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## EDITORIAL

I believe that hypnosis research and practice are important areas for comment and publication. Thus I am pleased to take on the role of the new editor of *AJCEH*, and consider that this is an essential contribution of the Australian Society of Hypnosis to the whole field of hypnosis. How the previous editor Dr Barry Evans gathered, crafted, and published articles for so long is a mystery, particularly as he carried the journal through a time when interest in hypnosis and hypnosis training peaked and ebbed. Thank you again, Barry.

Terpnos Logos. At recent conferences, the meaning of the ASH logo has been raised and a number of possibilities put forward. In the early 1960s, the name of the journal was *Terpnos Logos*, which the journal's copy editor Carl Harrison-Ford tells me means calm and regular words. Milton Erickson would have liked that translation. Carl also advised that the snake on the stick is a caduceus, a traditional symbol of the medical profession used, for example, on doctor plates on cars and by medical services in the army. Is the logo then little more than a medical symbol, a map, or a slogan? Additionally, Carl mentions that caduceus is associated with Mercury. Is there a case then for suggesting hypnotists are winged messengers? We welcome the corporate memory of ASH to contact us ([k.gow@qut.edu.au](mailto:k.gow@qut.edu.au)) to add any insights into the history of the logo for ASH and its use in the journal, as there has been international interest in the topic recently.

In the past, the name of the journal was changed to reflect a wider representation of hypnosis, in terms of the amount of clinical and experimental research conducted in this area, as well as the high quality output in clinical practice. With the changes in focus in the hypnosis field over the past decade or so, it may be reasonable that the journal now include other topic areas connected to hypnosis, such as sleep and dreams where they relate to similar contexts and experiences.

You may note a slight change to the existing format of the journal in that we have added film reviews as well as book reviews, and sometimes we will insert commentaries as well as research notes to cater for the publication of brief communications that have relevance to readers. In the next issue, following requests from participants at the Perth congress, we will include scripts with Australasian themes and terminology that are suitable for practitioners in Australia and New Zealand. In this edition, you will note that forensic issues and trauma and PTSD seem to predominate. This was not

intentional, but rather reflects the current interests and work of the contributors who are representative of the members of the Society.

There are also changes to the Editorial Board and Editorial Consultants. We welcome Norm Barling, Amanda Barnier, and Barry Evans as Associate Editors and Kevin McConkey, Joseph Barber, Michael Nash, and Jeffrey K Zeig as Editorial Consultants. We note the passing of some of our valued editorial consultants and the move to retirement of others. We would like to thank all of those people who have contributed to the journal in many different ways over the decades.

*Kathryn Gow*  
*May 2005*

## ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE: TRIGGERS TO REMEMBERING

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*This article focuses on the triggers to remembering reported by an Australian sample of adult survivors of sexual abuse (N = 16). Participants were interviewed about the types of, and conditions surrounding, the triggers of initial memories while in therapy, or with the use of hypnosis. These conditions have been nominated by the FMS support groups as contributing to the recovery of false CSA memories. Participants in this study reported that they did not have their initial abuse memories triggered by therapy or hypnosis. They experienced a variety of trigger events which fitted categories similar to those proposed by Courtois (1992). One additional category was found in this study and it was named spontaneous trigger events. It included triggers of which the participant was not consciously aware and could not define. There appeared to be no method of predicting the type of trigger event that individual adult survivors would experience.*

Although previous studies have found support for CSA forgetting, few have explored in-depth what kinds of events trigger initial CSA remembering and whether or not most survivors, who claim to have forgotten about their abuse for an extensive period of time, have their initial memories triggered while in therapy or by the use of hypnosis. These two conditions have been deemed to contribute to the development of false CSA memories (Brenneis, 1997).

This article is presented in the following format. First, the literature review covers the triggers to remembering after periods of forgetting. Second, the method outlines the selection process of the 16 cases under investigation, group characteristics, and the interview analysis methodology. Results are

presented, followed by a discussion for each sub-section, and any differences and similarities between the groups are outlined in the interview analysis categories. The discussion also explores how the results are viewed in comparison to the available literature. Finally, conclusions are drawn about the triggering of childhood sexual abuse memories by adult survivors who have either partially or totally forgotten about their abuse for a period of time.

Courtois (1992) defined a trigger as a cue to memory retrieval. In other words, the trigger event starts the memory retrieval process, leading to forgotten events being remembered. She suggested that there was no way to predict whether an event could trigger a person's memories of childhood sexual abuse. Triggers could, however, fall into five categories: (a) normative developmental events or crises, such as the birth of a child, the development of an intimate relationship, or the death of the abuser or significant other; (b) exposure to events which symbolise or resemble the actual trauma, such as a specific person, body type, sound, smell, media event, sexual activity, or medical/dental procedure; (c) crises associated with recollection, disclosure, confrontation, reporting and other criminal justice activities; (d) issues within therapy, such as issues of trust, support and validation; and (e) life stages, such as mid-life crisis, the "empty-nest syndrome," or achieving sobriety. Courtois also suggested that triggers vary from those that are quite specific to the trauma to those that are more subtle or general in nature.

Harvey and Herman (1994) reported their findings on the types of trigger events experienced by the participants in their research. The triggers included entering or ending an intimate relationship, having a child, caring for the perpetrator when ill or ageing, and learning that another person was abused by the same perpetrator. These events supported Courtois' categories, as did those found by Dale and Allen (1998) who described trigger events ranging from participation in therapy to being drunk, visiting a clairvoyant, mental breakdowns, and reading abuse-focused literature. Binder, McNeil, and Goldstone (1994) added survivor support groups, adult sexual experience, and adult traumatic events to the growing list of trigger events.

Albach, Moormann, and Bermond (1996) interviewed 97 sexually abused women about the trigger events they had experienced. They found that periods of intense emotion triggered recall of abuse episodes that were previously forgotten. Periods of intense emotion coincided with: watching a TV movie about incest, discovering that their daughter had been a victim of sexual abuse, experiencing rape as an adult, the death of the perpetrator, being physically and emotionally exhausted, touching, smells similar of those of the



abuser (soap, aftershave, tobacco), auditory (hearing footsteps or panting) and visual cues. Cameron (2000) also interviewed adult survivors to identify trigger events. Her results suggested two categories of trigger events. The first was broad in nature and included feeling safe or feeling overwhelmed, as establishing the conditions under which specific triggers could occur. Specific triggers included the death of the abuser, geographical distance from the abuser, surgery, birth, massage, dreams, nightmares, and contact with a similar person or setting.

Andrews et al. (2000) conducted telephone interviews with 108 therapists who reported having clients with recovered memories of traumatic events, including child sexual abuse. The therapists reported trigger events such as a therapeutic technique or therapist's comment/question, talking about the supposed perpetrator, events involving client's children, physical contact or danger to client or others, books/media, someone who knew about the abuse reminded the client, loss or threat of loss, and changes in medication or substance use. A significant majority of participants were unable to identify the events that triggered their memories. Most of the participants reported recovering their memories within the therapeutic setting, with 15% indicating that a therapeutic technique triggered their memories of trauma. The information contained in this study was reliant on the therapists' notes and remembered observations of client reports and behaviours, rather than directly from the clients, thus leading to possible errors and biases in reporting. In contrast, Wilsnack, Wonderlich, Kristjanson, Vogeltanz-Holm, and Wilsnack (2002) and Chu, Frey, Ganzel, and Matthews (1999) found that most survivors later remembered about the abuse on their own.

In contrast, some researchers have defined the triggers to false CSA memories as specific to the therapist, therapeutic techniques and other methods of treatment, such as self-help survivor groups and popular literature. The triggers, outlined by Courtois and others, include life events, such as forming an intimate relationship, or hearing about the death of the abuser. These triggers were not often mentioned in the false memory literature.

Courtois (1997), Hall and Kondora (1997), and Farrants (1998) outlined the history of the false memory movement from the time of Janet and Freud in the late 1800s to the current day, most recently coming to public awareness in 1992 in the United States via the establishment of the False Memory Syndrome Foundation and accompanying media attention. The members of the foundation board included eminent memory researchers who suggested that there was an epidemic of false memory accusations arising from a group

of therapy techniques called “recovered memory therapy” utilised by inexperienced therapists or therapists who allegedly wished to make a significant amount of money by implanting false memories of abuse and then treating the “abused” clients over a lengthy period of time. This therapy apparently included “systematic and indiscriminate application” of hypnosis, age regression, guided imagery, journaling, body memory and dream interpretation, recommendation of self-help books and self-help groups.

Brandon, Boakes, Glaser, and Green (1998) created a working party designed to examine the scientific evidence surrounding the debate between false memory and recovered memory. They reviewed their own and others’ experiences in the field, reviewed the literature, and interviewed false memory survivors who recanted, and their parents. These interviews were primarily conducted with members of the British False Memory Foundation. The purpose of this research was to provide clinicians with some clear guidelines for practice. They stated that the phenomenon of false memory did not always occur in the context of a therapeutic relationship, but also arose from the survivor who read popular literature on the topic, watched television, or talked to other survivors or survivor groups.

Brandon et al. (1998) and Horn (1993) identified a number of therapy techniques, including checklists of symptoms, hypnosis, age regression, dream interpretation, art therapy, and survivors’ groups, which they described as being appropriate techniques to use in orthodox therapy but questionable when used as memory recovery procedures.

Overall, they also suggested that there was evidence to support the view that these techniques were dangerous, especially when the memories that were recovered fell into the early period of a survivor’s life (infantile amnesia). They also criticised the mechanism of dissociation related to forgotten memories of child sexual abuse as arising from the interaction of a suggestible client and an expectant therapist, as did Brenneis (1997). Those authors’ primary perspective appeared to be that those survivors who had never forgotten their abuse were likely to be reporting a real experience, but that memories recovered from before the age of four and memories of repeated abuse that were forgotten were not credible.

Loftus (1993) described an experiment she undertook with five children, where they were told that they had been lost in a mall when they were younger. She enlisted the aid of older siblings to confirm the false story. From the results, Loftus concluded that false memories were implanted quite easily and that subjects found them as vivid and believable as true memories. Loftus

called this phenomenon the “misinformation effect.” This study has been the subject of criticism regarding various methodological flaws, such as the ethics of research based on a confabulated story, equating the experience of getting lost in a mall with the experience of child sexual abuse, and utilising older siblings to give the story credibility.

In summary, research has identified a variety of trigger events, with triggers specific to therapy more likely to lead to the creation of false CSA memories. Courtois provided a system of categories to organise specific trigger events, including a category that related to therapy issues. The focus of this category was the development of trust, rather than the deliberate implanting of false memories. The research also indicated that the addition of another category was warranted — that of the “spontaneous trigger event.” The spontaneous trigger event could include events that were not subsumed under the existing categories, and could be described as recall of childhood sexual abuse memory, without identification of a definite precipitating experience. Trigger events leading to either true or false CSA memories could fall into this category. A spontaneous trigger could arise from the interaction between the therapist and client, regardless of the focus of therapy (i.e., to develop trust or to implant false memories).

This study sought to identify specific trigger events and to investigate the conditions surrounding those events, predicting that participants’ responses would confirm previous findings and Courtois’ categories. Participants were asked to indicate whether their initial abuse memories were triggered in therapy or with the use of hypnosis. These questions were originally asked as a filter for identifying potential false memory reports.

## **RESEARCH DESIGN**

The research program required a mixed method design to facilitate the exploration of CSA forgetting, triggering, and remembering by adult survivors. Data were gathered through the completion of psychological tests (Stage One) and participation in a semi-structured interview (Stage Two). Smith (1995) outlined the semi-structured interview format as being the most appropriate for this research because: there is an attempt to establish rapport with the participant; the ordering of questions is less important, allowing exploration of interesting details if any arise; and the interviewer can respond to the participants’ concerns as the need arises. All these details are necessary for the successful and ethical conduct of research on CSA forgetting and remembering.

