecution as the defence. In cases involving hypnosis, the primary consideration, as far as he was concerned, was serving the interests of justice; this meant that everything had to be done to ensure that the wrong person was not incarcerated in some cases, and that the right person was convicted in others. I suspect that he learned much about justice from his (fortunately) brief experience of Nazi thought and practice in pre-World War II Vienna.

As if this were not enough to pack into 73 years, Martin was the editor of the *International Journal of Clinical and Experimental Hypnosis* for 30 years; a feat that is unlikely to be approached, let alone surpassed. He was a superb editor, and taught me most of what I know about editing during my near 20 years in various sub-editorial roles. His letters to manuscript contributors were rarely less than two pages long; often they went to several pages. They were encouraging, but reflected the reviewers' criticisms, and a few of his own that all of us had missed. Most of all, they were constructive with practical suggestions about how the manuscript could be improved. As a result, quite a

number of papers that started off badly finished up as polished gems.

He left another gift to the field of hypnosis. During the coming decade, Martin's research laboratory, the Unit for Experimental Psychiatry, will celebrate its 50th year of operation. This constitutes a truly imposing data base for our field that will greatly benefit future investigators. His work is being continued by his long-term collaborators, Emily Carota Orne and David F. Dinges, and this is important for all of us. Enlightened clinical practice depends, ultimately, upon a strong scientific underpinning; together with the various other laboratories that have flourished during the past half century, such as the Hilgard laboratory at Stanford, and T. X. Barber's laboratory at Medfield, MA, the Philadelphia laboratory has left a rich legacy. Not the least of this legacy was that Martin's laboratory was a role model for Peter Sheehan's laboratory at the University of Queensland, Kevin McConkey's laboratory at Macquarie University (since moved to the University of New South Wales), and my laboratory with Jean-Roch Laurence at Concordia. All three of us completed post-doctoral work at Martin's laboratory.

I cannot speak for the others, but my own period at Martin's laboratory, between 1966 and 1968, was not always a happy experience. Martin and I clashed on a number of issues, most notably on the laboratory's dress code, which required monkey suits and ties. I became so annoyed that I added a waistcoat, but the irony was too oblique to be noticed. We parted on far from cordial terms, and it took me a while to climb down from the ceiling. But after some months at what is now Concordia University, I realised that despite our run-ins, I had learned enormously from him. Gradually, we repaired this rupture in our relationship, which was as much my fault as his. In the following 20-plus years he became a loyal and generous friend, and my respect for him, which was always great, continued to grow.

### **J. Philip Sutcliffe (1926–2000)**

I have already noted that Phil Sutcliffe's arrival in the field of hypnosis was almost by accident; basically he was a mathematical psychologist, with a particular interest in set theory. Over the years, many people have asked me what Phil was like as a person. My standard reply was that he was the only person I knew who thought that reality is a special instance of set theory. Some people thought that it was a cheap shot, whereas Phil himself was much amused when I told him. He recognised the intended compliment; that he had set himself a lifelong research question of immense complexity and difficulty.

His talents as a systematist were recognised early on in my relationship with him. At the time, the computer at the university was named SILLIAC; in recognition of Phil's particular gifts, he was known around the department as Philliac. Further, there was a general agreement that in the event of a discrepancy between Phil and the computer, Phil was right. Phil was a very self-effacing man, with a warm, understated wit; he took to these observations of him with many self-deprecating jokes about his systematic skills being the product of an anal retentive personality.

Phil's foray into the field of hypnosis was relatively brief; less than 10 years. It resulted in five papers. One of them, with Jean Jones on Multiple Personality Disorder, received an award from SCEH for the best theoretical paper of 1962 (now known as the Ernest R. Hilgard Award), and is still regarded as a substantial contribution to the literature (see Merskey, 1992). Yet the combined weight of these five papers turned out to be highly influential; indeed, in his review of the methodology book by Sheehan and myself, Brian Fellows admitted that he had never heard of Phil and his work, but that after reading our chapter on Phil he agreed that his was a substantial contribution to the field (Fellows, 1977).

It is an index also of Phil's many contributions to psychology that, on his retirement in 1992, he was elevated to the rank of professor emeritus (as were Gordon and Martin), and in addition, a *Festschrift* was prepared by two of his colleagues (Latimer & Michell, 1996). Not merely does it cover Phil's various contributions to psychology; it also contains a valuable autobiographical note in which Phil as a person shines through his genuine modesty.

### **Closing Comment**

This was the state of Australian hypnosis in the 1960s, before ASH and the *Australian Journal of Clinical and Experimental Hypnosis* came into being. Gordon, in particular, was instrumental in building a foundation in both clinical and experimental terms, and this work was continued once ASH was put in place. In the early days of ASH, a series of American investigators were invited to speak, and conduct workshops at the annual meetings; they played the same role as Martin had in his Fulbright year of 1960.

I can remember with some pride how one of them, a highly respected clinician, described his impressions of the quality of the Australian hypnosis scene. He told me that Australia does not have a Jack Hilgard, or a Martin Orne, but that overall, the standard was very high. More importantly, he said

that the truly flaky clinicians who embarrass the field in the United States were happily lacking in Australian counterparts.

He could have added, I think, that these are the conditions necessary for nurturing excellence; high standards attract the most accomplished of each new succeeding generation, so that, ultimately, the general level is elevated. I believe that hypnosis in Australia is in the process of moving up another notch, and I hope that the contributions of Gordon, Martin and Phil will be remembered.

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## HYPNOSIS AND POST-TRAUMATIC STRESS DISORDER

Monica Moore  
Medical Practitioner

*This study describes the application of hypnosis in the treatment of a woman with acute post-traumatic stress disorder resulting from the client's exposure to an armed hold-up at work. She was self-referred, and through the use of hypnosis achieved her aims of abolishing the distressing flashbacks, feelings of not being safe, and sleep disturbance which she had been experiencing. She was also able to re-frame her experience from a negative to a more positive one, and to resume work.*

### PRESENTING PROBLEM

The client, Sandra, was a 24-year-old pharmacist who initially attended following an armed hold-up which had occurred the previous day at one of her three places of employment.

The hold-up occurred in the late afternoon, while she had been alone in the pharmacy. Two men came in, one threatening her with a knife, and while one raided the cash register, the other forced her to go up the back stairs (thereby implying prior knowledge of the set-up of the pharmacy) to the room where the safe was located and, at knifepoint, made her open it. They then left the pharmacy without physically harming her. She ran outside for help, but passers-by ignored her pleas and she eventually came back inside the pharmacy and called the police. She stated that the police were very helpful, but she did not feel protected because the pharmacy had been held-up in a similar fashion six weeks previously. She blamed these repeated robberies on the fact that the pharmacy was in the centre of Sydney, and therefore not in full view of busy pedestrian traffic. (There had been one or two robberies in the previous 12 months.)

At this first consultation, she requested help for problems including difficulty falling asleep, decreased appetite, distressing flashbacks, and a feeling of not being safe anymore. She was assessed using DSM-IV (American Psychiatric Association [APA], 1994) as having Acute Stress Disorder. I gave her information about the normality of her reaction, and practical advice about stress management (e.g., breathing and relaxation techniques)(Evans & Coman, 1998). Further treatment was not offered at this time as the patient's employer had already organised an appointment with a psychologist trained in dealing with work-stress issues.

Sandra returned three months later, stating that her treatment of graduated exposure (involving taking the train into the city, and then gradually coming closer to the pharmacy) was not progressing well. She stated that she could not get her anxiety down below 9 (on a scale of 0–10, where 10 = high anxiety), even though she would stay outside the pharmacy for 45 minutes.

At this point, she described nightmares related to or reliving the hold-up, and a baseline anxiety of 4/10 during the day, with higher levels if she was going into the city or doing something she felt was unsafe. She felt she had a “short fuse,” and that issues that would normally not be a problem to her seemed too difficult to contemplate; she also noted problems with concentration. She reported a feeling of dread about the future, and felt the world was no longer a safe place “because I thought that if something happens, people will help you, and they didn't.” She had disturbed appetite and memory, and was still experiencing flashbacks, palpitations, nausea, and tremor.

On being offered treatment with hypnosis, Sandra readily agreed. She added that she had been a bit apprehensive about working in the pharmacy after the hold-up six weeks prior to the one she was involved in, but that she had never experienced problems like this before and that she was keen to do anything that might help.

## **SOCIAL HISTORY**

Sandra had been married for three years and had no children. She described the marriage as one of her sources of happiness and safety, and, in fact, had chosen to see me as I had successfully treated her husband for anxiety-related diarrhoea due in part to dissatisfaction with his workplace.

Sandra was the eldest of three children, all born in Australia. Her father was born in Greece, arriving in Australia in 1972, and her mother was born in Australia. Her parents separated in 1986, and from then on she had limited contact with her father.



She stated that her grandparents had tried to soften the impact of constantly fighting, arguing parents by spending a lot of time with the children, and she recalled fishing, playing, and exploring with her grandfather, who died when she was seven.

Her relationship with her mother had been very close until the age of 12, but was at present neither close nor antagonistic, with Sandra saying that “I’ve outgrown her.” Her brothers still lived at home and Sandra felt slightly closer to the youngest sibling

She described her hobbies as fishing, water sports, and coaching her husband for marathons.

## **ACADEMIC HISTORY**

Sandra attended government schools, and stated that she had tried to cope with the “arguing and violence of my childhood” by studying. She commented that she had felt a failure if she achieved less than 100%, and had achieved HSC marks placing her in the top 2.5% of New South Wales students.

She attended university and obtained a Bachelor of Accountancy degree, followed by Bachelor of Pharmacy.

## **EMPLOYMENT HISTORY**

At the time of the hold-up, Sandra had been working four days per week, at three different venues. She spent two days per week at the pharmacy in the city. She stated that she enjoyed her work, which was varied and included being involved in medication reviews at nursing homes, educating patients who attended the pharmacies, and being the only pharmacist on duty, so she could practise in the way she preferred “ethically and morally.”

She did not enjoy what she saw as “politics, mismanagement and unprofessional behaviour” of some pharmacists, and patients being “unreasonable” about cost or service.

## **MEDICAL HISTORY**

Sandra had no history of illness or surgery, and specifically had never experienced symptoms of anxiety or depression. She was a non-smoker who did not like alcohol, and denied using prohibited drugs. She was taking the oral contraceptive pill. Specifically, she did not have anhedonia, hopelessness, or suicidal ideation.

## **TREATMENT APPROACHES — ROLE FOR HYPNOSIS IN THIS CASE**

There appear to be many features of PTSD which share similarities with hypnotic phenomena (e.g., hallucinations, dissociation, depersonalisation, and time distortion.) Many authors believe that PTSD is a condition which occurs in the highly hypnotisable, and is therefore amenable to treatment with hypnosis (Evans, 1991).

### **TREATMENT GOALS**

The agreed aims of therapy were to decrease or eliminate flashbacks, nightmares and feelings of anxiety and insecurity, and allow a successful return to Sandra's former working capacity.

### **ASSESSMENT OF SUITABILITY FOR HYPNOSIS**

Sandra already had basic knowledge about how a lessening of anxiety could be achieved, in that she was keen to learn and her visits to the psychologist had educated her about the role of relaxation in lowering anxiety symptoms, and exposure in the treatment of traumatic experiences.

To assess hypnotic ability, I asked Sandra to describe and elaborate upon a positive experience to establish her degree of focus and the level of imaginative involvement of which she was capable.

She was asked to recall a very positive and happy experience from her past. She chose to describe her wedding day amid the rose plantings in the Royal Botanic Gardens. She displayed great capacity for affective involvement, describing the experience of warm, safe, elated feelings, and of herself as a good person with a good life, surrounded by intimate and supportive family and friends. She was also able to experience the warmth and smells of the day, as well as visualising the event. She stated that she was able to experience it as if she were there.

Prior to commencing the use of hypnosis, Sandra was asked about her thoughts and attitudes to hypnosis. She stated that she did not know much about it. Common misconceptions were discussed (e.g., the hypnotist does not control the mind, rather guides the imagery, and that the patient would be able to remember all that was important). She was also reassured that she would not disclose any secrets, as I would explain each session's work before she sat in the "hypnosis chair."

I used the “Theatre of the Mind” Technique (Bandler & Grinder, 1982). I suggested to Sandra that she would be able to view the events from a distance, and not feel so vulnerable and emotionally involved. I also suggested that she would be able to replay the situation backwards and forwards, at different speeds and black-and-white or colour, to encourage her to place the event in her memory banks in a way that was not linked with the intense emotional recall she was experiencing. Particular reference was made to the fact that she could come out of the theatre whenever she wanted.

## **Session 1**

Sandra’s trance was induced in a reclining armchair in the room, used specifically for hypnosis. This in itself may encourage an expectation that trance will be experienced (Hartland, 1989).

A technique of early eye closure and progressive muscle relaxation, combined with the positive mental imagery of her wedding day to encourage feelings of peace, calm, comfort, and safety, was used. She stated that she felt warm and floaty, and very relaxed.

She was then asked to imagine herself walking into a quiet theatre, and sitting down to await the movie (she chose to have a choc-top ice-cream as her usual accompaniment). She was then asked to visualise herself walking up to the projection room, still seeing herself sitting in the theatre, and to start screening the movie of the hold-up. She was advised that when it started, it would be faint and grainy, far away, and barely audible.

As she commenced her imaginary movie, Sandra’s body became tense and her face, previously quietly smiling and relaxed, became distorted with distress. She started to whimper, and breathe more rapidly, and tears were starting to flow.

When asked about her experience, she related that she was in the pharmacy again at the time of the hold-up, and she was very upset and did not want to be there.

In response to the abreaction, she was asked to remember that she was safe, sitting in a chair in my room, and to allow her mind just to float back easily to her wedding day. She was reminded of all the sensory modalities she had documented, and also of the affective experiences she had related. Soon her body had relaxed, and as her breathing settled she stated that she felt better.

She was then asked if it would be okay to think of the events of the hold-up as a cartoon. She agreed, and chose the character of Porky Pig as the robber,

and Fred Flintstone for herself. When directed to relate the events occurring to the cartoon characters in the present tense, she was able to describe them with a much reduced experience of distress.

When asked whether she would like to change anything about the story, Sandra initially said that she would change it all so that it never happened. When asked about alternatives to that, she suggested that Fred Flintstone's wife Wilma came in with her friend Betty, and that they caught the pig and called the police, who then were very helpful.

Sandra was then brought back to the feelings she experienced during her wedding, and was given the post-hypnotic suggestion that at any time she wished she would be able to centre on the feelings of confidence and inner strength, and would be able to practise her graduated exposure exercises.

## **Session 2**

Sandra related that she felt so much lighter and more at ease after her session two weeks previously, although she had not felt as relaxed as during the session. She related that the psychologist she was working with had suggested going with her into the pharmacy in a fortnight's time, and as she had already reached the stage of going past the pharmacy by herself, it was felt that concentrating on relaxation exercises and persevering with exposure would be appropriate at this point in time.

She was offered further sessions of hypnosis to increase her sense of wellbeing and confidence, and her feeling of safety. She stated that she did not want to work on the event itself just yet, as she had found the theatre of the mind session too emotionally draining.

## **Session 3**

Sandra attended after her re-exposure to the pharmacy, stating that she had found the experience "exhausting and surreal." She felt that she was not in control of the situation, and was disappointed as she had not been able to "grab onto the good things in her mind." She stated she had experienced levels of anxiety fluctuating between 8 and 10, out of 10, for the whole time that she had been in the pharmacy (almost an hour) and that she had flashbacks to the hold-up every time she heard the cash register open.

As I had previously discussed with her, the aim of this third session was to provide some cognitive restructuring in relation to her perception that the

world was no longer a safe place. This was achieved by recalling episodes in her life where she had been helped by others, as she had been shaken in her conviction that the world was a safe place by the lack of help she received from passers-by outside the pharmacy.

Trance was again induced by progressive muscle relaxation and Sandra was asked to focus on the comfortable place in her body. She was asked to then visualise where in the world she would feel that comfort, and she described a beach on a hot day. The sensory modalities were elaborated, and she was then asked to obtain a symbol of the way she felt on the beach, to represent the comfort and peace she felt. She described a seashell, and moved her hands across her abdomen as if holding it.

She was then asked to imagine herself on her beach, but to let her mind wander to the episodes in her life where she had been helped by others.

Sandra then related an episode which occurred when she was four years old, and had been fishing with her grandfather. As they were walking home, they had been hit by a car. Sandra had been dragged under the car, and the driver had not stopped. Sandra stated that “a lady came and helped.” When asked how she felt, she said she felt fortunate and comfortable, and good that someone had been concerned for her safety. Interestingly, even though Sandra related the events in the present tense, she did not display any signs of emotional distress.

When asked for further instances of being helped by others, she mentioned that the teachers at her high school had also been very supportive and had gone out of their way to help her.

Sandra also remembered that when she first started working as a pharmacist, a more senior pharmacist had taken the time to explain how to make life easier in dealing with patients who were rude or demanding. (This point was elaborated, as being evidence that all human beings fail to behave well at one time or another, especially if ill or stressed. This was an attempt to reframe experience of the lack of help she received after the hold-up, with a suggestion that those people would have helped her if they had the resources.)

When asked to name the way in which she was proud of herself, and of her achievements, Sandra stated that she had been proud to be able to continue to study for her pharmacy degree even though she had married during the last year of the course, and there had been financial constraints. She also felt that her marriage was a success, and felt proud of the way she communicated with her husband.

Sandra was then asked to imagine that she could see herself in the future, in the way she wanted to be, doing the things she wanted to do (future orientation; Howsam, 2000). She described being able to walk confidently anywhere, not worried about what might happen.

She was then asked to obtain advice from this future self as to what she would be able to achieve. She said she would be able to store what had happened to her in a file and it wouldn't consume every thought.

Trance was gently ended as before, again with suggestions of peace and comfort on visualising her seashell.

#### **Session 4**

On review one week later, Sandra said that her sleep had improved, as well as her ability to deal with day-to-day issues, such as those arising in her two other places of employment.

Before entering trance, the aims of the session were discussed. I felt that training to help deal with negative emotions (and recall of having overcome previous crises) would be a good way to gently lead up to dealing with the hold-up. I suggested that Sandra could recall other negative events in her life, but reassured her that I would not mention "the event" or ask her to recall it. The goal was to "separate out the client's memories (cognitions) . . . from feelings of loss and depression . . . (emotions)" (Evans & Coman, 1998).

I suggested to Sandra that she could float above the event and dissociate from her usual unpleasant emotional reaction if she chose to (James & Woodsmall's Time Line, 1988). The concept of the Time line was explained to her. On questioning, she described her past as being in front of her (up close) and her future behind her. She felt that she was in time, that is, that the time line was through her. When asked about a better orientation for her past, so that she could look forward to the future, she volunteered that she would prefer her past to be on her left.

We then practised floating above the time line, and then seeing the chosen memory (a black area) as small, then becoming larger. Each event was run as a movie in black-and-white, with no sound, then played backwards and forwards fast. Gradually, with each re-run, sound was added, and then colour, and then she placed herself in the movie. She was then asked to compare the level and quality of emotion she had felt at the onset of the recall with that at the end of the multiple run-throughs of the movie.

Sandra was then asked what she had learnt from these events, and to

preserve them in that area of her memory reserved for such learning (James & Woodsmall, 1988).

Sandra used this technique to deal with her emotional reactions when, as a child, she had been told that “there is no Santa”; when she had a falling out with her friend in high school; and her feelings when she had found out from her husband about his problems at work.

Sandra was successful in achieving a marked lessening in the painful emotions associated with her memories, although she still felt a sadness there, which was translated into a learning. Examples of the learnings she mentioned were that she could still enjoy Christmas without believing that Santa existed, that it was a measure of maturity being able to accept that, and generally that she had survived and continued to enjoy life in spite of these events.

The post-hypnotic suggestion was that, from this session onward, she would be able to re-organise her time line to her specifications, which she nominated as past to the left, future to the right, and that she would again find it easy to relax when she needed to.

## **Session 5**

On review, Sandra related that she had a nightmare, but had been able to use her skills in relaxation to return to sleep soon after (previously, it would take her up to two hours to settle).

This session was planned to include work on dealing with negative events. I suggested that we try a technique of dealing with the emotion as the symptom, eliciting the sensory sub-modalities and then changing each one until the emotion became bearable and could be stored as a memory, with an appropriate “learning” (Dilts, Hallborn, & Smith, 1990).

Progressive muscle relaxation and beach imagery were used to make Sandra comfortable. She was then asked to recall an unpleasant emotion that she wanted to deal with.

Sandra nominated the stress from her family (an event was not elicited as the author wanted to deal with the emotion as a symptom). She was asked to describe it and, on prompting, she described it a purple-blue in colour, dull, rough, with an oval bulge. It felt cold and irregular, and it was moving, spinning, making the area in her epigastrium where she experienced this ache.

She was then asked to change one aspect of this, and she chose to stop it spinning, to pin it down. She then changed its irregularity to something

predictable and the same all over. She associated making it smooth with making it predictable and “being in control, knowing what it looks like and what to expect”; making it warmer and less harsh, and changing it to red — all made it feel better. She was then asked to move it further away, and she stated that she was moving it down her left arm to the area of her past where she could store it as a memory, “taking it down out of main functioning to somewhere where I can access it if I want but it won’t get in the way.”

The next emotion Sandra chose to tackle was fear. She described it as red, in the centre of her chest, hot, smooth but irregular, and hovering like a cloud. She could not see behind it or underneath it, but could see the top and the sides. She pictured it as big and intrusive. When asked to name what was behind it, she said, “better emotions, and feelings of happiness, a sense of independence and confidence.”

She proceeded to change each aspect, making it smaller, changing it to yellow, a brighter, less intense colour. She then noted that she could see a light behind the cloud, “like an emotion, confidence” which was breaking it up.

Sandra then felt confident to put this changed emotion behind her, on the left.

She then wanted to deal with anger. She experienced this in the right upper quadrant of her abdomen (where the liver is situated) and described it as green and rough, palm-sized, and emitting hot and heavy rays of dark green and red. It reminded her of bacteria, of harm, of feeling invaded, and she described the rays getting into her bloodstream and making her feel tense.

The changes she made were to make it barely warm, and to cut off the emissions. She then changed the colour to white, symbolising good feelings, clouds, peace, snow, and purity. She smoothed the surface and decreased its size, then put it behind her, far, far away.

During each of these processes, Sandra’s features had initially been tense and frowning, changing to relaxed smiling as she managed to deal with each emotion to her satisfaction.

Sandra was then asked to think of a troublesome event — as a still, not a movie — (we had been focusing on pure emotions until then) to work on, and she volunteered a still from the robbery. She described the robbers as they entered the shop. She was encouraged to enrich the still with as much detail as she could recall (in the present tense) and then to describe her emotions.

She stated that it made her feel frightened, threatened, out of control, unable to breathe, and terrified of what might happen. When asked about where the sensations were in her body, she described her body as giving way,



heavy legs, queasy stomach, heart pounding, and feeling short of air.

She then proceeded to work through her emotions in much the same way as previously, and with a similar positive change in affect. When asked to name the “learning,” she said, “You can never know what is around the corner.” This was repeated, and by way of cognitive restructuring the idea was added that both good and bad things come unexpectedly, and nobody could know what the future held, and that she had always known this without thinking about it.

## **Session 6**

When reviewed one week later, Sandra stated that she had found our session very helpful, and that she wanted to work through two still images from the robbery.

Trance was initiated with progressive muscle relaxation and mental imagery of being on the beach, before allowing her mind to focus on the image she had chosen, which was of being pushed up the stairs. She described having fallen so she could look at the robber, and had a clear view of him being angry and threatening. When asked what he was saying, she replied in a loud voice: “Get up the stair, don’t look at me or I’ll hurt you!”

Sandra was then prompted to describe the robber’s appearance, clothing, facial expression, and anything else that she could see from her position on the step, and what her body came in contact with, what she could hear, etc.

She was then asked to describe her emotion (terrified) and guided through the same exercise of eliciting the sensory sub-modalities and then changing them. On being asked about her “learning” from this event, she said that it was helpful to be concerned about the possibility of being attacked. I elaborated on this statement, confirming her view that self-protection was very important, and that this learning could be stored in her subconscious mind where it would protect her in the future, without her having to be constantly reminded of the events or emotions attached to them.

The second scene she wished to work through involved being at the top of the stairs, while the two robbers screamed at each other. She was asked to describe the scene in detail, and then to elaborate and then systematically change her emotion. I used the shape Sandra had arrived at — that of a pyramid — to symbolise the focusing of power, energy and wisdom that some people attribute to that shape, and to reinforce the learning she volunteered — that she had come out of the situation afraid but unhurt. I also pointed out

that she had a great degree of mental presence and inner strength not to “freak out” and to continue to comply quietly with the robber’s demands, so she was unhurt.

The symbol of the pyramid was suggested as a post-hypnotic suggestion to be a reminder of her inner strength and her survival skills.

## **Session 7**

Sandra reported no further flashbacks or nightmares, feeling more in control, and falling asleep easily. She did describe occasionally waking with a pounding heart, but could not recall any bad dreams.

This session was used to consolidate her learnings and to deal with any residual emotions which she felt were troubling her, as well as allowing her to experience revisiting the pharmacy in her mind.

Following the induction of trance with muscle relaxation and the beach scene, she was asked to let her mind travel to the thinking place where she could explore a filing cabinet in the part of the mind not recalled too often. She stated that she was aware of this filing cabinet where she had been putting all the emotions and learnings, behind her to the left.

When asked about her emotions, she said that she felt good in the chest and stomach, with only a small amount of the other feeling in her fingertips. It was then suggested that she would allow the good feelings of her chest and stomach to naturally flow into her arms and into her fingers. She then reported that she no longer felt weighed down, and felt “good all over.”

Sandra was then asked to imagine that she was taking the train into town and going into the pharmacy, as exposure to the feared stimulus is part of the treatment (Evans, 1991). When she stated that she was afraid seeing the stairs again and hearing the cash register, I made the comment that children often think inanimate objects are threatening, and feel more comfortable when they can touch them, to assure themselves that they are only inanimate objects. Sandra was then encouraged to touch whatever she wanted to in her imagination, and to let the warmth she experienced in her chest and her stomach flow through her body. Sandra found the idea helpful, and described a decrease in anxiety.

She stated that she felt confident that she could proceed with her plan to return to work.

## **EPILOGUE**

Sandra was seen a few weeks later. She had attended her workplace and now felt confident in dealing with another hold-up. Her job had been given to another pharmacist during her absence, and as she planned to take extended leave for six months to travel to Europe with her husband in the near future, she worked some shifts to overcome her fear and then resigned from that pharmacy.

## **DISCUSSION**

Sandra presented in distress, with the aim of having some help with her symptoms as an adjunct to the treatment she had been pursuing with the work-nominated psychologist. Discussion with her treating psychologist revealed that he intended to continue to use a cognitive-behaviour therapy approach consisting of challenging her negative thoughts, practising breathing and relaxation and other ‘grounding’ techniques, and practising graded exposure to the feared situation (entering and working in the pharmacy).

Given Sandra’s symptom profile and the documented efficacy of hypnosis in the treatment of PTSD, it was felt appropriate to use hypnotic techniques to enhance the relaxation response and safe place imagery, as well as providing a safe mechanism for going through the experience, and providing cognitive reframing.

Sandra appreciated the safety of having a more controlled exposure while in the “hypnosis chair,” and felt that she had acquired useful skills for dealing with upsetting events in the future.

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## BRIEF HYPNOSIS FOR NEEDLE PHOBIA

Steve Morgan  
Psychologist

*This study describes the use of hypnosis in a brief therapeutic engagement with a client who was slightly over eight months pregnant. The client described an acute phobia of needles and other invasive medical procedures that were associated with a high level of anticipatory pain. Hypnosis was used to effectively overcome her phobia and anxiety.*

### PRESENTING PROBLEM

Paula self-referred seeking relief and assistance with a self-identified phobia with respect to invasive medical procedures. This was acutely distressing, as Paula was slightly over eight months pregnant at the time of contact. During our initial telephone discussion she indicated she also felt overwhelmingly fearful of any possible pain experience that she might endure, given her strong aversion to needles that she was certain she would require to manage the pain of the birthing experience. She indicated that she had contacted me specifically as she believed that hypnosis would be able to assist her in managing this situation. She also wished any intervention to be undertaken within one week and in no more than two sessions, as she was fearful of entering labour early.

### ASSESSMENT

#### Situation

Paula was a 26 year-old married woman, eight months pregnant at the time of contact. She noted that she had become extremely fearful of the birthing experience, based on her fearfulness of medically associated pain and invasive procedures of any kind. She related a history of such fear and avoidance back to early adolescence and noted a minimum 10-year history of fainting when required to receive a needle or injection. She noted that she had been required to give blood as part of normal obstetric management and had fainted at the

pathology laboratory.

Paula also described a dread of hospitals, which she had avoided whenever possible. This included making excuses for not attending hospital to visit friends or family. When unavoidable, she had endured being within hospitals with great anxiety.

With the support of her husband, she had attempted to address these responses by attending the ante-natal classes that were being offered by the private hospital in which she had chosen to give birth. Unfortunately, at a recent session, the class had been shown a video of childbirth and at this point she had fainted.

This last experience had aroused great fears with regard to her capacity to cope with the birthing experience and she had contacted me shortly afterwards.

### **Relevant Social, Medical and Psychological History**

Paula indicated the belief that her phobia and its associated phenomena were related to a sequence of events that had occurred when she was 12 years of age. She noted that her father had developed a virulent stomach cancer and had been required to undergo extensive surgical procedures and generally endure great pain, ultimately dying within a short period of time following surgical intervention. Paula noted the emotional distress of herself, as an only child, and her mother as being unbearable at that time and she had found subsequent attendance at hospital for any purposes to have been “horrendous.”

Paula was contented as an only child until her father’s death. She noted significantly increased anxiety within the home following this and until she left school after completing year 12, by which time her mother had happily remarried. Following school, Paula travelled and worked in a variety of casual positions in Europe for approximately two years. On returning, she completed a business degree at university and joined a large industrial corporation, where she holds a human resource management role. She met her husband through the workplace several years previously and has been married for two years.