The mixed method extended to the mixture of statistical and qualitative data gathered during a two-phase process and the qualitative and quantitative techniques used to analyse the data. The two-phase design is used to facilitate a thorough investigation of the research topic. Creswell (1994, p. 175) proposed five reasons for using a combined method approach: (a) triangulation in the classic sense of seeking convergence of results; (b) complimentary, in that overlapping and different facets of a phenomenon may emerge; (c) developmental, wherein the first method is used sequentially to help inform the second method; (d) initiation, where contradictions and fresh perspectives emerge; and (e) expansion, where the mixed methods add scope and breadth to a study. The use of the mixed method by this current study was the most appropriate one in accordance with the depth and breadth of the research questions, the exploratory nature of much of this research, and the need to locate a sample of CSA survivors who were willing to participate in research about their abuse experiences and memories. In addition, the method used in Stage Two had to allow flexibility, as patterns in the data emerged, resulting in possible re-categorisation of the data (Holland, Holyoak, Nisbet, & Thagard, 1989).

This study required a nonprobability purposive sampling approach, which is used when the research required a sample with a specific characteristic. Probability sampling was not suitable, because not enough was known about the characteristics of the population to decide which people were suitable for inclusion (Denscombe, 1998).

Correlational research was used with the goal of identifying predictive relationships among naturally occurring variables, rather than the use of experimental research, which involved the manipulation of independent variables. A potential limitation of correlational research involves the interpretation of causal relationships between the variables.

This research used a between-groups and within-group approach. A between-groups approach was used because the variation in statistics and interview data arose from differences between the participants at a single point in time. The hypotheses were tested using a cross-sectional survey and interview design aimed at obtaining a description of the characteristics of the population, and the differences and similarities between groups of the population (Shaughnessy & Zechmeister, 1994). The hypotheses were not tested using a longitudinal methodology, because the research was only concerned with investigating the participants' one-time retrospective accounts of their experiences of memories about childhood sexual abuse.

## **METHODOLOGICAL ISSUE: CORROBORATION**

The methodological issues of the use of retrospective data and corroboration are examined in this section. These issues are closely related, in that the results of any research which relies on retrospective data without any form of corroboration may be criticised or invalid. This applies particularly to research conducted on CSA and CSA memory, where previous studies in which corroboration has not been sought have been heavily criticised. The primary criticism appears to be that uncorroborated accounts of childhood sexual abuse, and the associated memories, may be confabulated by the participants. This criticism relates particularly to reports of partial and total forgetting of the abuse. Those individuals who report always remembering their abuse do not appear to attract the same level of criticism, although their reports are also retrospective, often uncorroborated, and may have lost some of their memory detail due to the passage of time (i.e., normal forgetting).

These issues have important implications for current legal and psychological practice, in that increasing numbers of adult CSA survivors are seeking criminal and civil redress for the abuse they experienced. The use of retrospective accounts of abuse and lack of corroboration by forensic evidence are issues central to the accurate determination of these cases.

In this current study, corroboration of the abuse was sought in all cases. In the larger study, corroboration that the abuse had occurred was reported by 87.5% of those participants who reported partial forgetting, and by 63.6% of those participants who reported extensive forgetting. Corroboration of the abuse came from a variety of sources, including: physical scarring, suicide attempts, confirmation by family members, confirmation by the abuser, court proceedings, drug and alcohol abuse patterns, diagnosed mental and emotional disorders, and eating disorders. Some participants (30%) reported a combination of the above. The levels and types of corroboration in the current study were similar to those outlined by Herman and Schatzow (1987), where 74% of their sample was able to obtain corroboration for their abuse from other sources.

## **METHOD**

### **Participants**

The participants were selected from the larger Partial and Extensive Forgetting groups in Stage One of the research program ( $N = 77$ ). The first guideline for selection reflected the approximate ratio of Stage One participants who

partially forgot to participants who extensively forgot about the abuse (ratio 6:10). Therefore, six participants who partially forgot and ten participants who extensively forgot were required. The second selection decision was based on the DES II scores obtained by the participants in Stage One. High and low DES II scores were required to provide an even spread of scores and minimise skewness of the results. Cases 9, 22, 32, 43, 46 and 57 were selected from the Partial Forgetting group, in accordance with their DES II scores. Similarly, cases 5, 6, 11, 12, 13, 14, 15, 24, 39 and 54 were selected from the Extensive Forgetting group.

### **Demographic Characteristics (N = 16)**

For this analysis, the demographic characteristics of the overall group of participants are as follows. The mean DES II score for the overall group was 26.37, with a range of 04.29 to 63.93. The current mean age of the group was 41 years, with a range of 28 years to 58 years. The group comprised three males (19%) and 13 females (81%), which reflected the overall ratio of males and females for this whole study. The mean age of abuse onset was 3.3 years, with a range of under 1 year to 6 years of age. The mean abuse duration was 10.4 years, with a range of 3 years to 35 years. There were four missing cases for this statistic, with two unsure responses and two responses (six weeks and three months) that were not included in the calculation of the mean, which was calculated in whole years.

Thirteen participants (81%) reported repeated abuse; one participant (6%) reported abuse frequency of two to three times; and there were two participants (13%) who reported being unsure of the abuse frequency. Twelve participants (75%) reported multiple abusers and four participants (25%) reported one abuser. Twelve participants (75%) reported experiencing the full range of abuse incidents, from being kissed, the abuser touching their genitals, being made to touch the abuser's genitals, to rape. One participant (6%) reported the abuser touched their genitals. Two participants (13%) reported that the abuser touched their genitals and performed oral sex on them. One participant (6%) reported the abuser touched their genitals and attempted penetration.

### **Demographic Characteristics for the Partial Forgetting Cases (n = 6)**

The mean Dissociative Experiences Scale II (DES II) score for the partial forgetting sub-group was 17.74, with a range of 05.00 to 34.29. The current

mean age of the sub-group was 41.5 years, with a range of 29 years to 51 years. The sub-group comprised one male (17%) and 5 females (83%). The mean age of abuse onset was 5.75 years, with a range of 3 years to 15 years of age. The mean abuse duration was 6.5 years, with a range of 3 years to 12 years. Five participants (83%) reported repeated abuse and one participant (17%) reported being unsure of the abuse frequency. Five participants (83%) reported multiple abusers and one participant (17%) reported one abuser. Four participants (67%) reported experiencing the full range of abuse incidents, from being kissed, the abuser touching their genitals, being made to touch the abuser's genitals, attempted rape or penetration, to being raped or penetrated. One participant (17%) reported the abuser touched their genitals and performed oral sex on them. One participant (17%) reported the abuser touched their genitals and attempted penetration.

### **Demographic Characteristics for the Extensive Forgetting Cases ( $n = 10$ )**

The mean DES II score for the overall group was 31.54, with a range of 04.29 to 63.93. The current mean age of the group was 40.8 years, with a range of 28 years to 58 years. The group comprised two males (20%) and eight females (80%). The mean age of abuse onset was 3.0 years, with a range of under 1 year to 6 years of age. The mean abuse duration was 14.3 years, with a range of 8 years to 35 years. There were four missing cases for this statistic, with two unsure responses and two responses (six weeks and three months) that were not included in the calculation of the mean, which was calculated in whole years. Eight participants (80%) reported repeated abuse; one participant (10%) reported abuse frequency of two to three times; and one participant (10%) reported being unsure of the abuse frequency. Seven participants (70%) reported multiple abusers and three participants (30%) reported one abuser. Eight participants (80%) reported experiencing the full range of abuse incidents, as described in the previous section. One participant (10%) reported the abuser touched their genitals. One participant (10%) reported that the abuser touched their genitals and performed oral sex on them.

## **MATERIALS**

Participants had been asked to complete a battery of psychological surveys, identified in the literature review as being suitable for the measurement of abuse-related psychological and traumatic symptoms. The surveys included a

modified version of the Traumatic Events Questionnaire (TEQ), the Dissociative Experiences Scale II (DES II), the Impact of Events Scale — Revised (IES-R), and the Symptom Checklist 90 — Revised (SCL-90-R).

### **Traumatic Events Questionnaire (TEQ)**

A modified version of the Traumatic Events Questionnaire (TEQ) was used in this study. The TEQ was developed by Lipschitz, Kaplan, Sorkenn, Chorney, and Asnis (1996) to elicit details of abuse histories. The TEQ contains 49 self-report items that ask about the frequency, nature, age of occurrence and duration of both past and current physical and sexual abuse, in addition to perpetrator details. The questionnaire is not psychometrically mature, but does demonstrate a high rate of agreement with responses to the same questions in a face-to-face interview in a sample of 50 participants. The TEQ does not require reliability and validity Alphas because it is intended as a descriptive measure only.

### **Dissociative Experiences Scale II (DES II)**

The Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986) measures the frequency of dissociation for clinical or research purposes, with normal and clinical populations. The DES II, developed to facilitate ease of scoring, was used to measure the frequency of dissociative experiences in the participants of this study. The total score is obtained by averaging the item scores. The DES uses a cut-off score of 30 and above, based on the total average score, to facilitate identification of those people who may be severely dissociative. A score of 0 to 29 indicated mild to moderate dissociation.

The DES has been used in many (100+) studies, and has mature psychometric properties, with a mean alpha reliability of 0.93 across 16 studies (Van Ijzendoorn & Schuengel, 1996). According to Rosenthal and Rosnow (1991), reliability coefficients of 0.85 or above are considered indicators of dependable psychological tests. The DES has been analysed as demonstrating good construct validity, in that it has been shown to accurately measure the construct of dissociation, and good criterion-related validity, in that the DES scores agree with the DSM-III diagnostic criteria for dissociative disorders (Putnam et al., 1996).



### **Symptom Checklist 90 — Revised (SCL-90-R)**

Participants were asked to complete the Symptom Checklist 90 — Revised (SCL-90-R), developed by Derogatis et al. (1976) and designed to measure current symptomology in adults arising from childhood experiences. The SCL-90-R is a 90-item self-report instrument, consisting of six sub-scales and three global indices. The Global Severity Index provides the best indicator of the current level or depth of psychological distress. The SCL-90-R sub-scales are considered to be psychometrically reliable (Derogatis, 1993.)

Scoring of the SCL-90-R is straightforward. Raw scores are calculated by summing the values for every item in each of the nine symptom sub-scales and the seven additional items. The summed raw score is then divided by the number of endorsed items, for the relevant sub-scale, and converted to a standardised *T* score using the appropriate group norm. On all sub-scales, a standardised *T* score of 50 places the individual in the 50th percentile. Group norms include adult psychiatric outpatients (Norm A), adult nonpatients (Norm B), adult psychiatric patients (Norm C), and adolescent nonpatients (Norm E). This current study used norm B to convert the participants' raw scores to standardised *T* scores. Each of the norms has separate scores for males and females.

### **Impact of Events Scale — Revised (IES-R)**

The Impact of Events Scale is one of the most widely used surveys of post-traumatic symptomology in research studies (Elliott & Briere, 1995; Joseph, 2000). Horowitz, Wilner, and Alvarez (1979) designed the Impact of Events Scale (IES) as a 15-item survey designed to measure the subjective stress experienced by people related to a specific event. The original IES items formed two sub-scales related to the response to traumatic stress (i.e., intrusion and avoidance). The IES-R (Weiss & Marmar, 1997) added seven items designed to reflect a sub-scale termed hyperarousal. All items are scored on a four-point Likert response scale (“not at all” to “often”) and are targeted to measure levels of symptoms in the past seven days. The literature indicates that there are several Likert scales for scoring the IES-R. This study adopted the Horowitz et al. (1979) method for scoring the IES-R responses, that is, a score of “0” indicated a negative endorsement of the item and scores of “1,” “3,” or “5” indicated three degrees of positive endorsement for intensity and frequency.