Paula noted an enduring aversion to “all things medical,” having initially been inordinately fearful of a routine health check performed by her school nurse. Subsequently, she noted marked increase of anxiety in the proximity of hospitals and an increased fear of injections that she believed would be unbearably painful. She could not identify precisely when her phobia began,

but noted she had fainted on receiving an injection shortly thereafter and had subsequently fainted on a number of occasions when faced with similar circumstances.

This pattern of avoidance and fear had not interfered with social or occupational functioning. She noted her fear of pain was restricted to medical contexts. She had enjoyed a successful school hockey career during which she had received regular and substantial bruising, but without any trauma or difficulty. She noted other occasions of receiving cuts and bruises while moving house or decorating that had not resulted in any inordinate distress. She was certain that she had “no problem with blood.”

Paula had experienced no significant medical procedures or illnesses herself and had no prior admission to hospital. She noted that she found attending a GP to be extremely unpleasant and would avoid attendance unless “absolutely essential.” She had only ever attended dental appointments when essential and had insisted on “gas” on the only occasion in her adult life that dental work had been required.

Paula told me she had raised the issue of her phobia with a GP on two occasions, these being in the course of her pregnancy. She indicated that her GP and obstetrician had both offered reassurances and recommended relaxation tapes, “a good diet,” and exercise. Neither she nor they had any desire for medication in the course of her pregnancy.

The idea of professional psychological help had arisen in discussing her fears and her fainting episode with the midwife responsible for ante-natal classes. Treatment with hypnotic elements was raised and Paula indicated that it was her own idea to seek this possible solution, but that she had felt encouraged by the midwife, who agreed that “any help would be useful” under the circumstances.

## **Session 1**

The initial session was formulated as an assessment, with the opportunity to develop rapport and to allow some development of anxiety management skills. This session could also prove opportune for exploring the suitability of hypnosis within a following session.

Assessment revealed no further phobic responsiveness or generalised anxiety disorder, and that while Paula was of the view that her phobia might have commenced with an earlier traumatic incident, there were no current trauma symptoms present. She did not impress me as depressed and denied any

current sadness or other pressing concern. She described a strong and supportive marital relationship with a strong and shared desire for the baby within an overall optimism with life that she felt to be represented by the child. She denied any previous or current use of any illicit or prescribed medication, or alcohol.

This part of the session was used for assessment and to obtain a full history of the presenting problem and its antecedents, with an examination of some of her cognitions. It was clear that Paula was well aware that her level of fear was unreasonable. Such was her level of preoccupation with the event and her anticipation of pain in the course of birth and the likely receipt of a needle at some stage, that she had difficulty in anticipating the outcome of the birth and thinking beyond the birthing suite to the actual baby. She wished to be able to experience normal birth, but felt this was an unreasonable expectation — in which case she wanted simply to be able to not faint when she received an epidural anaesthesia and to be able to tolerate any injection. She was particularly concerned that her fainting might lead to some birthing complications detrimental to the baby.

I felt that Paula had no effective coping resources or skills, as she had never attempted to engage this problem area in a concerted manner. She did, however, describe herself as a very determined and motivated person, who had achieved a great deal in the work environment and felt determined to overcome this current difficulty.

The following treatment goals were identified:

1. To be able to receive an injection without fainting, thereby facilitating medical anaesthesia for childbirth;
2. To increase capability in managing anxiety associated with medical procedures;
3. To develop a range of pain management strategies, to increase confidence; and
4. To develop a range of distraction techniques.

Paula made it quite clear that only one further session, in four days time, would meet her present schedule. I indicated a preference for further contact, but was able to respect her rationale for a brief contact.

Paula specifically indicated that she wished to receive a hypnosis-based form of treatment, which allowed me the opportunity to inform her of the variability of hypnotic susceptibility and to explore her expectations in this regard. Although she had not experienced any formal hypnotic induction, she



was relatively appreciative of the nature of hypnosis. She stated that a close friend had received hypnotic treatment to manage a personal problem some years earlier. She indicated that she was extremely imaginative, having been prone to daydreaming as a child.

In exploring some of her automatic cognitions with regard to the needle phobia, Paula noted that she had always experienced the thought that “something bad” would happen when she was receiving medical procedures. Indeed in her case, something bad always had happened, albeit her own fainting. We spent some time exploring her anticipatory catastrophic thoughts and her underestimation of coping thoughts. Using the approach of Bruce and Sanderson (1998), I suggested that she might begin to think of these unwanted automatic cognitions as being “tape 1,” that might be counterbalanced by a more effective “tape 2” that she was to author between the two sessions.

At this stage, I explained that it would be preferable to complete the first session of treatment with an introduction to a range of breathing and relaxation techniques that overlapped effectively with some of the skills taught in her ante-natal classes, specifically diaphragmatic breathing and deep muscle relaxation techniques.

## **Session 2**

The session commenced with a review of the “tape 2” that Paula had begun to develop. She had included some self-condemnatory phrases, including “Don’t be silly, Paula.” I spent some time re-focusing her attention on positive comments, then discussed ways of addressing the unwanted “tape 1” and replacing it with the more affirmative “tape 2.” She indicated a preference for imaginal methods and she could internally visualise a small cassette player that offered an opportunity to facilitate this change. She was also able to imaginally locate a large red button, to be pressed in emergency situations, which would cease “tape 1.” Paula was also given the opportunity to further develop her deep muscle relaxation and breathing techniques.

We then examined some distraction techniques that would be of later utility in managing the experience of receiving a needle, if her anxiety management failed. I pointed out that these would be useful in the general management of acute pain.

At this stage, Paula indicated her willingness for hypnosis. I discussed the aim of hypnosis and induction was then undertaken with instructed eye closure. This was followed by a lengthy imaginal deepening, whereby she was able to find herself in, and to explore, a safe and tranquil place. My observation

of facial colour changes, eye movements and a general change in facial tone suggested she was quite hypnotisable. I slowed the third deepening phase, as I was aware that highly susceptible clients may be alarmed by the speedy acquisition of deep trance. Deepening consisted of a very slow and deliberate descent down an old staircase, to emerge in a corridor with many wondrous doors, beyond which lay a great number of special and wonderful rooms. Paula was able to walk down the corridor, to pause at a comfortable distance from the staircase at a room that seemed to beckon her and within which she would know deeply that she would enjoy sensations of comfort, confidence, and courage. Once in the room, she was encouraged to fully engage in these experiences for several minutes before happening upon a wooden box, within which she would find a special and significant object that she could take with her from the room.

Paula had indicated no previous positive experiences of having a needle or other invasive procedure. I attempted to induce such a positive memory through utilising some neuro-linguistic programming (NLP) concepts, the idea being that such a positive visualisation might be a good foundation to build upon in the development of phobia management skills.

To this end, I utilised a “cinema” framework and requested that she imagine herself watching a film at the cinema, showing her fainting when attending blood pathology unit. I first suggested that, because she was simply watching the film, she would not faint this time. To further enhance her dissociation, I indicated that she may notice the film was in black and white. Using ideomotor signalling, she indicated when this film had ceased. I then suggested she “conjure” a single still frame, representative of the whole incident. The film then played in reverse, to the start of the film, and then commenced again in colour, but this time under my own direction and allowing the needle to take the required level of blood without incident. This film was then rewound to a representative single image and finally back to the start again. At this stage, Paula was invited to enter the frame and to participate in the film. Finally, she was allowed to step back into the cinema and observe some size and position movements of the representative positive image, ending with the largest, boldest, closest image she could see (IMAX screen style).

From there, Paula was taken slowly through a new needle experience, that she would find herself in, exercising her capacity to manage her increasing anxiety with “tape swapping,” breathing, muscle relaxation, through “conjuring” memories of coping, and raising the image from the room previously visited. When she indicated she had received the injection and had not fainted, she

was to congratulate herself and allow herself to imagine her most treasured image of “being a mother.”

Subsequently she was returned to the safe place and fairly slowly encouraged out of hypnosis. The final debriefing stage allowed her to identify that she had been able to experience the described events and had found it to be a most unusual experience that she had been able to enjoy. In discussion, she said that she had found an old crucifix in the wooden box, similar to one that had been given to her by a family friend in her childhood, an experience that she had also found to be curious and interesting.

When asked about any new expectations about needles and the birth, Paula said that she now believed she would be able to receive an injection or have an intravenous line inserted without fainting, but that she might still be very anxious, especially if in pain. We discussed this and completed the session by going through a basic distraction technique, paying external attention to sights and sounds around her.

I encouraged a further session to consolidate this achievement, which she said she would like, but she had many matters to attend to so close to the birth. A further session was tentatively booked, but was later cancelled by the client, due to pressing alternative commitments that had arisen.

### **Follow-up**

I had no further contact from the client and was not inclined to make further contact until the occasion of some professional discussion of her case prompted my further communication. I made contact several weeks later and was informed that the birth had gone well. Paula had used the anxiety and distraction techniques to help manage her contractions but had requested an epidural at a fairly early stage of the delivery. The accompanying needle insertion had been fleetingly anxiety-inducing, but not to the extent that she had previously experienced, and using diaphragmatic breathing and “inserting tape 2” she had managed quite easily. She subsequently gave birth seven hours later, after which she received minor stitches and an injection of Syntometrine. She did not experience any problems with these procedures. She considered that the techniques were focal to her birthing success.

I concluded the conversation with my best regards for the future and the suggestion that she has “new beginnings that may find these achievement may sooner or later give rise to other and (m)other ways and more gains in other ways in the future.”

## DISCUSSION

The role of hypnosis in facilitating the therapeutic effects of imaginal desensitisation and the relaxation response in the treatment of people with phobia has been noted (Crawford & Barabasz, 1997; Wolpe, 1990). Neuro-linguistic programming also uses hypnosis and suggestion as essential elements of its model (Bodenhamer & Hall, 1999). It also offers techniques that may address phobic phenomena (Bandler & Grinder, 1979), although offering a different theoretical perspective to the cognitive behavioural approach described by Wolpe, and represented within treatment approaches of Bruce and Sanderson (1998) and Andrews, Crino, Hunt, Lampe, and Page (1994).

The synergy that arises from a combination of hypnotic phenomena with NLP techniques has been noted by Stanton (1996), among others. I considered this combination useful, given the time constraints placed upon the sessions. The combination of techniques also provided a way to “program” the client with an experience of which she had no conscious memory or experience — a positive experience of having a needle.

Evans and Coman note that “anxiety disorders are characterised by the sufferer’s absorption in their fear state” (1998, p. 72). The use of the “cinema technique” in this case helped the client establish a therapeutic distancing from the previously aversive situation, facilitating her ability to work on it without becoming unduly distressed. Changing colours, altering distance and joining in the picture are then further effective in managing the construction and then engagement within a new visual experience that she could then draw upon in further action (hypnotic, imaginal or otherwise).

The deepening techniques in the second session had been immediately followed by a suggested engagement within a “special room,” and the discovery of an object metaphor for confidence and courage. This approach, emphasising imaginative involvement, is well recognised in hypnosis literature, but in structure was directly adapted from a psychosynthesis exercise of Assagioli (1993).

Armed with this imagery, the mentally acquired crucifix image and some capacity to address anxiety through relaxation and basic cognitive interruption,

Paula was able to complete a desensitisation-type experience of a new needle situation.

Some authors, most prominently those authors discussing Erickson, have commented that many clients are unable to attribute elements of success to the hypnosis therapist. Perhaps through being so reminded of Erickson, my final telephone comment was thus arguably Erickson-like in its style, if not precisely in construction. I particularly remembered this statement, as it was in no means similar to my usual approach or the type of wording that I would normally have used.

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## HYPNOSIS FOR FEAR OF FLYING

Elliott Schreiber  
*Professor Emeritus of Psychology*  
Rowan University

*This case study reports the use of hypnosis with three clients who manifest a strong fear of flying. The clients' personality traits with regard to commercial flying were studied for two years prior to the use of hypnosis and for two years after its use. An analysis of their flight experiences showed strong improvement in the clients' attitudes toward flying and behaviours when flying after the use of hypnosis. Recommendations are made for further research.*

### INTRODUCTION

Fear of flying among airline passengers is a phenomenon with epidemic proportions, affecting 10 to 40 percent of the adult population (VanGerwen & Diekstra, 2000). Individuals who are fearful of flying fall into one of three groups: (a) those who do not fly at all; (b) those who restrict flying to an absolute minimum and experience strong discomfort and anxiety before and/or during each flight; and (c) those who experience continuous mild or moderate apprehension about flying but do not avoid it (Dean & Whitaker, 1982; Ekeberg, Seeberg, & Ellertsen, 1989, 1990).

Most studies on treatment for fear of flying have been conducted on military personnel, primarily using behaviour therapy (Krentz, Hopkins, & Moore, 1997; McCarthy & Craig, 1995; Wilhelm & Roth, 1997). Only recently have a studies been undertaken on commercial airline passengers (Borrill & Foreman, 1996; Haug, Brenne, Johnsen, & Berntzen, 1987; Walder, McCracken, Herbert, & James, 1987). These studies used muscle relaxation techniques and desensitisation to relieve anxiety.

Moller, Nortie, and Helders (1998), and Kroger (1977) indicated the importance of using hypnosis in the treatment of fear of flying. These authors motivated this case study on hypnosis and fear of flying.

This case study reports on three clients. They were referred by their family physicians; and, in one case, by a former client. These individuals were interested in hypnosis for helping them to deal with intense fears of flying. Two clients lived in New Jersey and one lived in Pennsylvania and were from a Euro-American background. The first two clients were college graduates and held professional jobs, and the third client was a retired legal secretary. They all had complete physicals and were in excellent health.

Each client was studied for two years prior to treatment with hypnosis and for two years after treatment with hypnosis for descriptive personality traits with regard to fear of commercial flying. The clients' personality traits studied for this case were: (a) overconcern, (b) anxiety, (c) fear, and (d) panic attacks. These traits were based upon the research of VanGerwen and Diekstra (2000), and Wilhelm and Roth (1997). The clients were told to note their descriptive personality traits while flying and then tabulate these traits on a behaviour chart. They were seen for five weekly sessions of hypnosis for treatment of their fear of flying. There was a follow-up review session for the three clients one week after each air flight.

In the sessions, the clients were told under hypnosis to visualise being on a sunny beach (Schreiber & Schreiber, 1998); and, in one case, in a flower garden; and to picture being relaxed and resting on a magic seat in these settings. They were also told that these thoughts and relaxed feelings would be transferred to their commercial flying experiences, which would be pleasant and enjoyable.

### **Client A: Margaret**

Margaret is a 28-year-old married female and a graduate student working on her master's degree in education. She is an excellent student who enjoys teaching and working with children. She has had a fear of flying for eight years. She developed panic attacks when thinking about flying and sought help from her family physician who gave her some light medication and referred the client for counselling.

During Margaret's first session, a case history was taken and an option for hypnosis was discussed for treatment of the problem. She had not previously received treatment for her fear of flying. At the end of the session, some information was given relative to hypnosis techniques, and Margaret was told that there would be a total of four weekly hypnosis sessions and a follow-up meeting after the treatment programme.