This study modified the time frame given in the administration instructions from the “past seven days” to read “after the abuse,” requiring the participants to attempt to remember their thoughts and feelings about the abuse shortly after the abuse had occurred. The instrument was modified in order to measure the participants’ subjective stress at the time of, or shortly after, the abuse occurred. A measure of current subjective stress, although useful, would not provide information as relevant to the processes of CSA forgetting. The rationale for this decision related to the literature, previously reviewed, on the development of Acute Stress Disorder, as being the most immediate stress response for some survivors to their abuse, with some survivors going on to develop PTSD. Both disorders include aspects of intrusion, avoidance, and hyperarousal, as measured by the IES-R.

Weiss and Marmar (1997) collected data about the internal consistency, test-retest reliability and item-to-scale correlations of the IES-R from two different studies. They found that the IES-R and sub-scales yielded coefficients that indicated highly internally consistent reliability and acceptable test-retest reliability.

## **Interviews**

Materials for this study included verbatim transcripts of the semi-structured interviews (Interview B) that the participants responded to during the second phase of data collection. The interviews were taped by the researcher and transcribed by external transcribers to negate possible researcher bias during the transcription process. Extracts of aspects of these interviews are reported here.

Details of the participants’ age, duration of abuse and severity of abuse, together with their scores on the DIS, Impact of Events, Symptom Checklist, and GSI, along with corroboration, are included in brackets at the end of the first set of individual quotes for those readers who wish to check their scores on the various scales. They are not investigated here in depth, as they are the subject of another article submitted to a journal which focuses on issues relating to childhood sexual abuse.

## **DATA ANALYSIS PROCEDURES**

The data were analysed using the interview analysis technique. This is a qualitative technique used to provide a systematic method of analysing the interview material (Silverman, 1993). The category of analysis was determined

as triggering. Sub-categories were then developed based on the actual interview questions as follows:

- What event(s) triggered the memories?
- Was hypnosis involved?
- Were you in therapy when your memories returned?

Quantitative statistics were derived from the raw data for all participants in this analysis, then for each sub-group ( $n = 6$ , Partial Forgetting;  $n = 10$ , Extensive Forgetting). Each sub-category was then structured to report the overall group statistics first, then the Partial Forgetting statistics and verbatim comments were presented, followed by the statistics and verbatim comments for the Extensive Forgetting group. Readers need to keep in mind that the 16 case studies have been selected, from an overall sample of 77, on the basis of a set of criteria; that is, on the basis of: whether they always remembered, partially forgot, or forgot everything; their level of dissociation; and the duration and severity of the abuse.

## **RESULTS AND DISCUSSION**

This section of the results relates to the types of trigger events experienced by the participants just prior to initially remembering their sexual abuse experiences. The participants were asked what specific events triggered their first abuse memories.

### **What Event(s) Triggered the Memories?**

*Overall Group* ( $n = 16$ ) Eighty-eight percent (14) reported specific events which triggered their initial memories of the abuse, but 12% (2) were unsure of how their memories were triggered.

*Partial Forgetting Group* ( $n = 6$ ) Eighty-three percent (5) reported experiencing a specific event or events which triggered their memories of the abuse. Seventeen percent (1) were unsure of how their memories were triggered. Their individual comments follow.

Case 9: *I started recovering a bit more detail when I gave birth to my first child at the age of 35 years. For some reason after the children were born I started to think about it more. Like remembering that I hadn't forgotten.*

(Age 43, female, abuse duration 6 years, genital touching, oral sex, multiple abusers. Scores: DES II 13.93, IES-R 14.3, SCL-90-R GSI 68. Corroborated by family member.)

Case 22: *This particular uncle ... I was in my thirties ... and he wanted to come and stay with us in Sydney ... I said to my brother if he stays I'm going. It hit me. Smells have triggered me for a long time and I don't know why. The same brand of pipe tobacco that he smoked ... the smell of the labour ward ... it smells like semen.*

(Age 49, female, abuse duration 8 years, full penetration, multiple abusers. Scores: DES II 16.43, IES-R 20.7, SCL-90-R GSI 76. Corroborated by abuser admission and family member.)

Case 32: *Becoming clean and sober at the age of 21.*

(Age 37, male, abuse duration not defined — under 5 onset, stopped age 7 years, attempted penetration, one abuser. Scores: DES II 20.0, IES-R 13.7, SCL-90-R GSI 74. Corroborated by family members.)

Case 43: *I guess I remembered when I was 38. Seeing other children at the same age I was when the abuse took place, behaving in a way that reminded me of things I used to do and I put two and two together. There was a little 3-year-old at the shopping centre who begged her father to lick her down there "like Poppie does." There are still big chunks missing.*

(Age 40, female, abuse duration 12 years, full penetration, multiple abusers. Scores: DES II 05.00, IES-R 20.0, SCL-90-R GSI 55. Corroborated by abuser admission.)

Case 46: *Age 28 ... my father got very angry with me in the street and just the look on his face and that passionate anger just brought me back to being a kid. Also my husband left.*

(Age 29, female, abuse duration 4 years, attempted penetration, multiple abusers. Scores: DES II 34.29, IES-R 34.7, SCL-90-R GSI 81. Corroborated by history of depression and eating disorder and physical scarring.)

Case 57: *I don't know what triggered it. I had been slowly going downhill ... having body memories but not knowing what they were ... then all these feelings came ... I got pictures and it was my father and that sort of shut me down then.*

(Age 51, female, abuse duration 6 years, full penetration, multiple abusers. Scores: DES II 16.79, IES-R 27.7, SCL-90-R GSI 81. Unable to corroborate.)

*Extensive Forgetting Group (n = 10)* Ninety percent (9) reported experiencing a specific event or events which triggered their memories of the abuse. Ten percent (1) were unsure of how their memories were triggered. Their individual comments follow:

Case 5: *At age 40 I was concerned about problems I had with my wife and various other things, so I contacted a therapist who suggested I join his men's group. I said to him I had thoughts that I was being abused ... but didn't really believe them. After a few months of hearing what other men talked about as far as behavioural problems ... one morning the whole passage of the abuse just suddenly appeared in my mind.*

(Age 42, male, abuse duration 6 weeks, full penetration, one abuser. Scores: DES II 63.57, IES-R 00.0, SCL-90-R GSI 81. Corroborated by family members and history of sexual confusion and depression.)

Case 6: *Participant forgot from ages 6 to 16/17 (briefly remembered) then forgot again to age 22 for two years, then forgot again age 24 to 31. Triggered by seeing someone who looked like the perpetrator, "watching a couple of horrific television programs like The Exorcist ... and my memories just kept coming out stronger and stronger over about a year, ... triggered as an adult by thinking, 'Okay I can look after myself now' and I actually made a conscious decision to get myself to do that." At age 34 "I actively sought out survivor groups ... I met another abuse survivor ... who had gone through similar experiences ... and I felt externally validated. The sense of control he felt increasingly as an adult was a big trigger."*

(Age 41, male, abuse duration 35 years, full penetration, multiple abusers. Scores: DES II 11.79, IES-R 15.3, SCL-90-R GSI 81. Corroborated by physical scarring.)

Case 11: *I think it was an ultimate piecing together ... my fiancé died four years ago ... I knew I had to sort of just do that and deal with that. It was a conscious decision then to force myself into it. A lot of it was looking at the family dynamics, particularly with my dad dying ... there were always missing elements.*

(Age 36, female, abuse duration one incident, genital touching, one abuser. Scores: DES II 29.64, IES-R 00.0, SCL-90-R GSI 72. Corroboration not yet sought.)

Case 12: *At age 26 ... I spoke to my sister and found myself asking her, "Has he ever hurt you?" ... this whole stream of the most obnoxious things came spewing out of my mouth ... she sat on the other end of the phone, sounding a bit shocked, and she said, "He's done some of those." He broke the promise ... he had abused her and then broken the promise so I was able to talk and let everything out.*

(Age 29, female, abuse duration 14 years, full penetration, multiple abusers. Scores: DES II 63.93, IES-R 25.0, SCL-90-R GSI 81. Corroborated by court conviction, abuser admission, family members, and diagnosis of DID.)

Case 13: *I was doing a series of workshops on sexual issues and sexual wholeness and the growing in relationships ... it came up when I was doing my homework [age 23] ... I couldn't ignore it anymore ... It just kept coming up and coming up ... I remember thinking I can't hide this anymore, I had to face it.*

(Age 28, female, abuse duration 3 months, genital touching and oral sex, one abuser. Scores: DES II 12.86, IES-R 19.3, SCL-90-R GSI 69. Too scared to seek corroboration. Has confirmed abuser access to participant during timeframe.)

Case 14: *There may have been a trigger that I don't remember ... it seemed like that out of the blue little bits of memory came ... it just sort of started.*

(Age 58, female, abuse duration 8 years, full penetration, multiple abusers. Scores: DES II 32.86, IES-R 26.7, SCL-90-R GSI 71. Corroborated by family members and history of self-harm.)

Case 15: *The name of one abuser was Barry and I was then with my first husband and we lived next door to an old man called Harry and he used to baby-sit my kids sometimes and I think being sober for the first time and drug free ... I started to thaw out.*

(Age 37, female, abuse duration 9 years, full penetration, multiple abusers. Scores: DES II 20.00, IES-R 00.0, SCL-90-R GSI 67. Corroborated by family members, vaginal scarring and history of suicide attempts.)

Case 24: *I met my husband and he was a safe person ... he was the total opposite to my father and something inside of me must have allowed this to start surfacing.*

(Age 43, female, abuse duration 10 years, full penetration, multiple abusers. Scores: DES II 42.50, IES-R 22.7, SCL-90-R GSI 73. Confronted abuser without response and history of bulimia and hospitalisation for depression.)

Case 39: *It was the stress of my husband's cancer and the death.*  
(Age 48, female, abuse duration 9 years, full penetration, multiple abusers. Scores: DES II 04.29, IES-R 25.3, SCL-90-R GSI 67. Corroborated by abuser admission.)

Case 54: *I think I started to rebel, I started rebelling from my home situation where I lived at the time.*  
(Age 46, female, abuse duration 11 years, full penetration, multiple abusers. Scores: DES II 35.00, IES-R 31.3, SCL-90-R GSI 81. Corroborated by family member.)

## **Section Summary**

Participants from both groups reported similar percentages relating to their experience of trigger events just prior to recovering their initial abuse memories, with the majority of both groups experiencing the trigger events. One participant from each group was either unable to name the trigger, experienced a spontaneous recovery of memory, or was unaware that they had experienced a trigger event.

The trigger events described by the participants confirmed the categories proposed by Courtois and other researchers reviewed in the literature. The triggers described in this analysis included giving birth, exposure to events, smells or people that resembled the original abuse events, attaining sobriety, separation from a spouse, joining a therapy group and hearing the stories of other survivors, death of a loved one, and commencement of an intimate relationship. The triggers did not appear to arise from a conscious desire to facilitate recovery of the abuse memories. Rather, they were unexpected and varied from participant to participant, confirming Courtois' proposition that anything can be a trigger for a survivor of abuse at any time.

The following section of the results and discussion relates to the use of hypnosis in recall of memories relating to CSA.

## **RECALL OF MEMORIES THROUGH HYPNOSIS**

### **Was Hypnosis Involved?**

*Overall Group (N = 16)* Three of the 16 participants reported the use of hypnosis; however, hypnosis was not used for memory recovery. Two participants reported the use of rapid eye movement therapy after the recovery of their initial memories. This was used to assist them make sense of the

memories. The remaining eleven participants did not use hypnosis at any time during memory recovery.

*Partial Forgetting Group (n = 6)* Thirty-three percent (2) reported the use of hypnosis. They stated that hypnosis was not used for memory recovery purposes. Rather, hypnosis was used to assist with relaxation. Seventeen percent (1) reported the use of rapid eye movement therapy after their initial memories were recovered to assist the subject make sense of the memories. The remaining 50% (3) did not undergo hypnosis at any time during memory recovery. Their individual comments follow:

Case 9: *No.*

Case 22: *No, I have used hypnosis for relaxation, but it wasn't used to recover any memories and I did not recover any memories as a result.*

Case 32: *No. However, I had hypnosis last year in relation to the abuse as a way of giving me somewhere safe to be when I needed to.*

Case 43: *No.*

Case 46: *No.*

Case 57: *No, I did undergo four sessions of REM after initial memories recovered.*

*Extensive Forgetting Group (n = 10)* Ten percent (1) reported the use of hypnosis with one therapist; however, hypnosis was not used for memory recovery. Ten percent (1) reported the use of rapid eye movement therapy; however, this was used after the initial memories were recovered to assist the subject make sense of the memories. The remaining 80% (8) did not undergo hypnosis at any time during memory recovery. Their individual comments follow:

Case 5: *No.*

Case 6: *No.*

Case 11: *One therapist did once but it was more with ... a lot of what we discussed was just family dynamics ... it was more at that level.*

Case 12: *No.*

Case 13: *No.*

Case 14: *No, no hypnosis, we used a bit of rapid eye movement.*

Case 15: *No.*

Case 24: *No, I'm terrified of it ... I'm terrified of what will happen.*

Case 39: *No.*

Case 54: *No.*



## **Section Summary**

There were no distinctions between the Partial Forgetting and Extensive Forgetting groups. The majority of participants in both groups did not report the use of hypnosis as an aid to recovering their abuse memories. For those who did report utilising hypnosis, it was used to assist them process the negative affect associated with their abuse memories, which they had already recovered. In addition, hypnosis was used to assist the participants make sense of their memories, possibly in terms of placing the memories in a sequence related to timing. This finding suggested that all of the participants in this stage recovered their memories via the use of trigger events.

## **RECALL OF MEMORIES IN THERAPY**

This section of the results and discussion relates to the triggering of initial CSA memories in therapy.

### **Were You in Therapy When Your Memories Returned?**

*Overall Group (N = 16)* Sixty-three percent (10) were not in therapy at the time they recovered their abuse memories. The remaining 37% (6) reported entering therapy to assist with associated abuse effects. The relevant therapists did not use any “recovered memory” therapy/techniques, nor did they suggest that the participants had been abused prior to memory recovery.

*Partial Forgetting Group (n = 6)* Sixty-seven percent (4) were not in therapy at the time they recovered their abuse memories. The remaining 33% (2) reported entering therapy to assist with associated abuse effects. The relevant therapists did not use “recovered memory” therapy/techniques, nor did they suggest that the participants had been abused prior to memory recovery. Their individual comments follow:

Case 9: *No, I had actually been twice to different doctors trying to ... I knew that I wasn't right ... I felt like I was losing my mind, that something was wrong. I started counselling when my sister contacted me and asked me outright if I had been sexually abused by our grandfather.*

Case 22: *No, I went to a psychiatrist about 15 years ago because I had a bad temper. I mentioned it to him but it wasn't really a firm issue then.*

Case 32: *Participating in an AA program where the abuse was a side issue and the main focus was on being clean and sober.*

Case 43: *No.*

Case 46: *No.*

Case 57: *I started getting therapy about the first perpetrator (always remembered) and I got sober ... whilst I was in therapy the memories of my father's abuse appeared ... I am still recovering memories now outside of therapy ... spontaneously.*

*Extensive Forgetting Group (n = 10)* Sixty percent (6) were not in therapy at the time they recovered their abuse memories. The remaining 40% (4) reported entering therapy to assist with associated abuse effects. The relevant therapists did not use “recovered memory” therapy/techniques, nor did they suggest that the participants had been abused prior to memory recovery. Their individual comments follow:

Case 5: *Yes, in a men's therapy group.*

Case 6: *The initial remembrance happened before therapy ... I sought therapy because I needed to have some sense of understanding of it.*

Case 11: *I was doing counselling and things like that but it wasn't for that reason ... it was because I've just suffered constantly from depression for a long, long, long time. None of my therapists ever suggested that I was abused before I had these memories.*

Case 12: *No.*

Case 13: *No.*

Case 14: *Yes, I was just going to this one psychiatrist, which I'd been going to for several years and slowly different pieces were coming out.*

Case 15: *I had started the AA program where the focus was becoming alcohol and drug free.*

Case 24: *No.*

Case 39: *No.*

Case 54: *No.*

## **Section Summary**

A similar percentage of participants in both groups reported that they were not in therapy when they recovered their initial abuse memories. The majority of those who reported being in therapy at the time stated that they were in therapy for other issues, primarily distressing symptomology related to CSA. They were not aware of their abuse histories at the time they entered therapy and stated that their therapists did not suggest they had been abused prior to memory recovery. When this finding was added to the finding about hypnosis, it would suggest that most therapists were very cautious in their treatment methods, and that awareness of abuse came from the client. In addition, it is possible that therapy provided a safe place for participants to commence remembering their abuse. Finally, those participants who reported recovering abuse memories while in therapy appeared to be in therapy to deal with the negative affect associated with their abuse experiences.

## **CONCLUSION**

The findings indicate that adult survivors who report partial or extensive forgetting experience triggers to remembering similar to those found by past researchers. All trigger events fall into one of the categories proposed by Courtois (1992), with the addition of a category titled “spontaneous” triggers. This category included triggers that could not be identified by the participants, or triggers of which they were not aware. These findings align with those of previous research. There was considerable variation in the type of trigger event experienced by participants. However, the one common theme was that none of the participants used hypnosis to recover their initial memories and the majority of participants recovered their initial memories prior to entering therapy.

The results found in this study indicate the following progression of events: the survivor experiences a trigger event and recovers initial memories, including intense associated negative affect; the survivor seeks therapy to deal with the associated affect and, in doing so, finds a safe place to explore their abuse memories; the combination of exploration of the abuse memories and finding a safe place in therapy leads to the recovery of further memories. This finding refutes, in part, the publicised stance that hypnosis leads to the emergence of CSA memories that are false. In addition, this finding indicates that most therapists are ethical in their treatment of CSA survivors, with therapy being utilised to assist with the strong negative affect associated with

abuse. CSA memories appear to arise, during therapy, as a natural result of processing the negative affect and the survivor feeling safe enough to remember more.

Further research, with survivors who have entered therapy, is needed to identify the aspects of therapy that enable them to feel safe and whether the above progression of events is experienced by most survivors who have forgotten about their abuse.

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## APPLYING ERICKSONIAN LANGUAGE AND NLP PRINCIPLES TO EDUCATIONAL SETTINGS

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*Ericksonian hypnotic techniques, NLP principles, and in particular language, are regularly used in a variety of environments. This paper provides the reader with an overview of various techniques used in Ericksonian hypnosis and how to apply these to a range of non-hypnotic situations, principally focused on the child, within an educational context. These languaging techniques might be utilised by those who practise hypnosis as well as others, such as teachers and counsellors, who are not necessarily well versed on hypnotic theory and practice.*

Since Anton Mesmer in the 1700s, hypnotherapeutic techniques have been successfully involved in treating a range of physical and psychological problems. Although commonly used in therapy, most people's knowledge of hypnosis comes from stage performances, in which volunteers are often directed in a humorous manner by the presenter (or hypnotist) for the benefit of entertainment. This has led to a considerable mystique surrounding hypnosis, with many assuming that the hypnotist has powerful control over others. Unfortunately, the general public does not generally have similar access to the use of the many creative and usually therapeutic possibilities afforded by the use of hypnosis.

While most non-therapeutic uses of hypnotherapy have led to exposure to certain aspects of trance states in certain susceptible individuals, the focus of this paper is directed at the application of hypnotic principles, techniques, and

language in educational settings. It is argued here that the creative use of the language component of hypnotherapy has potential application for improving student outcomes. Previously, Oldridge (1982) had pointed out that many teachers intuitively and unknowingly engage in many hypnotherapeutic-like techniques, as part of their current teaching practices. Accordingly, the use of hypnosis, without inducing trance or an altered state of consciousness, will be discussed in this paper, as it might be applied by teachers and counsellors when working with children.

While hypnosis often appears to have an aura of magic and power, it is essentially a process in which a hypnotherapist makes a series of suggestions, usually to a client, so that the client's consciousness is altered. This altered state of consciousness is usually characterised by relaxation, focused attention, and a greater receptivity to acceptable changes in behaviour and thought patterns. The trance-like state induced as a result of hypnosis is a natural everyday occurrence, which most people experience spontaneously and routinely, as in daydreaming, or when concentrating on a book or movie (Cowles, 1998). Dispelling further the myths associated with hypnosis, the renowned hypnotherapist Milton H. Erickson considered hypnosis as "essentially no more than a means of asking your [clients] to pay attention to you so that you can offer them some idea which can initiate them into an activation of their own capacities to behave" (1960/1980, p. 315). Consequently, rather than having a magical or mystical quality, the power of hypnosis tends to reside in the client's own healing and creative talents, as encouraged by the hypnotherapist.

Hypnotic like techniques have been applied to clients in various settings, without inducing a formal trance or state. For instance, hypnotic suggestions and principles have been applied generally in psychotherapy (Barber & Calverly, 1964; Gruenewald, 1971; Otani, 1989a, 1989b), in the management of pain and anxiety disorders (Channon-Little & Flatt, 1992), for children who have a learning difficulty (Oldridge, 1982; O'Leary, 1985), and in native healing procedures (Krippner, 1994). In this paper, the potential use of hypnosis-like procedures by hypnotists and non-hypnotists will be highlighted in three general ways: first, in behaviour management; second, when building relationships with children; and third, to enhance a child's self-esteem.

## BEHAVIOUR MANAGEMENT

A positive school environment that practises inclusive teaching processes is essential for managing and supporting a wide range of students with diverse needs. However, the individual classroom and the subsequent teacher–student interaction is the area where many teachers have the greatest difficulty with student behaviour problems (Conway, 2002). Table 1 summarises various hypnotic suggestions and techniques and examples of possible teacher or counsellor responses that aim to effect behaviour change in students.

One general principle of hypnosis is positive expectancy, and in particular, conveying this positiveness in directions and general interactions between teachers and students. Rather than use words such as “perhaps,” “maybe,” “can,” or “might,” hypnotherapists employ more positively framed language, a strategy that teachers might also use when directing students. For instance, rather than say to a student, “Perhaps you could listen to your teachers and this might make your homework easier to understand” they could say instead, “When you listen to your teachers, you will find that your homework is easier to understand.” Similarly, instructions need to be phrased as directives rather than requests, so rather than say to a child, “Could you please put your bag away?” a teacher needs to say, “Put your bag away, thanks.” The expectation that a desired and positive result will occur is an important principle in hypnosis and one that is readily transferable to the classroom.

Similarly, hypnotic suggestions are usually directed towards enhancing the positive, rather than eliminating the negative (Oldridge, 1982). For example, when working with an overweight client, O’Leary (1985) reports rarely using the words “weight” or “heavy” and would instead focus on the attractiveness of being slim, or the benefits of exercise. O’Leary summarises, “The goal is the object of attention, rather than focusing on the problems in reaching it” (p. 31). Accordingly, school personnel might also focus on the positive implications for a child of reaching his or her goal and clearly articulate this to the child, rather than the various problems and hurdles that he or she might encounter along the way.