The second session was conducted a week later. Margaret requested hypnosis for her fear of flying. Sensory induction techniques of Erickson, Rossi, and Rossi (1976) were used to obtain a medium level of hypnosis. Her average induction time was four minutes. Glove anaesthesia (Hilgard, 1965) was the technique used to determine a medium level of hypnosis. Since Margaret enjoyed being on the beach during the summer, this was used as a stimulus for inducing relaxation while going into hypnosis. She was instructed to picture herself on a reclining chair and experiencing total feelings of rest and pleasure. She would also be able to close off all external negative distractions and unpleasant feelings and have a wonderful flight. Margaret needed 30 minutes to obtain relaxation and the instructions.

The third, fourth, and fifth hypnosis sessions were held a week apart from each other. The same induction techniques and hypnotic instructions were used as in the second session. Margaret was more relaxed in these sessions and reached a somnambulistic level of hypnosis. She needed an average of 25 minutes of hypnosis in these three sessions to obtain progress.

During the pre-hypnosis sessions, which included eight air flights over a period of two years, Margaret expressed strong concern about air flight safety. She also manifested high anxiety, strong fears, and panic attacks. After treatment with hypnosis, she reported a 50% improvement from feelings of air flight overconcern and anxiety. She also exhibited a 75% reduction in fear of flying and was free of panic attacks.

### **Client B: Ben**

Ben is a 59-year-old married man, with four grown children. He lives in the New York City area and works in a college setting. He has had fears of flying since he was 16 years old but, because he enjoyed travelling, sought counselling so that he could enjoy commercial flying. In the first session, Ben described his fears about flying. A full case history was taken in this session and Ben indicated that he was interested in using hypnosis for his fear. He appeared to be a good candidate for hypnosis and the procedures were discussed with him after he gave permission. Ben was also told that there would be four weekly hypnosis sessions and a follow-up review session.

His second session was held the following week. Ben was motivated to begin hypnosis and sensory induction techniques of Erickson and Rossi (1979) were used to obtain a medium state of hypnosis. His average induction time was five minutes. Glove anaesthesia (Hilgard, 1965) was the method



utilised to reach a medium level of hypnosis. A beach scene was also used for Ben to relax him under hypnosis. He was given the same instructions under hypnosis for relaxation and positive feelings as those used for Margaret. Ben needed 28 minutes to achieve full relaxation and to absorb the instructions for future air flight.

The third, fourth, and fifth hypnosis sessions were held on consecutive Wednesdays. Ben was very motivated for treatment of his fears of flying. The same induction techniques and hypnotic instructions were utilised as in the second session for both clients. Ben reached a medium state of hypnosis in these three sessions and showed fewer fears and strong positive feelings about flying. This client needed an average of a 30-minute session of hypnosis to achieve progress in treatment.

In the pre-hypnosis sessions which included eight flights over a time period of two years, Ben exhibited an intense concern over his air flight safety. He also showed high anxiety, some fears, but no panic attacks. Hypnotic treatment resulted in a 75% reduction in overconcern over air safety and 75% improvement from feelings of anxiety. Along with this, Ben manifested no fear and no panic attacks.

### **Client C: Patricia**

Patricia is a 68-year-old married woman who has two grown children and four grandchildren. She lives in central New Jersey and is retired from her secretarial job. She has had strong fears of flying since the age of 30, when she experienced severe air turbulence in a flight from New York to Chicago.

During the first session, Patricia elaborated on her fear of flying. Case history information was taken, and she indicated that she never had any previous treatment for her fears. The interview revealed that she was a good candidate for hypnosis. Patricia gave her permission for hypnosis treatment and was told that there would be four sessions and a follow-up meeting at a later date.

The client was seen for the second session on the following Thursday. She was motivated for treatment of her fears of flying as she wanted to travel to Europe. Sensory induction techniques of Erickson et al. (1976) were used to achieve a medium level of hypnosis. This was determined by the method of glove anaesthesia (Hilgard, 1965). Patricia's average induction time was three minutes.

Patricia loved her garden, so this stimulus was used to relax her while under hypnosis. She was instructed under hypnosis to picture herself on a comfortable reclining chair with complete rest and pleasure. She was also told that there would be no negative thoughts and no unpleasant feelings during her future flying experiences. The word “rest” was utilised by the client to close out negative stimuli when flying. She needed 30 minutes in this session to absorb all the instructions and feelings which would be necessary for future successful commercial flying.

Patricia’s third, fourth, and fifth sessions were held a week apart from each other. She was more involved in the treatment process in these three sessions. The same induction techniques and hypnotic instructions were used as in the second treatment session. Patricia reached a somnambulism level of hypnosis in these sessions and revealed little anxiety along with considerable interest in flying. She also showed strong motivation for future air flight. Patricia required an average of 35 minutes of hypnosis to achieve success in treatment.

During the pre-hypnosis sessions which comprised eight air flights over a period of two years, Patricia displayed very strong concern about air flight safety and high anxiety levels. She also revealed strong fears and moderate panic attacks. After the hypnosis sessions, she reported a 50% reduction of excessive concern for air flight safety. In addition, her anxiety level dropped 75% and her fear of flying was reduced by 50%. Further, there was no evidence of any panic attacks.

## CONCLUSION

These cases suggest that hypnosis played a large role in lowering anxiety and fear of flying in the three clients, who did not need any relaxing medication during their flights. This investigation and the work of VanGerwen and Diekstra (2000) indicate the need for further study of larger and varying populations, along with longitudinal research of hypnosis and fear of flying.

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## **HYPNOSIS IN THE MULTI-MODAL TREATMENT OF CHRONIC ANXIETY**

Wendy Ellsmore  
Psychologist

*This study illustrates a multi-disciplinary approach, including the use of hypnosis, in the treatment of a middle-aged client initially diagnosed with generalised anxiety disorder and panic disorder and later re-framed as chronic post-traumatic stress disorder, the legacy of survival being chronic anxiety and a suppressed immune system. The description illustrates how effectively hypnosis may be integrated into the treatment plan, heightening its efficacy.*

### **PRESENTING PROBLEM**

The client, Bruce, was a 55-year-old man referred to me by a psychiatrist for treatment of generalised anxiety disorder with panic disorder (DSM4, APA, 1994). The psychiatrist had trialled Bruce on several antidepressant medications, to which he had adverse side-effects. At the time of referral Bruce was taking Luvox which he was tolerating quite well. He was also prescribed small dosages of Valium to limit his panic attacks.

Bruce reported his extreme anxiety began several months previously when he suffered a bout of bronchial pneumonia. His illness triggered constant worry with episodic panic attacks. Constantly nauseated, Bruce had lost 12.7 kg in weight, and was anorexic. His sleep had reduced to three hours a night and he was plagued by frequent headaches.

Bruce stated his anxiety worsened at night. He found that driving around for several hours accompanied by his wife reduced his anxiety levels. His wife's support was very important to him but he was concerned that night driving resulted in her being very tired for work the following day. In the initial

consultation, I assessed Bruce's anxiety and depression levels, on which he scored at the severe range.

Bruce also suffered bouts of agoraphobia and claustrophobia. He was becoming increasingly socially isolated and more dependent on his wife's company to cope with his anxiety.

## **PSYCHOSOCIAL HISTORY**

Born in 1943, Bruce is the youngest son of Rilla and Alistair (who died in 1944 in New Guinea). Bruce was one of twin brothers but his twin died at birth. He reported his childhood was characterised by extreme poverty as well as witnessing violence and emotional abuse in his extended family. He felt guilty for surviving the birth when his twin did not.

Rilla's hands were mutilated in an industrial accident at the age of 16. It was always very difficult for her to obtain work that she could perform, given this injury. Bruce said he felt guilty for being born and being another burden to his mother. As a boy he sold old newspapers to greengrocers, collected coal from railway tracks, etc. to help his mother.

At age four he suffered burns all over his body when their methylated spirit fuel stove exploded. He was hospitalised for two months. He remembered he was very fearful and sad at being separated from his mother. At age six, Bruce's stepfather, who had been cruel and abusive, died of cancer. From then on, he and his mother lived in boarding houses or with family. When they stayed with his much older sister, he witnessed much violence such as seeing his sister bloodily bashing his brother-in-law with the long stick from the copper laundry pot. His sister also beat her children. Bruce remembered they would run and hide under beds to protect themselves. He remembered attempting to protect his nieces by hitting his sister in their defence. Later in therapy, Bruce disclosed that at age seven, a friend of his sister sat on his chest and tried to force his penis into Bruce's mouth.

Very much the same age as his nieces and nephews, Bruce identified with them as his siblings. Bruce reported that, of these "siblings," he has been the most successful in life — one had suicided and the others were what he described as "battlers."

Bruce left school at age 14 to earn money to help his mother. He met his first wife at age 19. They married when he was 21. Later that same year, he was aggrieved by his mother's death. Bruce joined the Royal Australian Air Force at 23. He and his wife had three children. Bruce reported the marriage

was good for the first 10 years until he was posted to Butterworth, Malaysia. It was then that his wife became alcoholic, hostile, and abusive. One of the worst incidents occurred when she smashed a beer bottle over his head while Bruce was sleeping. From that time on Bruce began experiencing panic attacks.

Bruce divorced his wife after 20 years of marriage. Three years later he married Betty. They have no children together. Betty is childless and relates well to Bruce's adult children and grandchildren. Bruce reported he has had a happy marriage of 12 years.

Bruce indicated he constantly worries about the welfare and financial situations of his children and grandchildren. He has paid for the repair or replacement of their goods (e.g., washing machines and cars). He often supplies clothes for his grandchildren. He would keep his home stocked with beds and appliances — extras for when his family would stay over or in case they needed these goods. He came to realise that his concern for his mother's welfare was transferred to his children and grandchildren.

## **WORK HISTORY**

Bruce's work history was with the Royal Australian Air Force, from 23 to 43 years old. At 25, he was supervising the loading of a Hercules for departure to Vietnam when an accident caused him to be blown out of the aircraft. This resulted in severe injuries to his neck, shoulders and spine, injuries which prevented him from active service in the Vietnam War.

Since that time, Bruce had numerous specialist examinations, several operations, extensive physiotherapy and chronic pain. No longer being able to perform active duties, he pursued a career in strategic and managerial positions in the RAAF. He reported he enjoyed the challenge of his positions and was competent, quick, and effective in all tasks.

Over the years Bruce managed his chronic pain extremely well. He reported he learnt to cut himself off from the pain in the same way he had done when he was severely burnt as a child. However, his condition has deteriorated over the years. The opinion of several orthopaedic specialists was that he would be in a wheelchair by age 50.

Despite his abilities and achievements over the years, Bruce was medically discharged, much to his chagrin, after 20 years of service. For some time he worked in management at a major department store and was later offered an overseas directorship in another firm. However, increasing impairment from

his injuries made Bruce realise he could no longer work full-time and important managerial positions were not offered part-time.

Bruce resigned from work. He later sued the Commonwealth government for military compensation and was awarded the Totally and Permanently Incapacitated Pension (TPI). This guaranteed a regular income but restricted work to eight hours a week. Bruce then overcommitted himself, doing voluntary work for Vietnam Veterans until he contracted bronchial pneumonia. An early retirement was problematic for him, especially since Betty continued to work full-time.

## **MEDICAL HISTORY**

During my course of treatment over a 14-month period, Bruce was plagued by illnesses, due largely to his suppressed immune system. Illnesses included a recurrent systemic virus affecting sinuses, lungs, and balance, and requiring multiple courses of antibiotics. Later, he was admitted to hospital for several gastrointestinal investigations for suspected tumours. Fortunately, no growths were found.

Each bout of illness fuelled further anxiety, causing hypervigilance about his health. His worst fear was to lose his mobility and be, as predicted, in a wheelchair. Bruce walked with a stiff gait and had obvious difficulties standing and rising from a sitting position. He was just beginning to learn to pace his activities and accept his limitations but he was determined not to be wheelchair-bound.

## **SUITABILITY FOR HYPNOSIS**

Bruce reported he had consulted a hypnosis practitioner for five sessions some months before he was referred to me. He had found the sessions most helpful. He had also witnessed people in trance states on overseas postings while he served with the RAAF. He had seen people walk over hot coals, being pierced without bleeding or feeling pain and people dancing while in a trance. Bruce had a positive expectancy and good experiences of hypnosis.

Bruce's ability to become fully engrossed in what he was doing, his love of reading and classical music, indicated a good capacity for imaginative involvement and absorption. His ability to dissociate was most evident in his management of physical pain, beginning in early childhood as a burns victim. There was no previous psychiatric history, no evidence of personality disorder or substance abuse. Bruce's anxiety-proneness was another indicator associated

with high hypnotisability. The capacities for absorption, dissociation, and anxiety-proneness have been noted by Walker (1998) as indicative of high hypnotisability.

The eye-roll from the Hypnotic Induction Profile (Spiegel & Spiegel, 1978) was administered. From my observations, the roll score was 3 and the squint score was 1, giving Bruce an eye-roll sign of 4 — a good indication of hypnotic ability.

## **TREATMENT PLAN**

Within the first month of treatment, Bruce's treatment plan was developed through liaison between his psychiatrist, general practitioner, and psychologist

### **Role of the Psychiatrist**

The psychiatrist monitored medication and offered psychotherapy, being trained in psychoanalysis, marital, and family therapy. His formulation of the case was that Bruce was a survivor of multiple traumas, but had not yet allowed himself to fully enjoy his life. All sessions included Bruce's wife. Themes addressed were: survivor guilt; separation anxiety (first from his mother and now his wife); the importance of developing and pursuing passions in one's life; and solution-oriented conflict resolution. Sessions varied from fortnightly, to monthly, to six-weekly.

### **Role of the General Practitioner**

The general practitioner organised Bruce's medication schedule, including antidepressants, Valium, and, sleeping tablets, with the goal to wean him off, in sequence, sleeping tablets, Valium and then antidepressants. She referred him to specialists as required, organised numerous pathology tests, etc. She also coordinated a programme to boost his immune system, including antibiotics, flu vaccine, vitamin B12 injections, etc. She supervised an eating programme with various supplements to restore Bruce to his usual weight. He consulted her on a weekly basis.

### **Role of the Psychologist**

A summary of my contribution would be cognitive-behavioural therapy with hypnosis. The beginning stages of therapy consisted of: ongoing assessment;



psychoeducation regarding trauma; and anxiety-supportive psychotherapy, including sleep hygiene, activity scheduling and anxiety measures (using a Subjective Units of Distress Scale [SUDS]).

Middle stages of therapy consisted of hypnosis; anxiety management using breathing, grounding, and distraction techniques; eliciting his “self talk”; and a graduated programme to overcome agoraphobia. Final stages of treatment consisted of: hypnosis and teaching self-hypnosis; using rational emotive therapy to challenge negative core beliefs and Bruce’s tendency for catastrophic thinking; and goal-setting for a satisfying life of retirement. Sessions commenced weekly and progressed to fortnightly, then monthly.

## **THE USE OF HYPNOSIS IN TREATMENT**

In the initial session, I used the eye fixation technique (Hammond, 1990) for induction; arm levitation for deepening; and material from Newton (1998) as content. Dehypnotising was achieved by counting backwards from 20 to 1.

The arm levitation did not work. In the debriefing, Bruce reported that, even though he did not lift his hand, he visualised doing so in his mind. He suggested I use what had previously worked with him, that is, trying to open his eyes and visualising walking down a staircase. Bruce’s symbol of peace was sitting on a grassy bank by a stream. He reported he felt as deeply hypnotised as he had experienced before, that he had thoroughly enjoyed the session, and his SUDS level reduced from 8 at the beginning of the session to 1 at its conclusion.