While hypnotherapists expect positive results and exude confidence in their clients, they also consider a behavioural outcome in terms of “successive approximations” of the focal behaviour (Hammond, 1990, p. 13). Successive approximations are immediate steps or actions that, over time, will lead to larger behavioural outcomes. Hammond (1990) suggests that hypnotherapists do this by conveying confidence that their clients will change, and at the same



**Table 1:** Applying Hypnotic Language to Behaviour Management1

Hypnotic strategy	Application to behaviour management practises	Examples of teacher/ counsellor comments to children
Create positive expectancy	Expect to see results and have this reflected in the language used	<i>Directions:</i> "Put your pens down, thanks" <i>When goal setting:</i> Focus on the goal rather than possible hurdles or problems
The principle of successive approximation	Break down the desired outcome in intermediate steps, while still being positive that the end goal will be reached	"I am not sure when you will make friends, it might be today, it might be tomorrow ..." [but it will happen]. "Let's work on what you need to do today ..." [and then focus on a smaller step, such as group entry behaviour]
The double bind	Provide the student with two comparable choices that are both acceptable	"You may sit on the chair or on the table" [but you need to stop moving]
Contingency suggestion	Chain or link the desired behavioural outcome with behaviour the student is currently or will inevitably engage in	"When you sit at your desk, you will open up your book and start reading"
Truism	Fact-orientated statements, which also imply what is defined or desired	"You will need to relax sometimes" [but at other times you will also need to work]
Creating a yes set	Ask a series of closed questions to which the child will readily acquiesce, and then proceed asking the child about the targeted behaviour	"Is it hot today? Did you walk to school? Is Mr Roberts here today? Do we need to work on managing anger?"
The carrot principle	Provide an incentive or reward and imply that the desired result will occur	"When you finish your worksheet, then you may go to the computer"
Focusing attention	Begin with a statement that captures and focuses students' attention	"Today we will discover something interesting and vital ..." [Create some sense of mystery and ambiguity]
Repetition of suggestions	Repeat the same instruction in a variety of ways	Give the same instruction verbally and visually (e.g., in cartoon form)

time express permissiveness concerning when this will occur. For example, when instructing a client to do something, many hypnotherapists will not expect this desired result immediately, but instead suggest that it will occur at an ambiguous time in the future, “sooner or later” or “sometimes in the next week, I’m not sure exactly when,” thereby conveying confidence, but without being overly prescriptive. Hammond provides another example of this when he makes the following hypnotic suggestion, “*Soon* you’ll sense a lightness *starting* to develop in that hand. And you can begin to wonder just *when* you’ll first sense a twitch and sensation of movement in one of the fingers” (p. 13, emphasis in the original). Similarly, teachers and counsellors might also consider a behavioural outcome in terms of intermediate steps, while simultaneously implying that at some time (maybe now, maybe later) the student will achieve this. “First you will notice that you can do some of the four times table and you will notice that some of them, like two times four and ten times four, are easy, and then you will notice that others are also easy, like eleven times four, and one times four. And then, soon after, you will be able to do all of the four times table.” You will note that nothing we have covered to date in this article (with the exception of Hammond’s quote) is particularly hypnotic. They are simply positively worded suggestions and commands and therefore do not need a qualified hypnotherapist to deliver the messages.

The double bind (a technique used inside as well as outside hypnosis) is another method employed by hypnotherapists to create positive expectancy, in this case in an indirect manner. The double bind provides the client with a choice between two or more alternatives regarding the desired behaviour, while at the same time creating a bind so that not changing in the desired direction is not an option. For example, a hypnotherapist might ask a client who aims to stop smoking, “Are you going to stop smoking cold turkey or gradually?” In this example, it is assumed that the client will stop smoking; it is only a question of how. Accordingly, a counsellor might say to a child, “You can make big changes in this problem, or medium changes, or little changes. There are so many kinds of changes.” In the same way, a teacher might ask a student walking around the classroom: “Are you going to sit on your chair, or on the floor?” so that while providing the child with choice, the teacher nonetheless implies that walking around the classroom is not an option.

Directions can also be given in an indirect manner, via a contingency suggestion. Contingent suggestions connect a suggestion given by a hypnotherapist to ongoing or inevitable behaviour (Hammond, 1990). For

example, a hypnotherapist might say to an anxious client, “When you start talking, you will feel more relaxed.” Here, the client’s expected verbal behaviour when meeting with a therapist (that is, talking) is linked or chained to the desired behaviour (that is, feeling relaxed). Accordingly, teachers might say to a student, “When you sit down at your desk, you will take out your book and start reading.” The teacher needs to identify a behaviour that the student currently engages in, and then chain this behaviour with the desired behaviour the teacher would like to see more of.

Truisms are another hypnotic technique, and consist of fact-orientated statements given to a client that are true and cannot be denied or refuted. It is important that suggestions are based on facts that the client is aware of and understands (Oldridge, 1982). Hammond (1990) describes truisms as statements of fact that most people have experienced so often that they cannot deny them, and reports the use of various phrases such as “Most people ...” “Everyone ...” “You already know ...” “Most of us ...” (p. 29). While true, truisms are effective because of what is not defined by the given facts (Otani, 1989a). For instance, a hypnotherapist might say to a client who wishes to stop smoking, “You don’t want to stop smoking *suddenly*.” The implicit message here is that the client does, however, want to stop smoking. Consequently, instead of stopping smoking suddenly, the implication is that the client will gradually decrease his or her smoking behaviour. Oldridge (1982) adds that truisms are more effective when made by an authority figure.

To create a truism, Otani (1989a) advises counsellors to first identify the facts relevant to the client and then qualify the information in terms of time, extent, and/or frequency. Applying this to the educational context, a counsellor might say to a student exhibiting challenging behaviours, “You may need to argue with your teacher *sometimes*,” implying that there will be also be times when the student will not want to argue with his or her teacher. Subsequent discussions could then discuss when it might be appropriate to “argue” with a teacher, and in the way in which such “arguments” might be carried out.

Similar to truisms, another hypnotic technique routinely employed is to create a “yes set.” This involves a series of comments made to the client that are factual or undeniably true and serve to reinforce a client’s mind-set or compliance to accept subsequent suggestions. Teachers and counsellors might also apply the yes-set procedure when attempting to effect behavioural change. For instance, a teacher might ask the child a series of factual statements and other yes-generating questions such as, “Is it getting hot outside?,” “Did your mother drop you off at school today?,” “Are you sitting with Tommy?” and so

on. This positive yes set serves to enhance the child's motivation to then consider what behaviours need to be targeted and changed, with the next question being: "Do you need to work on how you manage anger?", "Do you think you need to be quieter when the teacher talks in class?" As the excessive use of closed questions might prove intrusive or detrimental to the overall counselling process (Egan, 2002), it is recommended that closed questions used to create a yes set should also be used in conjunction with other basic attending skills such as clarification, paraphrasing, and the reflection of feeling.

The carrot principle (Hammond, 1990) is another way of describing the provision of a reward or positive reinforcement. In hypnosis, clients are encouraged to link their goals with various hypnotic suggestions, and the link is subsequently made in the instruction. Accordingly, rather than use the word "if," which implies that the client might fail to obtain the desired result, hypnotherapists often say, "When [the desired behaviour], then [reward]." This not only provides the client with an incentive towards specific goals, but also implies that the desired result will happen; it is just a matter of when. Accordingly, rather than say to a student, "If you work hard today, you will receive computer time," it is preferable to say, "When you complete the worksheet, you will have some free time on the computer."

Other hypnotic techniques are also readily transferable into educational settings. Hammond (1990) recommends that hypnotherapists begin a session with something that captures or focuses on the client's attention. For instance, a therapist might say, "Something is beginning to happen to one of your hands, but you don't know what it is yet" (Hammond, 1990, p. 42). Similarly, educators might also provide some initial statement to create a sense of curiosity as to what might happen at the end of the lesson or unit. This "opening grabber or motivator" (Onosko & Jorgensen, 1998, p. 78) aims to motivate students to explore further the central questions or themes of a particular unit or lesson. Another technique utilised by many hypnotherapists is to provide the same suggestion or instruction throughout a single session with a client, repeatedly and in a variety of ways, including direct verbal suggestion using synonymous words, phrases, and metaphors. In the same way, teachers might also provide the same instruction or message in a multitude of ways over the course of a lesson. Such strategies are useful for maintaining clearly defined and positive classroom environments.

## RELATIONSHIP BUILDING

The importance of building warm and trusting relationships, when working with children, is widely acknowledged in both therapeutic and teaching environments. Here again, the various ways a hypnotherapist might develop rapport with a client has applications for school personnel building effective relationships with children.

When talking to clients, effective hypnotherapists often pace their instructions to reflect what the client is currently doing. For instance, while the hypnotherapist might ask a client to “breathe in and out ... in and out,” his or her instructions will be matched to the actual breath of the client. While the instruction might initially be adjusted to the client’s rate of response, suggestions might then be introduced to accelerate or slow down the speed of the response, according to the desired therapeutic aim (Hammond, 1990, describes this as “leading” the client). Many hypnotherapists’ own speech will reflect the idiosyncratic syntax and style of their clients’ verbalisations. Similarly, teachers and counsellors might identify the manner in which a child understands his or her world and the language he or she uses as an important way to “work with,” rather than “on,” the student and subsequently build a trusting working relationship. In the same way, lesson planning can be directed to the energy and attention levels of students so that more academically focused activities are structured earlier in the day and more action oriented activities later in the school day and school week.

Another important hypnotherapeutic technique, and in particular in the work of Erickson, was to listen carefully to what each client had to say, and to regard each client as an individual rather than a representative of a group (as some teachers/therapists might stereotype certain groups of students or clients). To this end, Erickson strongly urged therapists to listen to both explicit and implicit messages from clients. Erickson stated: “I listen to the meaningfulness of what [clients] describe ... And too many people listen to the problem and they don’t hear what the [client] *isn’t* saying” (Zeig, 1985, pp. 125-126; emphasis in the original).

Referring to Erickson, Otani (1989a) suggests that there are three factors that need to be considered in order to understand a client’s implicit and explicit messages: content, style of expression, and meaning. Otani (1989a) describes *content* as what the client verbally expresses. In comparison, the *style of expression* refers to how the client communicates the content, including non-verbal and paralinguistic details. Finally, *meaning* entails the message

significant to the client. While explicit messages come from the content, implicit messages might be conveyed in style of expression and meaning (Zeig, 1980). Accordingly, teachers and counsellors might also consider all three factors when counselling children, particularly those with little or impoverished language abilities and with subsequent unclear explicit message- conveying capacities. This means that they will need to listen to what children say, but more importantly, what they don't say, how they look, and the various non-verbal and paralinguistic details emulating from the child.

## **ENHANCING SELF-ESTEEM**

As well as applying hypnotic like principles to behaviour management and rapport building, another potential application is for enhancing children's self-esteem. The principle of positive expectancy emphasises the expansion of the positive, rather than eliminating the negative (Oldridge, 1982). Consequently, as "a child behaves according to the way he believes himself to be perceived by the important people in his life" (Oldridge, 1982, p. 285), it is important that teacher suggestions and instructions are directed towards improving a child's self-concept and that the teacher believes in the capability of the individual student in front of him or her.

The principle of positive expectancy particularly applies to children with learning difficulties. Working with children who are struggling at school often requires a fresh and positive attitude on the part of both the teacher and student. O'Leary (1985, p. 32) sums up this point when he argues that "Failure is not always overcome by hard work, but by new innovations and ideas about how to do that work." In other words, before changes can be made, students may need to see themselves differently and believe that they can become competent readers or students. To this end, O'Leary (1985) advocates the use of creativity and play, as sourced from hypnosis, in the aim of stimulating hope and resiliency.

Pretending to be someone else, for instance, can be useful in that children who have difficulty doing certain things as themselves may instead perform differently when role playing a princess or a king. Describing a child with physical disabilities, O'Leary (1985, p. 32) writes: "As a princess, Gwen is not thinking about what she cannot or does not want to do. Freed from this conflict, her muscles are more responsive and hidden problem solving skills are stimulated. What the Princess learned is retained by the little girl." O'Leary argues that such an approach does not constitute an attempt at "positive

thinking” or forced cheerfulness, but instead represents an effort to find helpful ideas through considering a situation in a different way. The power of suggestion and role playing helped this student overcome her physical limitations and negativity, and consequently enhanced her capacities and self-esteem.