Further sessions continued, using the following variations from the initial session: (a) from Walker (1998), walking downstairs and outside to a garden seat for deepening; (b) variation on Newton (1998) for content; and (c) ideomotor challenge of trying to open his eyes was used every time. Bruce reported these sessions were even more enjoyable; the ideomotor challenge was always successful and convinced him he was deeply hypnotised. He expressed an interest in learning self-hypnosis using classical music.

In later sessions, I also used music for deepening and to teach Bruce to use music for self-hypnosis. Pieces used included: *The Brandenburg Concertos, Nos. 3 & 4*, Albinoni’s *Adagio*, and Pachelbel’s *Canon*. His favourite was his own choice, a compact disc, *Opera Without Singing* which he liked played very softly throughout all further sessions of hypnosis. For the content of these sessions I wrote a script which focused on two themes. First, the difference between “guilt” and “entitlement,” that Bruce had paid his dues and deserved to enjoy

his food, rest, retirement, etc. Second, the script seeded a future sense of achievement and enjoyment through the pursuit of meaningful goals and interests.

Final sessions consisted of music played throughout the entire session; the staircase for deepening; and variations of content using two scripts from Stanton (1994). This included two techniques: “The Cloud” (pp. 35–36) was used for getting rid of negativity and unhelpful beliefs; and “The Clenched Fist technique” (pp. 92–93) used to replace anxiety and self-doubt with confidence and calmness. The last session used Steven Gurgevich’s “Metaphor to Begin Reframing” from Hammond (1990) to reinforce cognitive therapy.

## **OUTCOME**

For the first seven months, progress was erratic. The worst setback occurred in January when Bruce was admitted to hospital with gastrointestinal complaints. This forced his wife to take six weeks’ leave from work to nurse and support him. Bruce later interpreted his illness as a form of separation anxiety from his doctors and psychologist who were all on holidays in January. This crisis was a turning point in individual and marital therapy. He was hoping his wife Betty would resign from work. She did not want to do so. His psychiatrist offered Bruce in-patient treatment but he did not wish to be separated from his wife. The psychiatrist and I increased frequency of sessions until he restabilised. Betty returned to full-time work but a few months later decided to go part-time.

The following seven months were characterised by sound and steady progress. Bruce regained most of his lost weight and he was sleeping better (even enjoying “sleeping in,” which he had never done in his life). He was no longer irritable and had regained his sense of humour. He continued to have a few bouts of illness but they no longer triggered excessive anxiety and depression. Bruce sold their large home and gave away all the extra items previously stored for his family and grandchildren. He bought and organised the renovation of a smaller house in which he felt more comfortable, and invested his residual money. He stopped financing his children’s debts and excessively worrying about their wellbeing and the welfare of his grandchildren. Bruce and his wife planned small trips away in preparation for long overseas tours in the future.

Bruce reported he used self-hypnosis every morning. He would stretch out in his massage chair with headphones on and play classical music for half an

hour. Upon re-administration of the anxiety and depression checklists after 13 months of treatment, Bruce obtained scores in the minimal range for both measures.

He also indicated he was enjoying social life as before and found that he was more comfortable with people than ever before. He was more open and his wry sense of humour had returned.

In our last session at 14 months Bruce reported he felt 31 again. His mind and concentration were sharp and clear, he had not taken an evening drive in four months, his breathing rate was often down to seven breaths a minute, and he was looking forward to the future. He was not pessimistic about his disabilities, nor was he unduly concerned if he needed a wheelchair at a later time.

Several months later, the last correspondence from the psychiatrist to the general practitioner and myself concluded: "I feel that his chronic PTSD has improved at least 90%. He no longer requires either psychological or psychiatric treatment. At his request I have agreed to his gradual tapering off antidepressant medication."

## **DISCUSSION**

The successful outcome of this difficult case can be attributed to the characteristics of the client (and his wife), as well as the well-defined roles, treatment plan, and liaison among the three health professionals.

The most helpful characteristics of the client were his motivation, intelligence, and high hypnotisability. The least helpful characteristic was his dependency, which manifested as separation anxiety and came to a crisis over the January period. Spiegel and Spiegel (1978) note that the hypnotic situation can intensify dependency problems if conducted in an authoritarian manner and they recommend that the client understand that the responsibility for the nature of the trance state rests with him/her, by teaching the client self-hypnosis. Bruce indicated that hypnosis and self-hypnosis were integral to his recovery. All goals being accomplished, it was rewarding to see him conclude therapy and get on with his life.

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## I'VE GOT YOU UNDER MY SKIN: HYPNOSIS FOR DERMATITIS AND UNREQUITED LOVE

Anne Hollingworth  
Psychologist

*This study details the use of hypnosis in relieving symptoms of dermatitis. Ongoing therapy then focused on feelings of discontent and joylessness, resulting from unrequited love. The client's rash was more readily amenable to psychotherapy than were the underlying existential dilemmas.*

### PRESENTING PROBLEM

Bernice was referred by a natural therapist for a skin irritation which had begun about 12 years previously, apparently as a reaction to chemicals in the workplace. Change of work duties and treatment from a dermatologist had cleared the problem up on that occasion. However, from time to time she developed a reaction to some common chemical in the home or workplace and would suffer an outbreak. Her skin would itch, redden, and peel. She was careful to avoid all known irritants. This time there had been no obvious trigger, but the allergic reaction had been especially severe on her hands and wrists and had also spread to the chest and legs for the first time. The itch was maddening. During the day Bernice resisted scratching but often woke up bleeding, having scratched her legs in her sleep. Topical ointments prescribed had eased her discomfort but not eliminated the symptoms. Given her commitment to alternative medicine, Bernice objected to the continued use of cortisone creams. The natural therapist had advised certain herbal remedies and dietary measures but felt there might be a psychosomatic component, and in such cases she had known hypnosis to be very effective.

Bernice rang for an appointment just as I was about to go on leave for a

month. She said she was desperate and would try anything. She asked if there was any magic cure I could suggest. I said since her body already knew how to respond to the cortisone ointment she might imagine rubbing a soothing cream all over the affected areas and see how that helped. We made an appointment for five weeks time.

## **INITIAL ASSESSMENT**

### **Personal Presentation**

Bernice was a tall, pleasant-looking woman in her early thirties who gave the impression of someone rather ill-at-ease in her body. She was dressed rather drably in very loose-fitting clothes a few sizes too big. She wore no make-up, jewellery, or perfume and had a very severe haircut, pulled back at the side with the sort of clip a pre-adolescent girl would use. She moved rather clumsily, with a rather gawky lumbering side-to-side gait. She had timid mannerisms (averted gaze, head down). Her voice was rather shaky, with a surprisingly light girlish timbre for her age and size, and she seemed rather shy and inarticulate. I particularly noticed several traits at the first meeting:

1. She spoke very vaguely, and had difficulty describing anything in specific detail (e.g., feelings, goals, social situations, other people in her life);
2. Her responsiveness to minimal non-verbal cues (e.g., she sat in the chair I glanced at although she had initially started to move towards the other); and
3. She seemed very literal-minded, almost childishy credulous and had a very compliant response style.

### **Interests and Attributes**

Bernice is an athletic girl, who loves outdoor pursuits — bushwalking, skiing, swimming. She also loves singing and dancing. She is quick to learn a new dance step, or a sport, and is adept at singing. She has an average capacity to visualise (images are incomplete and not always vivid) but has a very good capacity to vividly imagine physical sensations. She enjoys most music, especially South American and Asian music for flute, pan pipes, and shakuhachi. She wants to travel, especially to places with high mountains such as the Andes or Swiss Alps, although so far she has been afraid to do so. She has studied Reiki, Feldenkreis, the Alexander method, Jungian psychology, and Eastern

religions. She is interested in all systems of prognostication (astrology, numerology) and has consulted a clairvoyant at various critical times in her life.

## **History**

Bernice never married and lives with her mother and younger brother. She is in full-time employment and is considered by others to be capable in her occupation, although she lacks confidence both in her attractiveness and her competence. She is tall (about 6 feet [182 cm]). Unfortunately she reached her full adult height at 11 and, as a result, was teased badly. She said she was very shy and the teasing made her timidity worse. She still feels “oversized and unfeminine.” Her parents’ marriage broke up when she was 13. Her account of her family was remarkable only for its blandness. Family relationships seem amiable but rather aloof. She had no health problems apart from the skin problem and was taking no medications. There was no reported history of trauma. There was no history of mental illness, no neurological impairment and no sign of depression.

## **SUITABILITY FOR HYPNOSIS**

The suitability of hypnosis to this case was assessed by considering the nature of the problem, the client’s hypnotic capacity and previous experience, and whether there were any contraindications

## **Nature of the Problem**

The initial complaint was dermatological, although the severity of the physical symptoms and discomfort had abated remarkably by the first interview. She had been using the “magic ointment.” Her legs were healed or healing, although I could see from the scabs and scars how bad the problem had been. Her hands were still red and tender at the time of the first interview, but not itchy or flaky except for one small patch. Whatever the beginnings of a skin complaint, a vicious cycle can be set up whereby emotional states (including responses to the condition) can increase and prolong the severity of the symptoms. The role of hypnosis in dermatology has long been recognised, either as a main treatment or as an adjunct to other psychological and medical interventions (Hartland 1982). Hypnosis is also held to be of use in boosting mind-body healing and immunocompetence generally (Booth 1998; Hannigan 1999; Rossi 1986).

Another major problem mentioned by Bernice in the first interview was that her life was unfulfilled emotionally. As part of a multi-pronged approach to psychotherapy, hypnosis can be used as a means of enriching inner life, as well as for general ego-strengthening (Hammond, 1990).

### **Hypnotic Capacity**

I thought Bernice's ready acceptance of the "magic ointment" suggestion bespoke a commitment as well as a capacity to use hypnosis. Various studies related to the effects of hypnosis and mind-body healing indicate that immune system changes are positively correlated with high hypnotisability (Hall 1983; Ruzyla-Smith, Barabasz, Barabasz, & Warner, 1998). Judging by her response to our telephone conversation, and irrespective of whether the condition was psychosomatic or immunological (e.g., allergic reaction), I felt she was probably highly hypnotisable. During the first interview we developed a good rapport and she seemed very willing to trust and cooperate with me. Aside from small tests to establish the sensory modalities she preferred for guided imagery, I did not think it necessary to make any formal assessment of her hypnotic ability.

There were no contraindications to hypnosis.

### **Previous Experience of Hypnosis and Psychotherapy**

Bernice had previously been hypnotised for dental anaesthesia, with good results. She had also attended courses in relaxation training, and meditation and some NLP sessions involving guided imagery. All of these were reported positively. On the other hand, the searching analysis of the past in which she had been engaged during her previous insight-oriented therapy seemed to have demoralised her, probably because it generated no hopeful new options and also possibly because it made her feel inadequate as a conversationalist. She was likely to do better in hypnosis where the conversational demands are less.

### **DIAGNOSIS**

Fortune favours the brave. Bernice lacked courage to live her life to the full. Her emotional problems were somatised, indicating they lay outside verbalised awareness and were not readily accessible to her via introspection.



## **TREATMENT PLAN**

We determined that the initial treatment plan explicitly involved hypnosis to achieve the following goals:

1. To relieve the skin problem to a tolerable level.
2. To increase her comfort and enjoyment of her body.
3. To help her to use her imagination to reconnect with her inner world, particularly sources of joy and hope.

Other treatment goals evolved over time, only some of which involved the explicit use of hypnotic techniques. I felt that Bernice needed to build courage. Her thoughts that were too deep for words and feelings indicated to me that treatment should involve communication with her unconscious mind. The unconscious is engaged via imagery and embodied experience rather than via rational disputation.

## **TREATMENT**

### **Session 1**

The dermatitis had gone from Bernice's legs and was much improved on her hands, although it still interfered with her occupational duties. She said the "magic ointment" had worked but she was worried about whether it would last. I said that I did not know, but as long as we could read what was written on the body we would know what to do and I suggested she keep the small itchy patch (above the Mount of Venus on her right palm ) as a monitor.

I asked her, "Apart from solving the problem with your skin, what do you plan to do in therapy?" She said her main problem was she that felt general discontent and she hoped to get some clarity about what direction her life should take. She was interested in the idea of using hypnosis to access her imagination, to help resolve her problems. After seeking the personal information described above and getting informed consent, I induced hypnosis. Bernice had no concerns or apprehensions to dispel, but I began by telling her that everyone was different and this first time would be a learning experience for us both, that I did not know which of the techniques I used would be the most helpful and interesting for her, it could be the first or the third or the sixth and would she let me know afterwards which it was. She agreed. I asked her which CD she preferred to use to go into trance today and she chose shakuhachi — *Riley Lee's Deep Calm*.

Instructed eye closure was used, with paced suggestions about relaxation spreading with each easy breath she took. Deepening consisted of going further and further into hypnosis as she walked down a set of steps on a bush path to a previously chosen beach/rock pool scene, whose evocation carried the content of the session. When she had indicated by ideomotor signalling her complete immersion in all the delightful sensations of that scene, I suggested that as one part of her mind continued to enjoy the delights, another deeper part could listen to my voice. Then I as I continued to intersperse suggestions about the soothing delights of the imaginary scene I used a trance script about building “boundaries” (see Yapko 1995, pp. 144 ff.). The relevance to her situation was obvious. Skin is our boundary with the outside world — it’s what “keeps our insides in.”

I was utilising a common cognitive-behaviour therapy tenet that global thinking underlies many problems. From this point of view our ability to draw boundaries is important: both being able to separate our own experience from that of others, but also to break experience/schemas into their component parts in order to be able to focus on them in some order of priority. Bernice’s manner of speaking and her body language, as well as the nature of her complaint, suggested that boundary-strengthening would be helpful for her. She was dehypnotised by counting back from 20 to 1.

During debriefing Bernice was able to further ratify the depth of trance for herself. I thought this was important because I wanted her to realise how talented she was and I had deliberately avoided ideomotor challenges, etc. (see DISCUSSION). She reported tingling in her hands and feet, time distortion and some patchy amnesia. She felt pleasantly warm and found this surprising from what she knew of anatomy and physiology, given her inactivity.

I pointed out that I had noticed a complete suppression of the swallow reflex and the startle response. (My room is by the back door and halfway through the induction one of the GPs left, banging it hard. Bernice did not flinch a muscle. I had anticipated such an eventuality and suggested that any little sound would only help her go deeper.) She reported a strong feeling she was in the lovely bush and beach scene although she could not always see the scene clearly. I had concentrated on the physical sensations (e.g., balmy breeze, sand underfoot) and clearly the kinaesthetic suggestions worked best for her. She enjoyed the shakuhachi music and said it helped to have continuity of sensory input because she could not always sustain vivid visual images.

## **Session 2**

The dermatitis on Bernice's hands was much improved and no longer a problem for her at work. She was very pleased with this and wanted to talk about how to be happier in her life. She reported widespread anhedonia. She had been seeing another counsellor for over a year and been talking ad infinitum about how sad and abandoned she had felt when her father had left the family. The counsellor had told her she had to "let go" of the past but she did not know how to. She obsessed about all these "explanations."