Oldridge (1982) extends these points when he notes that suggestions for enhancing self-esteem are most effective when made during times of physical relaxation. Accordingly, he advocates the use of guided imagery and other relaxation techniques for both individuals and groups, during which time students might be given various suggestions. Some of these suggestions include an acknowledgement that mistakes might be made but are an indication of effort. Students might also be told that how hard they try will determine how good they feel. Another suggestion is that their bodies will be relaxed but their minds wide aware and ready to work and learn.

In one of the few research studies in this area, Oldridge (1982) investigated the use of hypnotic-like instructions, without the process of inducing trance, for enhancing children’s self-esteem and reading ability. Three groups of remedial readers were compared: one group received hypnotic suggestions designed to reduce anxiety and build self-confidence, another group received the same suggestions but without inducing trance, and the last group received neither suggestion nor hypnosis. The study was conducted for six weeks, during which time all children received a remedial reading course. Oldridge found both experimental groups scored significantly higher on several self-esteem and reading achievement scores than the control group, demonstrating the efficacy of teachers using a variety of non-hypnotic like suggestions. The non-hypnotic like suggestions used in this study are similar to those described above.

## **SUMMARY AND CONCLUSION**

Although limited research has been undertaken in the use of hypnotic principles in non-hypnotic settings, it has been argued here that a range of Ericksonian and NLP techniques might be useful in behaviour management, when building relationships with students, and for enhancing children’s self-esteem and confidence. These might include: creating positive expectancy; using the principle of successive approximation; utilising the double bind principle, making use of contingency suggestions; incorporating truisms; creating yes sets; adopting the carrot principle; and of course, focusing attention and repeating suggestions.

While research is required to support the efficacy of such techniques, teachers and counsellors might nonetheless find these techniques useful when working with children in educational settings. We value feedback on your experiments in this regard.

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## **AFTER THE ACCIDENT: HYPNOTHERAPY IN THE PSYCHO-LEGAL CONTEXT**

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*The presence of litigation causes additional complications in psychological and physiological healing after accidents. Compensation systems add to the loss of social and economic power experienced by the injured person; particularly when exposed to questioning, investigations, and repeated medical and psychological assessments, the adversarial nature of the compensation and litigation process tends to bewilder clients and causes this sense of powerlessness. Hence, in a climate redolent with power issues that place inherent limits on gaining their trust, injured persons are especially resistant to formal hypnosis. In this context, indirect hypnotic techniques are especially useful. The author presents a variety of techniques and scripts for alleviating anxiety, panic, and pain, in the context of the case histories of two women who have experienced whiplash and other injuries in motor vehicle accidents.*

Because I have a law degree as well as being a registered psychologist, I have specialised in the assessment and subsequent treatment of clients involved in litigation. The lion's share of my business is with victims of motor vehicle accidents (~ 25%) and workplace injuries (~ 70%). The nature of my specialisation is such that virtually all of my WorkCover clients have physical injuries of a severity which will make them unemployable. The role is demanding and stressful, as it is always potentially subject to a high degree of scrutiny, is "at the coal face of conflict between labour and capital," and the climate of the workers' compensation system is generally one of conflict and occasional outright belligerence.

I think it is for these reasons that I have commonly found resistance to hypnotherapy amongst my clients. The majority of the resistance is, as far as I can tell, for three reasons.

First, to my client demographic, “hypnosis” is a word which implies a loss of control, a surrendering to the will of another, “going under,” and being a puppet of the stage hypnotist. My current clientele are typically educated to around Year 11, and seldom further. The experience of injury, and the knowledge that they are unlikely to find work again, means that they are highly sensitised to power issues. Although it is possible to gain a certain degree of trust, the depth of trance, if any, is limited by the client’s wariness of change and losing control.

Second, I am seldom involved in a case before a year or more after the initial injury. By this time, chronicity and conflict have set in, and often there is little that can be achieved beyond alleviation of panic and “at risk” levels of depression.

Third, I suspect that, in some clients, there is resistance to healing or curing pain because of the perception (usually erroneous, in practical legal terms, and a matter which, using the totemic authority which having a law degree imparts, I endeavour to persuade clients of) that to reduce or eliminate their pain will lead to a smaller settlement or a forced return to work. (For further comments, see Discussion at the end of this paper.) The WorkCover Corporation’s statistics indicate that 60% of clients who go through the compensation system will never find re-employment. Because the typical profile of my clients is that they have already been off work for 12 months or more, the percentage is probably even higher in my practice. Hence, my clients often have conscious and unconscious needs to present the best possible case for the largest possible settlement, since they can expect thereafter to spend the rest of their lives surviving on less than \$200 per week on social security benefits.<sup>1</sup> Hence, in therapeutic terms I attempt to construct interventions which not only attempt to facilitate return to work if possible and to alleviate current suffering, but also to set the client up for further healing and reduction in distress and discomfort post-settlement if they do not or cannot return to work at that time.<sup>2</sup>

Hence, only a small number of clients are amenable to formal hypnotherapy. Mostly I find that I am performing indirect hypnotherapy, in a quasi-

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1 That is, after an exclusion period of approximately one week for every \$1,000 ultimately received in compensation.

2 I have a large number of other hypnotic stories to prepare them for this; regrettably, there is not space for these stories here.

Ericksonian mode.<sup>3</sup> My clients frequently have adjustment disorders with anxious and depressed mood, which is a response to the situational stressors. As chronicity continues, the clients frequently develop generalised anxiety disorders, major depressive disorders, and panic disorders. The first stage in their therapy, of course, is the establishment of therapeutic alliance. Then, at each consultation, they inform me of relevant developments, and this is followed by ventilating relevant emotions. Only after venting do I find that clients are typically ready to receive suggestions. After expressing deep empathy, I may typically say, “Hmm, that reminds me of someone else that I treated. Do you want to hear a story?” At this stage, looking for hope, and cued into a childlike state for the reception of stories, I unfold a tale relevant to the client’s situation, and hence provide a hypnotherapeutic framework for future growth. In this context, it is necessary to work with the client’s own cosmology; an example of this will be presented in the first case history below.

In addition to describing the use of hypnotherapy in the wider context of my practice, this paper will present two complete histories — Mrs P and Mrs Q. Session 3 of Mrs P contains a script that I have devised which I have used successfully on dozens of clients with anxiety and panic disorders. Mrs P’s case history illustrates the use of this script adequately; I vary my tone of voice and some language to match the personality, gender, culture, and relevant individual characteristics of the client.<sup>4</sup> The Mrs P case history will also outline the general course from first interview to termination in my practice. The Mrs Q history is similar in basic problem and solution, but will additionally focus specifically on how the hypnotherapy was used to remedy anger, pain, and poor ego-strength, which are commonly occurring co-morbid issues with physical injuries.<sup>5</sup>

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3 Because of the power issues and the threatening medico-legal environment, the indirect hypnotic methods are often the only ones available. This, of course, raises ethical issues, as indeed do all indirect hypnosis techniques. As this paper is not the forum for the exploration of these, I simply note here that I am aware of and have critically examined these issues in my practice. Consulting a psychologist can be construed as implied consent to such techniques; if the client has expressed a desire to reduce unpleasant symptoms, they have given implied consent. I am frequently later thanked for my “help,” even though the client cannot articulate how help was provided.

4 In a manner which is frequently attributed to Milton Erickson in the hypnosis literature but which I believe is certainly predated by Carl Rogers in non-directive counselling, and probably by other theorists and practitioners in many fields of human communication before that.

5 Interested readers should look out for future articles by this author for direct information and indirect hypnotic scripts to reduce the exacerbation of conditions produced by the litigation process itself.

## **CASE HISTORY 1: MRS P**

Mrs P was a woman of 38 years; she had married at 22 and was the mother of two daughters. She worked full-time as receptionist and bookkeeper for a local business. Her avocation was gymnastics and she was especially dedicated to her daughters' pursuit of that sport; they competed at the national level, which Mrs P facilitated. Mrs P stated that she had no other serious pursuits or interests of her own. There was no psychiatric history.

Mrs P developed a severe driving phobia after an MVA (motor vehicle accident) in which she was rear-ended at speed on Main North Road. Session 1 with Mrs P was a formal assessment, from which a psycho-legal report was written. The full diagnostic criteria for PTSD were not met, but there was an adjustment disorder with anxious mood, and a considerable driving phobia and many post-traumatic stress features. The severity of anxiety symptoms approached full-blown panic attack intensity. There was also anxiety regarding her life generally since the accident; this was due to the limitations on her working and domestic capacities due to whiplash pain, and worry about the consequent effects on her family and their finances. Mrs P did not seem worried about the effect on the marital relationship, which seemed functional and stable.

Mrs P came for psychological consultations on a fortnightly basis, with six sessions of hypnotherapy. The features of the driving phobia were:

- will not drive at speeds greater than 60 km/h,
- will not drive at night, and
- will not drive on Main North Road.

### **Session 1**

Session 1 comprised a formal psycho-legal assessment and report, and establishment of a therapeutic alliance. In this process, I always establish a psychiatric history, including psychotic and depressive symptoms; I do this without mentioning the possibility of future hypnotherapy to the client, but with a view to possible contra-indicators for hypnosis should it be appropriate later. Depression per se is no contra-indicator in my practice — a large percentage of my clients have depression to some degree due to the chronicity of their pain.<sup>6</sup> However, I do not use hypnosis on suicidal clients, due to the risk of empowering a depressed person to carry out the ideated suicide

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6 See Mott (1998). Yapko (1992) routinely uses hypnotherapy with depressed clients.

method. Typically, during the assessment process I also set up a curiosity and desire for therapy in future weeks. I work at creating a yes-set response by asking, “Are you saying that you would like to feel strong, calm and confident again?” “Would you like to feel relaxed and secure enough to drive anywhere again?” Typically, when I sense the likelihood of resistance I make these inquiries in an off-hand way in the interview; this seeds the idea that the feeling of comfort and security is both desirable and achievable. Toward the end of the first interview a sense of trust and rapport is usually obtained, and this occurred in Mrs P’s case. I then asked if she would like to learn how to limit her anxiety, then reduce her anxiety, as well as to restore her comfort and confidence on the roads. She said that she would. I told her that there is a process which I use, which is actually the bread-and-butter of my practice, to help people do so. I have a few key phrases, which again I used with Mrs P. “Unless people have experienced it themselves, they don’t understand what it is like to have injuries such as these.” And, “People who have been through something like this say to me, ‘I never knew that the human body could feel so much pain and fear.’ It comes as a real shock.” It is vital that clients sense their emotion to be reflected, validated, and understood. At this stage, my voice tone reflects the severity of the emotion to the client, and I look them in the eyes in a calm, strong, and serious manner. Then I say: “It is my pleasure and my privilege to help people through the emotional ordeal and odyssey of recovery. The process of recovery frequently involves a lot of anxiety, fear or terror, anger, rage or fury, sadness, grief and pain, before life can get back to normal. Or, if that is not possible, to create a new life which is satisfying and meaningful. Right now it feels like you have been thrown into a deep, dark hole, a place you have never been before, and you don’t know the way out. So it seems that you might have to try some new things, find some new ways, to get out of a place like this. Do you think you would want to try some new things to find a new way out of this black hole?”

Hypnosis is only one of the techniques that I use. CBT exercises, psycho-education and general health education, prescription of physical exercise, a supportive relationship, and ego-strengthening are also essential components in my therapeutic style.<sup>7</sup> In Mrs P’s case, the problem was clearly delineated as a driving phobia; her avoidance of and distress when driving were having

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7 For the most effective and succinct summary of this topic I have read, see Evans and Coman (2003). See also Kroger and Fezler (1976) and Jennings (2002).

ramifications in the family. Her husband was becoming irritated by having to do more driving, and the daughters were agitated that their school functions and some gymnastics events were being missed.

## Session 2

In Session 2 some minor remaining details of assessment and reporting were completed. Then, using a collaborative approach, I asked Mrs P what ideally she would like to happen. She stated, “I want to feel safe when driving again.” I asked: “How will you know when this has happened?” and discussed this point until goals were set. Her goal was “to be able to drive on Main North Road past the Parafield Airport.” This is a 100 km/h stretch of road. I inquired if she would also like to be able to drive at night. She said that she did not want to drive at night, as the distress was too intense. I asked her to rate the degree of distress (on a 1 to 10 scale with 10 representing the highest stress) that she experienced when driving in daylight on Main North Road past the Parafield Airport at the present time; she said, “9 out of 10.”

Mrs P was a conservative, suburban woman, and a practising Christian; she was intelligent and highly functional, but not an embracer of new ideas, and — to use an apposite vernacular expression — “a bit of a control freak.” With pleasant and friendly manners, Mrs P was nonetheless a no-nonsense type who was genuinely perplexed by the feelings of overwhelming anxiety, which she had never felt before at this intensity. Understanding these factors, I suspected that there would be immediate resistance to the suggestion of hypnosis or hypnotherapy, no matter whether it was coerced, prescribed outright, or even merely suggested. So I asked her if she had ever heard of the discipline of sports psychology.<sup>8</sup> When she said that she had, I asked her if she knew of the famous case of the Swedish basketball team in the Helsinki Olympics, who physically practised shooting baskets less often than other teams, but *mentally rehearsed* successfully throwing baskets instead, and that they won the gold medal because of this technique. Mrs P said she had heard that story. I explained that the ability to get good results from this method was both an innate *talent* and a *skill* amenable to practice.<sup>9</sup> We discussed the use of positive

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8 I was certain that she would have; in this question I was, in Erickson’s words, “joining the patient” and “speaking the patient’s language.” See Erickson and Rosen (1982, p. 198).

9 With this series of questions I hoped to engage her competitive nature: namely Hammond’s (1998) “carrot principle” and principle of positive suggestion.

imagery by top athletes, and she reported that she had heard that people at the Australian Institute of Sport used this technique, and that she often thought, “the girls should be using it in gymnastics.”

Sensing that I had buy-in, I added that this technique is known by many names, such as guided imagery, visualisation, or mental rehearsal, and even hypnosis. We then discussed her experience of mental rehearsal or hypnosis, which was nil, and her ideas about hypnosis, and I reinforced that all of these techniques are simply using the power of the imagination to create a positive expectation, and guide a person’s actions toward the successful completion of a desired goal. I added that one does not “go under,” that one is in complete control at all times, and that the experience is pleasant and innocuous, saying “It is simply safe practice in the comfort of your own imagination.” However, I apologised to Mrs P for being unable to assist her with the process in this session, as there was insufficient time remaining to do a proper “mental rehearsal.” In truth, I *could* have extended that consultation, and I had overcome her resistance and created a curiosity and desire for her to do so. I felt, however, that it might work better to delay this until the next consultation; this was because I also sensed that the control freak in Mrs P would be miffed at being denied the treatment, and this would hence increase her receptiveness in future. I asked if she would like to return for another consultation.<sup>10</sup> I felt that a week’s delay would intensify her desire to try it, and deepen her trance state when the essential therapeutic work was attempted. To convince her further that the experience would be safe and innocuous, I performed a short, light trance progressive relaxation exercise. Once this was over, I asked her how she felt, drawing attention to the fact that she had not “gone under” or “lost control,” and I invited further questions. Mrs P said that she was happy with the experience, and we ended the session with a positive expectation for the next consultation.

### **Session 3**

In Session 3, we chatted briefly about the current condition of her work, self, and family, and then casually but fairly quickly moved into the hypnotherapeutic work. I have a standard therapeutic story for anxiety and panic management,

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<sup>10</sup> Unless a client is suicidal, this is my consistent practice, regardless of treatment modality, client type, or any other characteristic: The choice to continue therapy must be the client’s at every consultation



which I have now used many dozens of times and will reproduce here, with variations as told in Mrs P's context.

*Indirect Hypnotherapeutic Story for Anxiety and Panic Management* First, I asked Mrs P: "Is it fair enough to say that your body currently has an excess of emotion — anxiety, fear, anger, sadness and pain?" To which she said yes. I asked her if she was interested in learning a method to reduce that level of emotion, because "your body has a reservoir of excess emotion — in fact, it is probably more like an entire lake!" Mrs P said yes. "And is it fair enough to say that even a little pebble thrown into this full lake causes splashes over the edge, even literally in the form of your own tears, and ripples of panic throughout your body?" Another yes. I then asked if Mrs P would be "interested in learning a technique which would allow her to reduce that level of emotion — to reduce the level in the lake?"<sup>11</sup> Another yes.

Next, in an abrupt and completely unrelated tangent,<sup>12</sup> I instructed Mrs P to take a deep breath, and I conspicuously observed her. Then, without explaining my instruction, I immediately proceeded to another unrelated question: I asked Mrs P if she had a pet dog or cat at home. (If the client has small children, I use this as an example. Usually I can find some positive experience of this kind.) I asked Mrs P if her dog has had "a blissful, untraumatised life in the lap of suburban luxury, with regular meals, a warm bed and wanting for nothing." Once again I am searching for a yes response. Mrs P said "Yes, and he even sleeps on our bed!" I asked Mrs P, as I ask all such clients, if she can recall how the dog — when it is relaxed, safe, and sleeping — breathes: Is it the chest, or is it the upper belly which goes in and out? If a client correctly notices that it is the diaphragmatic muscles which do so, I congratulate their observation skills; if they cannot, I suggest that they not take my word for it, but that they should be empirical and observe their pet that evening when they are at home.

I then begin the therapeutic story, which goes thus: "Have you heard of the flight or fight response? Humans — like all mammals, the gazelle being chased by the lion, the dog in a dogfight — tense up when there is a crisis. We tense up, to survive a threat, whether it be an attack by a sabre-tooth tiger, a domestic dog, another person, or a vehicle impact. This helps us to survive; we tense up, our muscles become rigid, we chest-breathe rapidly and shallowly,

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11 This is part of the process of creating a yes set. See Hammond (1990, pp. 15-16).

12 This script is a paragon of the "multiple embedded metaphor framework" described by Lankton and Lankton (1983).

and this suppresses our feelings — including even the pain of being hit or cut or bitten. This is because fully feeling the painful sensations during the emergency would stop us functioning in the crisis. *After* the crisis, once the gazelle has escaped from the lion, the animal will typically shake, wee and poo itself, experience the feeling of pain if there has been any damage, begin diaphragmatically breathing again — but only after *the crisis has passed*.<sup>13</sup> No point in feeling pain, if it means your body won't run and you get beaten or eaten! But we humans, unlike other mammals, because of our big brains, we don't *stop feeling like there is a crisis*, even weeks or months after that short crisis event is over. The car accident has happened. It is over. But we stay tense and breathless, with our hearts pounding and breathing rapidly and shallowly into our upper chests — and not with our diaphragm muscle, which our body naturally breathes with, when it is relaxed and safe. Our flight or fight emergency response is supposed to be instant-acting and short-lived, but now it stays on permanently. And the problem is, we get tired out by using so much energy — and then we don't have that energy if we should actually need it! So we need to *re-learn to be relaxed*, to allow the natural processes of the body to *rest and restore and regenerate and rejuvenate*. We have to *re-learn how to be relaxed*.<sup>14</sup> So, to do this, we have to begin breathing diaphragmatically again. It sounds absurdly easy, doesn't it. And your mind may be sceptical — 'Breathing differently will change my anxiety levels? I don't believe this crazy psychologist!' And I encourage your scepticism! I didn't believe it myself, when I was first told. I used to be a chronic chest-breather — but now, whenever I am told to take a deep breath [and I do this in front of the client] I now *automatically* belly-breathe. And I can tell you that I personally am considerably more relaxed now than I have ever been in my life before. But that's just me — you are you, you probably want to find out things for yourself. So I encourage you to experiment with this."

The client then attempts to breathe diaphragmatically — and typically fails. They sit there with some dismay, as they realise that they cannot get their belly and diaphragm to go in and out when they breathe. So I then say: "Okay, that's okay, but listen — and this is important, because I don't want you using this technique as just another excuse to beat yourself up or put yourself down — don't expect that it will be easy, or happen quickly. But keep at it. Don't force

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13 For a fuller explanation of the flight or fight response and, beyond this, the immobility response see, for example, Levine (1997).

14 Utilisation of principle of repetition (Hammond, 1998, p. 43).

it, or put more energy into it — you are already trying too hard, putting too much energy into it — that’s what being tense is! Instead, simply *allow* more fresh air to get deeper down into your diaphragm. That’s it, *allow*. And you may notice, as you do so, that you begin to feel a little light-headed. Good. That’s because your brain is now getting much more fresh air and oxygen than it has been used to for quite some time.<sup>15</sup>

“And it doesn’t sound much, breathing. But as you know, breathing gives the body oxygen, and oxygen gives the body energy, and emotion is energy in motion. Chest-breathing suppresses the flow of emotion, in and out of your body. And, isn’t it fair enough to say that your body currently has an excess of emotion — anxiety, fear, anger, sadness and pain? To breathe in this way may not reduce *all of your excess emotion*; each breath perhaps only removes a teaspoon — and you have a whole lake full. But! There are many breaths in a minute, and many minutes in an hour, and many hours in a day. And as the days and weeks and months go by, diaphragmatic breathing drops the level of emotion in your reservoir. It is not a magic wand; if I had a magic wand, believe me, I would have fixed you and already sent you on your happy way! It is just a way to *open up the tap at the bottom of the reservoir*; by breathing diaphragmatically all the time you will inevitably drain out all of the unnecessary emotion. And it is a skill, and a maintenance activity — the more you do it, the better you get at it, and the more automatic it becomes, so that sooner or later you don’t even need to think about it, it happens all the time, you *don’t even need to be conscious that your tap is wide open, draining away all the unnecessary emotion all of the time and then turning off just at the right time*.

“Now, I am aware that I have given you a huge amount of information to absorb today. If you have even an inkling of how this might work in the days to come, you have done extremely well.<sup>16</sup> Now, I could suggest that you go home and do 20 minutes straight practice of diaphragmatic breathing. But I know that would bore me to tears, and my mind would wander off for about 19 minutes of that. So what I recommend is that you take just two or three minutes, five or six times a day, to breathe in this way. At home, watching the telly, sitting at the kitchen table, before bed; in your car, sitting at traffic lights; at work, whenever you have a pause. *Any time is a good time to allow diaphragmatic breathing*, to breathe out excess emotion and breathe in fresh air to *rest and restore and regenerate and rejuvenate* you. Some people even report a sense of

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15 Using physiological responses to deepen the trance (Hammond, 1998, p. 43).

16 That is, the principle of positive reinforcement (Hammond, 1998).

breathing out little gritty black stress particles! And if you feel a panic attack coming on, you can know that it is only a panic attack, that it will last a few minutes at most, so all that you have to do is sit down, or lie down, and breathe, and allow the excess emotion to be breathed out. And, sooner or later, the level of your reservoir will be much lower, so that little events won't splash tears and panic over the edges any more."

I then "coached" Mrs P further until she had some success with her diaphragm moving when breathing. After that I suggested that she close her eyes and see herself in the various familiar places she had listed doing this technique.

This method is a good example of the Lanktons' "multiple embedded metaphor framework." A review of the script will illustrate the stages the Lanktons describe: induction; match metaphor; retrieve resources; direct work; link resources; end matching metaphor; re-orient. It is also a good example of Erickson's "interspersal" technique, in which suggestions are interspersed in a hypnotic story or metaphor. (See, e.g., Hammond, 1990, p. 22; the suggestions are italicised in the script above.) The sense of mystery created by the abrupt and random shifts in the story, and the apparent legitimacy of formal education and scientific language, engage the client and their need to solve the puzzle assists them to internalise the message.