I asked her if she had any joy talking about the unchangeable past and she replied, in surprise, "No." I asked her if she would be interested to use hypnosis so that her conscious mind could continue to ruminate pointlessly on this while her unconscious helped her to find a way with more joy. She agreed.

After a brief induction using counting down and evocation of her favourite bush/beach scene as before, I asked her to just let her mind drift as she enjoyed that relaxing scene and listened to my voice. "It does not matter what your conscious mind is doing or where it wanders, because your unconscious mind will hear."

I talked about the wisdom of the body, automatic processes of self-regulation which happened out of awareness and without effort, and how things happened when the time was right. After some more time spent enjoying the pleasant scene, I wondered if there were any way she might be able to further transport the wisdom of the body upwards into the mind, heart, and spirit. I talked about the "thoughtful pause" of the Alexander method, and wondered what form this might take if it were transported from the realms of physiology into the psychological and social world. I suggested that this was something to begin to be curious about, then gave lots of confusing suggestions about "wandering" and "wondering." I suggested that her unconscious mind would not let her conscious mind discover or remember anything too soon, and "waffled on" a bit more about how funny forgetting was and whether it meant remembering to forget or forgetting to remember, etc., which made her smile. (Afterwards she spontaneously reported being amused about something I had said but could not remember what it was.)

### **Subsequent Seven Sessions**

In subsequent sessions we worked on furthering Bernice's goals of enjoying her life and finding a partner. I did not use hypnosis much. She lacked the worldliness and social aplomb appropriate to her stage of life, which I thought she could belatedly learn by carrying out an investigation into social life among earthlings — much like an anthropologist from Mars. It was as though she had been “absent” for important parts of her socialisation and had just not learned some of life's lessons. Her previous therapy had taken an archaeological approach without yielding any good result. Although I wanted to emphasise the future rather than the past, I suspected that she cherished secret unrealistic hopes from the past that blinded her to her opportunities in the present. My strategy was to hint at this obliquely, at the same time suggesting overlooked possibilities and resources. She gradually became more aware of the inner world to which she had closed the door and more able to identify what she really felt, needed, and wanted (exemplified by excerpts below).

In session 3, she cited her star sign as an explanation as to why she had to stay in her shell. Commenting that her birthday was the same as my husband's, I said that I had personal experience that someone born on that day was very lovable and very loving, although it took a long time for such reserved and cautious people to reveal themselves. I advised her that people born on that day need to be very careful who they love because they love very steadfastly. I told her a story of faithful love rewarded which included a sub-theme about how non-discriminating misguided love could be redirected more appropriately. We talked about how the numerologists had told her that this year was the end of a nine-year cycle in her life, as well as being the year of her Chinese astrological sign, so a big change was coming. I wondered aloud, when she looked back on this year, what would stand out as a particularly illuminating realisation.

The following session Bernice reported a vivid dream had revealed to her that, although she bemoaned her single state, she had been overlooking overtures from other men because for the last 10 years she had been cherishing a secret love for a friend's husband (the friends had divorced two years previously and the husband had recently moved back into the district). This was the first dream she could remember recalling since she was eight years of age, when she had decided never to dream again after a nightmare. The nightmares had begun, it seemed, after she had an unexpected hospitalisation for a minor medical problem, at the age of six. She was surprised as she

discussed this because, although she had remembered the incident, she had forgotten how sad and scary it was for her as a child to be separated without warning from her mother. I commented that her ability to freeze out portions of experience was very remarkable, and showed that she could protect herself against untimely messages from her unconscious mind, and I wondered if indecision and confusion might also be helpful in any way as a preparation for desired changes which she had hoped might happen by magic. I asked her to think about how she could continue to keep her life frozen in time. I suggested as an experiment she look around her for examples of people who had frozen their lives in time to see how it was done, and what the results were (I knew her mother had done this, refusing to mix socially since the divorce and still bemoaning the desertion after 20 years).

Bernice went home and took to her bed for 10 days — a long dark night of the soul. She rang during this time and told me how miserable and alone she felt. I told her I was with her in spirit and that she could conjure me up in imagination whenever she needed my advice. She had thought of a magic cure for her lungs (to drink in healing energy with her lemon drinks and let it spread) and wondered if it was the sort of thing I might suggest. I said this was indeed evidence she was not alone because that was just the sort of thing I would suggest. I reminded her that magic sometimes works, although not always quite as we expect. That's what makes it magic. I told her she was possibly wavering on the brink of a leap forward which she could not have made any earlier because previously she had lacked the psychological resources.

The next session Bernice said that, lying in bed feeling sorry for herself, she had realised that she had been hoping for a magic cure to all her problems in life but that nothing would change unless she gave up self-pity and got up the courage to act. It was time to make some big practical changes in her living circumstances, job, and relationships. In particular she needed to find out if there was any chance her old friend could return her love and/or if that friendship could progress to become a sexual relationship. I said asking was the way to find out — but it was a pretty bold step, and advised her not to recklessly throw caution to the winds. We talked about how she could prepare herself for action via a graded programme of self-discovery and learning. This involved the usual sort of homework tasks and thought experiments which permit testing beliefs and ascriptions against lived experience. During this period hypnosis was used on only two occasions, for enjoyment and general ego-strengthening. On another occasion I used an NLP “time line” technique,

which involves imaginative involvement without formal induction of trance. There is a process of guided imagery with the client assuming alternatively associated and dissociated protagonist/narrator roles (see James & Woodsmall, 1988).

As her courage grew Bernice began behaving more like her own person than like everybody else's person, less like a person infantilised and frozen in time; and more like a competent woman inhabiting her own mature body. Some of the milestones included moving away from home, confronting her male friend about their ambiguous relationship and resigning herself to its limits, going on an overseas holiday with a friend, and taking up two new sports as a way of widening her social circle. People commented that she was much more cheerful and pleasant to be near, whereas previously they had been irritated by her whininess and apathy. However, she did not feel she was yet in full flower as a woman, and was still discontented because she had not found a lover. Nonetheless, she resisted taking some of the practical steps to solve these problems which I suggested. I have seldom met anyone as afraid of life with as little apparent cause but knew that her reluctance to act must be founded on reasons that seemed good to her although they were invisible to me. Although I was impatient with her, I thought that she had probably come to the end of her daring for the time being, and that this was not the time to push for more change. I suggested we had a three-month break to allow new developments to unfold because she would take the next step when she was ready and not before.

### **Sessions 10–12**

Bernice came back slightly before time, needing support during a crisis at work. Once that was resolved (session 10 was spent reviewing options and developing an action plan), she said she was ready to go forward again. I suggested we begin with a progress review and audit (session 11). She was surprised to discover how much her stocks had increased since we last met. During the crisis she had in fact coped very well, taking quite a few new initiatives, but she had overlooked these signs of her increased personal power. This was because the strategies had been so negatively received by others and her own emotions were running so high that her judgment was clouded. As a result of the stock-taking she realised how much real progress she had made towards her goal of becoming more self-directing, socially confident, and assertive and, in fact, had behaved in ways she never would have thought possible a year earlier.

Bernice bemoaned that the love of her life had still not appeared, despite her efforts. We discussed other remedies (e.g., introduction agencies, relocating to where there were more men, etc.) but she felt she was not brave enough to take some of the financial and social risks involved with these drastic steps. We had come to the end of what therapy could achieve in this regard, since matchmaking is not a service I offer. However, before finishing I thought we could do something to boost her courage and self-confidence.

In Session 12, I constructed an induction built around mountains, snow, and skiing. This was developed from two scripts in Hammond (1990). One involved a snowball (representing an increasing determination to sweep obstacles out of your path); the other riding to the peak of a mountain of joy. She enjoyed this enormously and it left her feeling happy and energised. We agreed to a repeat session at some unspecified future time, during which we would tape the induction with background music, but this has not yet occurred.

## **FOLLOW-UP**

Therapy has only just ended, and may resume next time Bernice faces a crisis or development for which she needs ideas and encouragement. I think she is coping well. Her life has its dissatisfactions, but therapy is not the answer to every human predicament. Obviously, no amount of hypnosis or counselling will increase the limitations of her social world.

## **DISCUSSION**

It will be noted that although there was good reason to believe that this client was a talented hypnotic subject, my inductions were very minimal. I did not attempt to increase or explore her virtuosity by asking her to do anything very adventurous or difficult in hypnosis. For example, in the first session, I used instructed eye closure and avoided ideomotor challenges. My approach was cautious for several reasons. First, because she had such a compliant response style, I felt sure she would do anything I asked her, but I thought it would be a good thing for her to feel like her own person. Also, I guessed that she had been complying with other people's agendas for most of her life. I did not want to abuse her trust and her good nature by asking her to do anything not on her agenda.

Second, I assumed that her rate and degree of change would be related more to her readiness for change than to the depth of trance she could achieve.

My own experience, as well as the literature, convinces me that working in harmony with how people change naturally is the best approach. The work of Prochaska and colleagues (1982, 1992) supports the claim that the best prognostic indicator is the client's readiness for change (as measured in terms of six stages, each with characteristic features). Bernice's pre-treatment improvement indicated her readiness to change. One preliminary study (Beyebach, Morejon, Palenzuela, & Rodriguez, 1996) found that those clients who report initiating pre-treatment change were four times more likely to finish treatment with a good outcome. Other findings indicated that change within the first four sessions is a good indicator of a successful outcome and vice versa (Bergin & Garfield, 1994). Miller, Duncan and Hubble (1997) claim that meta-analyses of studies of therapeutic outcomes indicate that client variables account for 40% of the variance in outcomes. Motivation to change must surely constitute a substantial part of that 40%!

By dissociating from painful feelings (presumably after some emotional trauma in childhood or adolescence), Bernice had dissociated from almost all other intense feelings — which made it very hard for her to identify what she felt or wanted, and as a result she seemed to move through her life like a sleepwalker. If hypnosis is a state in which there is a “weakening of the generalised reality orientation” (Shor, 1959), coming out of trance was more of an issue for Bernice than entering it. After the first session, formal induction of hypnosis was only an occasional feature of the treatment. Nonetheless, hypnosis was an important element in this therapy. Arguably, one of the great benefits of hypnosis is that it demonstrates, with powerful sensory immediacy, that experience is malleable. Also, hypnosis is believed to magnify rapport and trust, and a robust finding of therapy outcome research is that the therapeutic relationship seems to be a much more important ingredient of therapy than technique (Bergin & Garfield, 1994; Miller et al., 1997). Seen this way, Bernice's experience of hypnosis in early sessions might have made her receptive to suggestions I made in later sessions.

All the schools of psychotherapy which offer a “talking cure” assume a relationship between psychological states and ways of speaking. This might be stated crudely as follows: People have internal models of the world. These models can be better or worse as guides for navigating life's challenges. There are ways that people reveal their internal models — some of them are ways of speaking. It is possible to explicitly describe these ways of speaking, along with what they reveal about internal world models. Therapists can use these descriptions to draw conclusions about problems in people's internal world-



models. By using certain special ways of speaking, therapists can influence people's internal models of the world, and by so doing help them solve their problems.

If therapists think they can talk people into changing their minds, and that there are better and worse ways of doing this, then it follows that:

1. Therapists' rhetorical skills must be an important ingredient of therapy; and
2. Therapists must have some theory of language.

To date the insights of linguistics have not been widely used to illuminate the role of language in therapy, which is as a result sadly under-theorised within the disciplines which deal with psychotherapy in general and hypnosis in particular (e.g., psychology, psychiatry, medicine). Therapists' theories of language are tacit at worst and folk-theories at best. However, the existence of carefully constructed scripts, suggestions, and metaphors for hypnosis is a *de facto* acknowledgment that rhetoric is important.

Conversation in counselling and psychotherapy shows genre-specific discourse features (Silverman, 1997). As a sub-genre of the genre of therapeutic conversation, hypnosis involves its own distinctive ways of speaking on the part of the therapist, as well as distinctive discourse rules (e.g., unequally distributed speaking rights during inductions). One generic feature of hypnotic inductions relevant to this discussion is that instructions are conveyed via conversational implicature — or indirect speech acts. Indirect speech acts enable a speaker to propose an idea or course of action rather than prescribe it, thus politely respecting the other's right to self-determination. For example: "How would you feel about waiting outside for a moment?" "Do you think it's rather hot in here?" or "Can you reach that folder?" are requests for *actions* rather than for *information*. They work by implication. That is to say, such questions probe whether the preconditions exist for fulfilling a reasonable request — preconditions such as that the action is acceptable or possible or desirable. The implication is that if preconditions are met, the action should be carried out by the listener. However, since the request is not openly made, the status of neither the speaker nor listener is risked if the listener chooses not to comply. Direct instructions (orders, advice) infringe on personal sovereignty. Indirect speech acts are very important linguistic resources for politeness, particularly for politeness based on negative face. Saving negative face includes social interaction which operates by avoidance (i.e., avoiding moves which impinge on others' rights to unimpeded freedom of action [e.g., interrupting, giving

orders]). Positive face-saving includes gambits which convey a positive appraisal of the other (e.g., acknowledging the other's attributes/status via compliments, polite forms of address, etc). For a full discussion of politeness and indirect speech acts see Brown and Levinson, 1978.

There is an obvious potential for clients entering therapy to feel incompetent for not being able to manage their emotional states or personal affairs. Obeying orders is not likely to enhance self-efficacy or increase a sense of personal agency. Furthermore, orders can legitimately be disobeyed with respect to responses not normally held to be under volitional control, such as panic, anxiety, or depression. Both cognitive-behaviour therapy and neurolinguistic programming use techniques for treating anxiety disorders which alternate between associated and dissociated narration of noxious autobiographical events, and which typically involve narration in the present continuous rather than the past tense. Setting aside standard psychological explanations of how these techniques might work, as an indirect speech act, the technique metaphorically conveys the instruction, "View the past from a different position!" Asking someone to shift between narrator and audience perspectives for the purpose of the exercise presupposes that they are capable of flexibly repositioning themselves with respect to events in their own autobiography. The client's compliance confirms that postulate since, according to the rule of Socratic confirmation, cooperation with a request without explicitly challenging underlying presuppositions is read as acceptance of those presuppositions (see Labov & Fanshel, 1977, for discussion of the rhetorical conventions of English as they apply in therapeutic discourse). In the same way, the use of metaphor in hypnosis can also be seen as an indirect speech act. By presenting an imaginal analogue to experience, the therapist is able to suggest how what is known about one domain can be transferred to another — thereby promoting cognitive restructuring without any explicit advice-giving. If metaphor assists in reconfiguring experience, and if hypnotic discourse relies extensively on conversational implicature, and if (as the cognitive linguists suggest, see Lakoff, 1993) conversational implicature/indirect speech and metaphor involve the same cognitive structures and processes, then is formal induction of trance always necessary for the effective delivery of hypnotic suggestions?

## **CONCLUSION**

In this case, hypnosis was used to treat a skin condition, and apparently brought about rapid symptomatic relief. Hypnosis was also used as an adjunct treatment

— for general ego-strengthening and for enriching the client's inner world. Although progress was made towards the client's goals of increasing hope and joy and courage, hypnosis was much more successful in helping her to improve her skin condition than her love life. Assuming that a physical symptom might be providing a way of expressing, dealing with (or avoiding dealing with) a painful dilemma, then confronting the dilemma openly would obviate the need for the symptom. However, many human dilemmas encompass non-trivial issues of existential choice which are not so easily or quickly resolved as a rash.

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## HYPNOSIS FOR ANXIETY REDUCTION AND EGO-ENHANCEMENT

Helen Baker  
Psychologist

*Hypnosis can be a powerful aid to anxiety reduction and ego enhancement either as a therapeutic goal in its own right, or as an adjunct in more complex presentations. The subject in this case is an adolescent with whom hypnosis was and still is being used as an adjunct to other treatment modalities.*

### CLIENT DETAILS

Barbara is a 16-year-old girl, the younger of two children born to Jim and Rosemary, who separated when she was nine years of age. Both parents have remarried and there is severe conflict between Barbara and her parents' new partners and each parent and the other's new partner. She has a brother Sam who is three years older than she. She has until this year been attending a local high school and is now starting senior college.

### Presenting Issues

Barbara's presenting issues on referral were compulsive checking rituals at night in her bedroom and social phobia. The checking rituals were prompted by the belief that bad things would happen if she did not repeatedly check. She had a generalised anxiety and poor self-esteem.

### History

Barbara was an anxious child, her symptoms being more apparent in primary school years when she experienced considerable anxiety separating from her mother. She reported some vaguely remembered sexual abuse from her

paternal grandfather between the ages of four and nine years. At about the latter age she first began having irrational fears (e.g., changing into a crocodile, or having her head fall off). At the age of 12 she told her parents about the sexual abuse. In September 1997, her obsessive checking started and she was referred by her family doctor to a child psychiatrist, who then referred her for ongoing work on the OCD symptoms and for help in relaxation and more independent behaviour.

### **Justification for the Use of Hypnosis**

Barbara seemed resistant to behavioural techniques but seemed to have a good imagination as demonstrated in her drawing and poetry. Hypnosis can have the effect of reducing stress and anxiety (Yapko, 1995). The process was explained to her mother who gave consent. Barbara herself seemed interested in the imagination/relaxation exercise.

### **TREATMENT**

Barbara identified three goals:

1. Not worrying about checking objects in her room;
2. Not worrying about going to the shopping mall; and
3. Not being too sensitive to criticism.

I set out the following treatment plan:

1. Assessment of response to hypnotic techniques.
2. Use of hypnosis to reduce anxiety and encourage confidence in visiting the mall which Barbara was avoiding.
3. Use of hypnosis to increase self-esteem and reduce anxiety.
4. Use of hypnosis to reduce anxiety about bad things happening, thus decreasing the need for checking behaviour. This was left to last because it was agreed that this was the most difficult area.

### **Session 1**

I administered the Stanford Hypnotic Clinical Scale for Children (Morgan & Hilgard, 1975). Eye fixation on an ornamental owl was used for the induction. Barbara successfully completed the hand lowering, arm rigidity, visual and auditory hallucination, dream and the post-hypnotic response items. On the age regression test she reported that she just thought about the memory but

she did not feel it was like being there. On debriefing she had forgotten about the hand lowering and arm rigidity, but remembered with prompting.

### **Sessions 2–5**

Barbara's next four sessions involved inductions by eye fixation either on the owl ornament or on a dolphin picture. Deepening occurred by walking down five steps and dehypnotising occurred to the backwards count from 5 to 1. She was asked to see herself entering and looking around several shops that were particularly attractive to her. She identified her greatest anxiety while crossing over the floor to and from each shop. She was asked to visualise a screen between her and people. She thought of a shower screen. This was later modified to a white mist as it would be easier for her to manipulate when ready to have closer contact with people. She chose a physical cue to remind her of her relaxed state, namely, pressing her index finger to her thumb. The sessions involving the white mist were taped and played at night.

Barbara has since visited the shopping mall three times with some difficulty (after being very resistant to any practice runs), the local shop, and shops in the city with greater ease. She found that using her physical cue provided some relief from anxiety.

### **Session 6**

The secret room technique was used to increase feelings of safety and to improve self-esteem. After an eye fixation induction, relaxation and deepening (1 to 5 as being most comfortable for her), Barbara found her secret room. She found some lovely pale roses and physical reminders of the positives in her life — her family, her poetry, her skills caring for children. She found pictures of angry faces which she smashed and put in the bin. There was also a reminder of her abuse which she took and put in a safe and locked it until she wished to address it. She reported this helped relax her. This was taped and replayed at home each night. Barbara reported that this was very helpful in making her feel free of worry and relaxed.

### **Session 7**

I used a garden scene, with Barbara as a flower, as another technique to build her self-esteem. Use was made of the fingers' gap procedure (i.e., looking with fingers, except index fingers, clasped and the index fingers held upright and

slowly coming together). She said she would like to try it. Suggestions to explore the garden and find one representative of herself were accompanied by other suggestions that she could live without being burdened by anxiety, fear of criticism, and her OCD.

On debriefing Barbara described a sunflower which was big, bright, peaceful by itself with its face open to the sky. This description could be interpreted as reflecting her preference to be alone but also her wish to stand up straight and open her face to the world. This session was also taped and has been used on a regular basis by her each night to help her relax and feel free from anxiety.

### **Session 8**

This session focused on the fourth goal of treatment and Barbara's first goal. The fingers' gap eye fixation technique was used in this session also, as she had found it easier than the previous induction technique. Deepening was achieved by counting one to five down some steps. It was suggested that she give that "tiny" part of herself, which believed the OCD was silly, permission to grow stronger and that she think about the positive consequences of stopping the checking and of being free from the chains of OCD. During the session she was also asked to think of her sunflower self.

Dehypnotising occurred by counting from 5 down to 1 as usual. On debriefing Barbara said that she saw her sunflower self in a field of sunflowers, taller than the rest and "upright." She seemed to be identifying herself with a group rather than alone, but expressing a desire to be superior to the rest (because of worries about being inferior?). The idea of being "upright" seemed to indicate progress in her image of herself. She called this session "the strength to overcome." This session was also taped for daily use.

On further debriefing a month later, Barbara reported that she had stopped playing the tape, given that when her checking time came up, memory of the tape caused her to lose concentration and thus to check more. On further questioning, I identified that the particular aspects of the tape that disturbed her were permission for her "tiny" part to get stronger and talk of stopping the checking. In a similar case of obsessive compulsive neurosis (Crasilneck & Hall, 1975), it was noted that hypnosis was used not in a direct manner to remove symptoms but in a permissive manner. As a consequence of more detailed feedback from Barbara, I planned to couch improvement in some such terms as, "As you can relax more deeply you may find that your fear of



bad things happening and your need to check begin to decrease.” It is unclear at this point in time when there will be an opportunity to continue, as Barbara has recently become very depressed owing to the longstanding family conflict and her difficulty in coping with college. She is soon to be hospitalised to treat depression.

## **Conclusion**

Hypnosis was found to be helpful in the treatment of a 16-year-old girl with complex problems, in that it led to some reduction in anxiety and increased self-esteem. It was not helpful in reducing fear of bad things happening or the need to check but this may well have been due to the use of direct suggestions and the fact that, as in the shopping mall, the level of anxiety increased markedly *in vivo*.

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## SUGGESTION AND DEGREE OF PLEASANTNESS OF RAPID SELF-HYPNOSIS AND ITS ABBREVIATED VARIANT

Isabel Reig  
University of Valencia, Spain

Antonio Capafons  
University of Valencia, Spain

Agustín Bayot  
University of Castilla-La Mancha, Spain

Antonio Bustillo  
Private practice, San Juan, Puerto Rico

*The aim of this study was to validate the short version of rapid self-hypnosis (arm dissociation) developed by Capafons (1999). Utilising a mixed multi-factorial longitudinal design with a control and experimental group (N = 60), we found that: (a) the short version produced significantly higher objective suggestibility scores than the complete quick self-hypnosis, and (b) the arm dissociation technique was found more pleasant and useful than the complete rapid self-hypnosis. The data indicate that arm dissociation overcomes the deficiencies in efficiency of rapid self-hypnosis.*

From a cognitive-behavioral perspective, all hypnotic induction procedures are equally effective at promoting hypnotic test responses when labelled as hypnotic and participants perceive them as such (Kirsch, 1990). However, not all induction procedures are equally pleasant and efficient (Cardena, Alarcón, Capafons, & Bayot, 1998; Martínez-Tendero, Capafons, & Cardena, 1996). This is important if we consider that the pleasantness of the induction method can influence the final result of the hypnotic process. At least, it could improve

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attrition rates and dissemination possibilities. Results obtained unexpectedly in a recent study show that pleasantness can affect even hypnotic suggestibility (Alarcón, Capafons, Bayot, & Cardeña, 1999; Cardeña et al., 1998), and could be related to the efficiency concept and the acceptance of treatment (Wolf, 1978). Several studies link patients' perceptions of quality and efficacy of treatment, considering the former as one important to the consideration in the final result of therapy (Hunsley, 1992; Spirrison, Noland, & Savoie, 1992), although this is not always the case (Van Dyck & Spinhoven, 1997).

We have not found any work that links pleasantness with suggestion. Cardeña et al. (1998) found that pleasantness was significantly related to hypnotic suggestibility. Later analysis (Alarcón et al., 1999; Capafons, Alarcón, Bayot, & Bustillo, in preparation) showed that pleasantness could be a modulating variable of suggestion and could affect therapy efficacy. Pleasant adjunctive hypnotic techniques can influence the subjective quality of treatment, and may affect its efficacy and efficiency. Thus, in addition to the label of "hypnosis," there are other variables that could be affecting suggestibility levels and the efficiency of the method: its verbalisations and exercises, the power in prompting suggested sensations within it, its perceived credibility, pleasantness, applicability, speed of application, and internal logic.

Specifically self-hypnosis is utilised to reinforce therapeutic gains in patients with practice outside of therapy sessions, and to increase their active role in treatment. Therefore, a self-hypnosis method should be performed in the circumstances of the everyday life of the person (Capafons, 1998b). Thus, for a better use of self-hypnosis it is useful to develop methods from a "waking hypnosis" perspective (Capafons, 1999; Kratochvil, 1970; Wells, 1924) where people do not need to be relaxed or have eyes closed, making it possible to follow suggestions while performing activities in daily life (Capafons, 1998a; 1999). In this way, waking hypnosis could increase hypnotic efficiency (Pascal & Salzberg, 1959).

One well-known and useful method for self-hypnosis is the Hypnotic Induction Profile (HIP: Spiegel & Spiegel, 1978). However, the HIP does have some difficulties: Having to raise the iris of the eye, the incongruent feeling of being relaxed while experimenting with arm levitation for some participants, and having to keep one's eyes closed. These difficulties suggest that the HIP method would be difficult to integrate with daily activities and would be difficult to perform in public (Martínez-Tendero, Capafons, Cardeña, & Weber, in press).

Rapid self-hypnosis (RSH: Capafons, 1998a; 1998b) overcomes these difficulties, adding additional advantages: the feasibility of learning and utilisation in daily life, since it can be done with open eyes and goes unnoticed in public. Moreover, RSH utilises prompts for helping the client experiment with hypnotic reactions. Such prompts disappear upon practice of the method. The purpose of RSH is that people learn a self-control method, in order to be able to self-apply suggestions in everyday life.

Previous studies (Martínez-Tendero et al., 1996; Martínez-Tendero et al., in press) showed that RSH is a good self-hypnosis method. Nevertheless, RSH is not easy to use covertly in public, an essential characteristic for its application to everyday life. Thus, Capafons (1999) created a briefer variation of RSH named arm dissociation (AD). The purpose was to make RSH less conspicuous in public, increasing its application in everyday life. The client learns and practises RSH, but then AD is instituted by dropping “hand clasping” and “falling backwards,” letting the person concentrate on the feeling of the arm dissociation (feeling the arm “different,” heavy, glued, etc.).

This study aims to compare the degree of participants’ self-report of experience and obtained level of suggestion between the complete method of rapid self-hypnosis (RSH) and its brief version (AD). The study also took into account participants’ self-reports of AD’s level of pleasantness and preference compared with the RSH.

## **METHOD**

### **Participants**

The sample comprised 60 “blind” volunteers (19 males [31.7%] and 41 females [68.3%]) who did not receive any economic or academic reward. They were randomly assigned to two groups: intervention group ( $N = 30$ ; 9 [30%] males; 21 [70%] females) and control group ( $N = 10$  [30%] males; 20 [70%] females). Age range was: 18–41 years ( $X = 23.30$ ;  $SD = 5.70$ ) for the intervention group, and 18–43 years ( $X = 25.03$ ;  $SD = 6.05$ ) for the control group.

In advertising posters for the study, it was explained that the study was about imagination and self-hypnosis.

### **Measures**

Each participant completed the Barber Suggestibility Scale (BSS: Barber, 1965, Barber & Wilson, 1979); a pleasantness scale (PS); and preference questionnaire (PQ).

The BSS includes a subjective and objective scale, with eight items each, in response to various kinds of suggestions. The objective scale (completed by the experimenter) has a score range from 0 to 8. The subjective scale's score range (completed by the participant) is 0–24. Test–retest is over .80 for both scales. Split-half reliability is between .70 and .84 for objective scores and .84 to .88 for subjective ones.

We used the BSS for the following reasons: reduced completion time; its inclusion of both objective and subjective scales; its use with and without an hypnotic induction; and its strong correlation with the Stanford Hypnotic Suggestibility Scale (SHCS:A: Weitzenhoffer & Hilgard, 1959), showing also validity and reliability (Council, 1999).

The pleasantness scale has 21 items with a 10-point Likert style scoring format, from “not agree” to “totally agree” with statements of each item. This scale evaluates participants' reports of level of pleasantness with RSH and AD, asking how pleasant is its utilisation, degree of understanding of the formats, and usage in public. There are no reliability or validity data for the PS.

The preference questionnaire asked participants to choose which method they preferred. There are no reliability or validity data for the PQ.

## **Procedure**

A mixed-multifactorial longitudinal design was used to test the data. The scales were administered once per week over a period of three weeks. In the intervention group, the first session lasted approximately three hours, the second half an hour, and the third an hour. Each of the three sessions for the control group lasted approximately half an hour.

One female experimenter conducted test administrations for the intervention group and half the control group. The other half was conducted by a second female experimenter naive to the goals of the study, so that the effect of the researcher variable could be controlled. A third naive female researcher recorded the objective scores of the BSS scale, to control for the effect of the researcher variable over the objective scores.

## **Experimental Group**

In the first session, after establishing rapport, the experimenter showed the RSH method to participants, who later used the method alone. Once the RSH method had been demonstrated, each participant completed the pleasantness scale. Each participant then practised the RSH. When feeling

hypnotised (with the sign of arm dissociation) each participant would signal the experimenter, who administered the BSS scale to the participant, and the BSS was scored by both experimenters. At the completion of the session, each participant would count themselves out of self-hypnosis. The participant then completed the BSS subjective scale. Finally, a brief booklet with instructions to practise RSH was given to each participant, instructing them to practise three times a day for one week. The exercises should be completed in an inconspicuous way, with eyes open and in different postures and situations.

In the second session, participants self-applied RSH again. They then completed the questionnaires. They were asked to again practise self-hypnosis and apply the BSS as in the previous session.

Participants were then instructed in the use of AD. They were told that they were ready to experience the “arm immobility-dissociation” from the RSH, without needing to use the full RSH method. They were asked to pay attention to one arm (chosen by them) and reproduce the sensation of the arm feeling heavy/glued, as experienced when practising the full method. Noticing that one’s arm is heavy/glued to the leg, as if the participant cannot move it, or feeling that moving it would be very difficult or uncomfortable, constitutes “arm dissociation,” the cue indicating that participants are self-hypnotised.

Following self-hypnosis with AD, participants again completed the questionnaires. They then used self-hypnosis again with AD and the BSS was administered. Practice with AD was prescribed for the following week (exactly the same as for RSH). On the third and last session, participants self-applied only AD and again filled in the questionnaires.

## **Control Group**

Here it was explained to participants during the first session that they would be completing some exercises of imagination. The experimenter then administered the BSS without applying any kind of hypnotic induction. Similar steps were followed in the remaining sessions.

## **RESULTS**

### **Suggestion**

A high correlation was shown between total objective scores of the BSS recorded by the principal researcher and the blind observer ( $r = .98, p < .001$  on the first two sessions:  $r = .99, p < .001$  on the third one) in the intervention

group, and in the control group (.99,  $p < .001$  for all sessions). Correlations between the second researcher and the blind one were .96, 1.00 and .99 ( $p < .001$ ). Thus, we have utilised the scores of the principal researcher for all the other analyses, and the scores of the second experimenter for the 50% of the participants of the control group. No significant differences were found between registered scores on the BSS by the second naïve control group experimenter and those obtained by the principal researcher ( $t = -.81, p > .43$  on the first session;  $t = -1.11, p > .28$  on the second session;  $t = -.89, p > .38$  on the third session).

MANOVA analyses were conducted to compare total scores on the BSS on the three sessions for both groups. For the experimental group, significant differences were found between total objective scores of all three instances ( $\lambda = .74, F = 4.95, p < .05, (\eta^2 = .18)$ ). Means were increasing through the different sessions ( $X = 5.23, SD = 1.12; X = 5.43, SD = 1.13; X = 5.78, SD = 1.06$ ), with the largest differences between the first and third session ( $T2 = 3.20, p < .005$ ). No significant statistical differences between sessions ( $\lambda = .89, F = 1.75, p > .19$ ) appeared in subjective scores of the experimental group ( $X = 14.6, SD = 3.61; X = 14.73, SD = 4.48; X = 15.37, SD = 3.99$ ).

For the control group, no statistically significant differences were found between total objective scores ( $\lambda = .87, F = 2.09, p > .14$ ), with a tendency to decrease through the sessions ( $X = 3.93, SD = 1.79; X = 3.43, SD = 1.98; X = 3.33, SD = 2.04$ ). On the subjective scores, no differences were found ( $\lambda = .98, F = .27, p > .76; X = 9.83, SD = 4.19; X = 9.5, SD = 5.03; X = 9.5, SD = 5.56$ ).

Test of differences in means were conducted to compare the total BSS scores (objective and subjective) obtained in both groups. As we expected, a group effect was shown in both objective ( $t = 3.37, p = .001$  on the first session,  $t = 4.8, p < .001$  on the second session,  $t = 5.83, p > .001$  on the third session), and subjective scores ( $t = 4.73, p < .001$  on the first session;  $t = 4.26, p < .001$  on the second session;  $t = 4.7, p < .001$  on the third session). Significant differences between control and experimental groups were found in all three sessions, with the experimental group recording higher scores.

As expected, objective and subjective scores of the BSS had an acceptable correlation when scores of both groups are combined ( $r = .70, p < .001$  on the first session;  $r = .77, p < .001$  on the second session;  $r = .78, p < .001$  on the third session).

A mix ANOVA was conducted on experimental group data to evaluate the effect of the sex variable on hypnotic suggestibility: objective ( $F = 3.26, p >$

.08) and subjective scores ( $F = .65, p > .43$ ) did not show significant differences between the sexes. No significant differences were found on the effect of the interaction of sex and method on the BSS scales ( $F = .06, p > .94$ ;  $F = .28, p > .76$ ).

An intra repeated measures ANOVA was conducted for each sex in the experimental group, to see if there are significant differences in the objective suggestion scores between the three sessions. No significant differences were found between sessions for men ( $F = 2.46, p > .12$ ). Significant differences for women were found between sessions ( $F = 3.88, p < 0.5, (\eta^2 = .16)$ ), specifically between the first and third session ( $T2 = 5.69, p < .05$ ) ( $X = 5.05, SD = 1.16$  for RSH;  $X = 5.57, SD = 1.18$  for AD). The same analysis were performed for the subjective scores without finding significant differences between sessions for men ( $F = 1.07, p > .37$ ) or women ( $F = .66, p > .52$ ).

### Pleasantness

Four exploratory factorial analyses of principal components with varimax rotation, including the items of PS of the four experimental instances, were performed. Results supported the utilisation of total scores. The percentage for the variance explained for the first obtained factor was 39% on the first try, 47.5% on the second, 55.7% on the third, and 57.1% on the fourth.

A MANOVA was performed to determine if there were differences in the total pleasantness scores between the distinct instances on which the techniques were applied (corresponding in the first two instances to the application of RSH and in the two last ones to the AD application). Significant differences exist on pleasantness ( $\lambda = .35 F = 16-41, p < .001, (= .34)$  between the first and fourth instance ( $T2 = 4.29, p < .001$ ), in favor of the later, and between the third one and the others ( $T4 = -4.00, p < .001$ ), in favor of the third one. The differences found between the third instance and the rest should be attributed to change in the technique on the third session, because significant differences between the second instance and the combination of the first and fourth one did not show up ( $T3 = -1.80, p > .08$ ). Moreover, similar means between the first and second instance were found. Means of total scores for pleasantness in the distinct instances are provided in Table 1.

A MANOVA of scores for pleasantness per item was performed, to determine which ones show differences between techniques. Results are also shown in Table 1. Pleasantness items, where there are statistically significant differences, are higher on the third and fourth instances. Significant differences appeared between the first application of RSH (first instance) and the second



**Table 1:** Significant Scores for Pleasantness Item by Item with Totals on Different Instances on Which RSH and AD Was Applied ( $N=30$ )

Items	Instance 1	Instance 2	Instance 3	Instance 4
	RSH 1st time Mean (SD)	RSH 2nd time Mean (SD)	AD 1st time Mean (SD)	AD 2nd time Mean (SD)
Makes sense	8.03 (1.54)	8.33 (1.60)	8.73 (1.39) *	8.57 (1.57)
Easy to understand	8.87 (1.17)	8.87 (1.22)	9.43 (.82) *	9.20 (1.09)
Pleasant to perform	9.03 (1.16)	8.37 (1.40)	9.17 (1.05) **	8.97 (1.16)
Quick to learn	8.77 (1.45)	9.03 (1.24)	9.23 (1.01)	9.27 (.98) *
Easy in everyday life	8.00 (1.70)	7.83 (1.86)	8.97 (1.50) **	8.73 (1.57)
Would use it in everyday life	7.70 (1.73)	7.77 (1.87)	8.47 (1.57) **	8.13 (2.29)
Easy to perform	8.37 (1.47)	8.13 (1.81)	9.00 (1.20)	9.10 (1.24) ***
Don't bother	9.50 (1.11) *	8.57 (1.50)	9.20 (1.10)	9.20 (1.13)
Unnoticed in public	6.07 (2.96)	6.60 (2.57)	8.60 (2.08) **	8.13 (2.03)
Quick to perform	8.33 (1.24)	8.40 (1.50)	9.07 (1.23)	9.33 (.88) ***
Would use it in public	6.10 (2.62)	6.50 (2.66)	8.23 (2.19) ***	8.03 (2.01)
Comfortable with technique	9.00 (1.26)	8.80 (1.30)	9.27 (.91) *	9.00 (1.31)
TOTAL PLEASANTNESS	171.07 (21.71)	173.17 (22.65)	184.07 (21.88) **	181.67 (24.16)
TOTAL MALES	170.56 (15.65)	175.67 (18.08)	183.44 (21.54)	181.78 (29.61)
TOTAL FEMALES	171.29 (24.19)	172.09 (24.68)	184.33 (22.55) ***	181.62 (22.25)

\* $p < .05$  \*\* $p < .005$  \*\*\* $p < .0005$

of AD (fourth instance). Items that show those differences are the following: "This technique makes sense" ( $T2 = 2.40, p < .05$ ) "Easy to understand" ( $T2 = 2.07, p < .05$ ), "Quick to learn" ( $T2 = 3.32, p < .005$ ), "Easy to apply in everyday life" ( $T2 = 2.81, p < .01$ ), "Easy to perform" ( $T2 = 4.82, p < .001$ ), "Unnoticed in public" ( $T2 = 4.17, p < .001$ ), "Quick to perform" ( $T2 = 5.38, p < .001$ ) and "Would use it in public" ( $T2 = 4.80, p < .001$ ).

We compared also the two applications of RSH (first and second instances) and the second application of AD (fourth instance), with the first one of AD (third instance) that corresponds to the change in method. Statistically significant differences were obtained in the following pleasantness items: "This technique is easy to understand" ( $T4 = -2.60, p < .05$ ), "Pleasant to perform" ( $T4 = -3.95, p < .001$ ), "Easy to apply in everyday life" ( $T4 = -3.99, p < .001$ ), "Would use it in everyday life" ( $T4 = -2.69, p < .05$ ), "Easy to perform" ( $T4 = -2.51, p < .05$ ), "Does not bother" ( $T4 = -3.19, p < .005$ ), "Unnoticed in public" ( $T4 = -2.81, p < .01$ ), "Would use it in public" ( $T4 = -3.29, p < .005$ ), and "I have felt comfortable with the technique" ( $T4 = -2.75, p < .05$ ). In all cases the first application of AD obtained the highest score with the exception of the item "it bothers to perform." The differences in this item seems due to the second application of RSH (second instance). It is the only comparison of this application with the first of RSH (first instance) and the last one of AD (fourth instance), on which significant differences were found ( $T3 = 2.58, p > .05$ ) in detriment of the former, that obtained the lowest score of all four applications.

For the majority of the items where there were significant differences between the third instance (first application of AD) and the others, differences between the fourth instance (second of AD) and the first one (first of RSH) where also shown (items: "Easy to understand," "Easy to apply to everyday life," "Easy to perform," "Unnoticed in public," and "Would use it in public").

These results are corroborated with those obtained on the preference questionnaire between methods on the second and third session. Chi-square tests were used to analyse data between the elements of this questionnaire in two ways: (a) comparing the three levels of choice responses (RSH, AD and both equally), and (b) forcing the choice (considering one technique or the other as an alternative, without including those participants who did not choose either method or chose both equally). In all the items and in the two instances of the application of this questionnaire, participants preferred AD or both techniques equally, and in no case was RSH preferred. Significant differences were found in favour of AD (forced choice) on the items "Would use it in everyday life," "Easy to apply in everyday life," "Easy to remember," "Unnoticed in public" (100% preferred arm dissociation on both tries), "Would use it in public" (also 100% preferred it on the first try), and "Comfortable with the technique," as well as after the first application of AD (Table 2) like after its second application after a week of practice (Table 3).

In the last session there were also differences in favor of AD in the item “Hypnotised faster.” To corroborate if participants’ preferences were constant from one session to another a McNemar test was performed for each item, showing no significant differences between the two completions of the questionnaire.

Focusing only on the items related with the application of the techniques in public, it was found that all participants preferred the AD as “More unnoticed in public” and “Would use it more in public” after its first application. After the week of practice, 96.7% of all participants considered the AD “More unnoticed in public” and 96.6% “Would use it in public” over the RSH.

To evaluate the influence of the sex variable and the interaction effect between the sex variable and the temporary moments of pleasantness, a MIX ANOVA was conducted showing no significant differences between sex on pleasantness ( $F = .00$   $p > .95$ ). The effect of the interaction between sex and

**Table 2:** Significant Scores for Item by Item Preference on the Second Session with Forced Choice

Items	$\chi^2$	<i>df</i>	<i>p</i>	% AD	<i>N</i>
Would use it in everyday life	19.59	1	.000	92.6	27
Easy to apply in everyday life	25.14	1	.000	96.6	29
Easy to remember	15.21	1	.001	94.7	19
Unnoticed in public	*	–	–	100.0	30
Would use it in public	*	–	–	100.0	30
Comfortable with the technique	4.00	1	.045	75.0	16

\*100% preferred AD

**Table 3:** Significant Scores for Item by Item Preference on the Third Session with Forced Choice

Items	$\chi^2$	<i>df</i>	<i>p</i>	% AD	<i>N</i>
Would use it in everyday life	13.50	1	.000	87.5	24
Easy to apply in everyday life	19.59	1	.000	92.6	27
Easy to remember	14.22	1	.000	94.4	18
Unnoticed in public	*	–	–	100.0	29
Would use it in public	25.14	1	.000	96.6	29
Comfortable with the technique	6.25	1	.012	81.3	16
Hypnotised faster	5.76	1	.016	76.2	21

\*100% preferred AD

the moment of application (and hence, technique) also was not significant ( $F = .33, p > .80$ ).

An INTRA ANOVA analysis was also conducted on the female data ( $N = 21$ ) and another on that of the men ( $N = 9$ ), to corroborate if there are differences in total scores between technique for each sex. No significant differences were found for men ( $F = 2.12, p > .12$ ). For female participants, significant differences occurred between all four instances of application ( $F = 16.47, p < .000, (\eta^2 = .45)$  specifically between the first application of RSH and the second of AD ( $T2 = 21.68, p < .000$ ) in favour of the latter, and between the first of AD and all others ( $T4 = 17.97, p < .000$ ) in favour of the former. In the same way, no significant differences showed up in comparing the first application of RSH and the last one of AD with the second of RSH ( $T3 = 1.80, p > .19$ ).

## DISCUSSION

In light of these results, we have accomplished the goal for this study of validating AD.

We found an unexpected increase in the level of suggestion produced by AD with respect to RSH. The pleasantness of an hypnotic method does seem to affect the produced level of suggestion, as shown by other research of our group (Cardena et al., 1998; Alarcón et al., 1999). The hypothesis that the increase in suggestion over the sessions could be due to practice in the suggestibility scale is rejected, given that the control group did not show such practice effect.

With respect to pleasantness, AD was preferred over the RSH. AD was perceived as easier to practise in public and easier to use in daily living. Items related with these dimensions (notice in public, application in daily living, use in public) showed that AD was preferred from its first application. In the same way, participants have found AD faster and easier to perform and indicated that it was easier to remember, which makes it a more efficient technique.

As expected, differences between male and female were not found. Gender appears not to affect hypnotic techniques utilised. It confirms that sex is not a relevant variable in hypnotic suggestibility, since sex differences have not been found in the majority of studies in the field of hypnosis (Barber, 1965; D'Eon, Mah, Pawlak, & Spanos, 1979; Stanton, 1994), even though in some studies there are differences favouring females (Cardena et al., 1998; Martínez-Tendero, et al., 1996; Weeks & Lynn, 1990). On the other hand, neither did we

find gender differences in the general level of pleasantness, nor preferences for each technique.

We conclude that the AD method makes the RSH a more efficient and effective hypnotic method. AD surpasses the initial method in several important characteristics: It is more pleasant, can be more easily applied to the everyday living of the client, it is shorter, less conspicuous in public, and results in greater client suggestibility.

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