Mrs P was certainly in mild trance during the story, as evidenced by her unwavering involvement in the story, the almost glazed tone in her eyes, and the fact that she made no attempt to question, criticise, or interject. I then explained to her that the breathing technique is actually only the first step in a longer "training program" of tension reduction, anxiety reduction, and, ultimately, pain reduction. Would she like to continue with the next step? With Mrs P, as with most of my clients, it was comparatively easy then to explain that anxiety causes muscle tension, and muscle tension causes increased pain, headaches, and fatigue (see Garver, 1990). Resistance was now no longer an issue and Mrs P was very keen to try the progressive relaxation technique. This was used to lower her anxiety levels and achieve more bodily relaxation generally. Mrs P's muscles visibly relaxed; I therefore commented on how she might notice that her muscles were now considerably more relaxed (i.e., Hammond's 1998 principle of trance ratification). As Kroger and Felzer (1976) state, "the hypnotic process with its associated relaxation is ... advocated for all forms of behaviour therapy" (p. 90) and, "The basic premise in the hypnobeavioural model is that all maladaptive responses are anxiety-mediated" (p. 91). Hypnobeavioural therapy, or imagery conditioning, makes

use of the relaxation response and the capacity of the client in trance to re-learn how to feel at ease when performing a task to which a client has developed a phobia. Hence, with Mrs P now cooperative and inquisitive, direct hypnotic methods were then used.

While Mrs P was enjoying a sensation of calmness, ease, and confidence, I began a systematic desensitisation technique via successive approximation of hypnotic images. First, my direct suggestions allowed her to visualise successful, low-anxiety driving in the back streets around her home.<sup>17</sup> My suggested visualisations then increased her actual driving speed to 65 km/h, then 70, then 75, then 80. As Mrs P showed no visible signs of anxiety, my suggestions visualised Mrs P driving on Main North Road, as agreed in the goals setting part of Session 2. Again, successive approximations of feelings of comfort and ease, pleasantly alert, and having plenty of time and energy to respond to others road users were given. I suggested first driving with almost no traffic around, then more traffic. At this time, I again noted obvious changes in facial tension; I then simply asked her to note how well she had done in this session, reiterated the basic techniques of breathing and self-relaxation, and gently brought Mrs P out of trance.

After reorienting, I asked Mrs P to rate her subjective units of distress (SUD) in this visualisation. Mrs P said that at its worst in that session it reached “5 out of 10.” I then noted that the consultation was out of time, and, still wary of resistance in Mrs P, and knowing that she was fully aware of the goal of utilising the relaxation in situ, I consciously did *not* set any “homework” in a traditional behavioural modification manner. Instead, I simply said, “I wonder if you will use the things you have learned today in the two weeks until our next session, or if you will just be relaxed, safe, and alert anyway?”<sup>18</sup>

## **Session 4**

Mrs P stated that she had been calmer, “perhaps by a third or a half” when

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17 I was not familiar with the technique of ideomotor finger signalling at the time of treating Mrs P. Prior to using IFS I would tell clients that they could speak while in trance; naturally they seldom did, so ostensibly it was the client’s non-verbals that would prompt me to move to the next level of difficulty in the desensitisation process. Nowadays, however, I use IFS to check whether client are having reasonable success in lowering their anxiety level in their imagination before moving on.

18 Cf Lankton and Lankton (1983, p. 172): “Using learning after trance: ‘Will you use these learnings after trance, or will you simply change your maladaptive behaviour?’”

driving locally since the last session. Her SUDs were “6/10.” However, she did not attempt to drive over 60 km/h, nor did she attempt to drive on Main North Road. The hypnotic work then began with a rapid review of previous learnings, followed by deepening the relaxation level attained using images and metaphors similar to those outlined by Hammond (1990, p. 156), and de Rios and Friedman (1990, p. 335). Again I provided a detailed visualisation of successful driving, with “feelings of comfort and safety, knowing you are relaxed and alert, able to see everything around you, and about to take evasive action well ahead of time.” Rapport was well established by now and trance appeared deeper, as evidenced by the vastly softened muscle tone of Mrs P’s face and posture, and her slower breathing rate. I took the opportunity to directly suggest homework: to drive over 60 km/h, and perhaps to take the Main North Road if this was successful.

### **Session 5**

Mrs P had driven at 80 km/h — on Main North Road — on one occasion between these sessions. She said that she was quite anxious, but managed it with the breathing technique. She added that she did not try more than once because “the road was wet” at other times, as winter had begun. The trance work this session included visualising her comfort and safety when the road was wet. This was assimilated well in trance, which was confirmed once terminated. However, Mrs P became visibly anxious and distressed when the visualisation suggestion of driving at 100 km/h was attempted. I reinforced her efforts with ego-strengthening suggestions.

### **Session 6**

Mrs P had managed to drive on three occasions on Main North Road at 80 km/h since the last session. She had also coped with the wet road. Her SUD when doing so was “4/10.” However, she said, “I won’t drive at 100 km/h by Parafield Airport,” and she again resisted attempts even to visualise this in the hypnotic work. It seemed clear that to press her further would re-traumatise her; she seemed very happy with her current level, knowing that she could drive for all essential tasks now, and resume contributing more to her family’s transport needs. Mrs P said that she was going to Brisbane with the gymnastics and would be in touch with me on her return if she felt the need for further therapy.

## **Session 7**

Six months elapsed before I saw Mrs P again. I was asked to write a final assessment and report for her insurance claim. Essentially, Mrs P had not progressed in her driving tolerance at all since our last consultation. Happily, however, she had not regressed either, and was comfortably able to drive her children around and get to work. Mrs P was happy with the driving ability she had regained, even though it was incomplete, and she refused to entertain the idea of driving faster than 80 km/h. Her injury claim then settled, and her treatment stopped. She was offered further assistance if she so requested, but none has been asked for.

## **Discussion**

Mrs P was a typical MVA case in my practice, and I use these techniques with almost all of my clients suffering from driving phobia. Mrs P's case was a fairly simple and straightforward phobia, and this case history is a straightforward demonstration of my use of hypnosis, in combination with other psychological techniques. It was successful in terms of Mrs P's wants.

However, it is unusual to find such uncomplicated problems in clients. Mrs Q's case, below, is more common, and more complex.

## **CASE HISTORY 2: MRS Q**

Mrs Q was taken through the same initial process as Mrs P. As is usual in my practice, Mrs Q's driving phobia was co-morbid with pain from the MVA, and also with psychosocial issues. Her case illustrates techniques that I use with these two frequent complications of driving phobias.

As with Mrs P, Mrs Q was referred to me for a psycho-legal assessment and report. She was a 30-year-old Polish woman, married, with a 6-year-old daughter, and resident in Australia for seven years. Mrs Q was a wife, mother and homemaker, but as her daughter was due to start school she intended to find work. This plan was rudely interrupted by a serious rear-end collision, in which she sustained moderately severe whiplash injuries. Mrs Q was significantly more distressed than Mrs P; she was in tears several times in the initial interview, with more pain and, I suspected, less social and emotional support than Mrs P. Mrs Q continued to present with tears and anxious distress in each of the first four sessions. Her daughter (then aged five years) was in the car at the time of the MVA, but was not seriously injured. Mrs Q

suffered immediate pain and an acute post-traumatic shock reaction. Four months after the accident, she was referred to me for assessment and treatment.

### **Session 1**

Mrs Q was referred to me for a psycho-legal report. I performed the typical case history, incorporating questions which screen for contra-indicators for hypnotherapy, notably asking her of any previous experience of depressive and psychotic symptoms. I diagnosed a pain disorder resulting from a general medical condition, and a mild post-traumatic stress disorder, with all DSM-IV criteria (APA, 2000) clearly met. (Typically, however, the full PTSD criteria are not met in MVAs and I differentially diagnose the less severe adjustment disorder with anxious and depressed mood, often with driving phobia and/or post-traumatic stress features.) Mrs Q was taking Cipramil, prescribed by her GP since the accident. Pain was present in her lower back and neck, and she suffered from headaches, but not migraines. She was using also Capadex and Vioxx as analgesia and anti-inflammatory, and had had significant physiotherapy. Anxiety symptoms approached the level of full-blown panic attacks, especially when she was on the roads. This was especially so around the accident site and when seeing cars coming up quickly behind her, and frequently necessitated her pulling over for up to 15 minutes until the anxiety passed. This level of anxiety occurred virtually every time that Mrs Q drove, and she was minimising and avoiding doing so. Mrs Q was worried about the negative effects of her incapacity and irritability on her young daughter, and on her marriage. There appeared to be no pre-existing psychological disorders.

### **Session 2**

I prepared Mrs Q for hypnotherapeutic treatment using the indirect hypnotic story described in Mrs P's case history, above. The breathing technique was taught and, unlike the resistant Mrs P, it was clear that Mrs Q was willing to believe and utilise these methods. This was almost certainly helped by my correct identification of Mrs Q's nationality, saying "Cześć" (hello) and pronouncing her name correctly in Polish when introducing myself at the first consultation. Psycho-education (or "information giving," to use the term favoured by Evans, 2003) was given regarding anxiety and pain,<sup>19</sup> including some description of the anatomy and histology involved, the interaction of anxiety, muscular tension, pain, inflammation, nerve conduction, and the gate



theories of pain,<sup>20</sup> and that — even though it can be a difficult skill to learn — it can be possible to train ourselves to consciously perceive much less distressing levels of pain. Alert to the possibility of social isolation, given Mrs Q's status as an immigrant, I ascertained that her husband worked in remote Australia, sometimes for weeks at a time, leaving her at home alone with their daughter. It was also clear that Mrs Q was of above-average intelligence, yet living in a low socioeconomic suburb. Upon further investigation, Mrs Q accidentally revealed a sense of disappointment that a close friend in the area, with whom she had been involved since arriving in Australia, was notably absent and unsupportive in her hours of need, despite Mrs Q's considerable efforts to assist the friend in child-care and other needs when this friend had experienced several personal crises. This friend, who was essentially Mrs Q's only other close support, was still demanding of Mrs Q's time, energy, and money, even though she knew that Mrs Q was now injured. Mrs Q quickly chastised herself for speaking ill of her friend and changed the subject. I noted this point for future exploration. As Mrs Q had no previous experience with hypnosis, I invited questions and explained how hypnosis worked. Again, to allow a sense of expectation to build, I apologised for the lack of time to make a start this session, but promised to do so in the next consultation. I established SUD for driving; this was "9, sometimes 10" on the anxiety scale. In the interim and as a parting suggestion, I offered Mrs Q one further device to reduce her anxiety when driving. My standard hypnotherapeutic story for clients with PTSD or driving phobias after rear-end collisions is as follows.

*Indirect Hypnotherapeutic Story for MVA Rear-Ended Victims* First, I asked Mrs Q if she had ever seen those flashing red bicycle lights that cyclists have begun using in recent years. She said she had. I then asked her if she ever found that she noticed these from a long distance away, much more so than unblinking lights. She said she had.

Changing the topic, I asked if she had ever had the experience of driving from point A to point B, arriving at point B and not remembering any features of the journey. Mrs Q said she had. (Again, this uses both the yes-set method, and the Lanktons' method of multiple embedded metaphor framework, and

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19 My favoured resource is Caudill (1995), who lucidly explains all that a typical client needs to know, including a section on diaphragmatic breathing and the "relaxation response" – self-hypnosis by any other language.

20 See Melzack and Wall (1973) and personal communication.

the Erickson “interspersal” method.) I then explained the nature of the human perceptual apparatus: that our conscious minds stray to contemplate other life matters when performing repetitive and over-learned tasks — such as driving on regular routes. In fact, this is called “highway hypnosis,” and everyone has experienced it, usually hundreds of times. However, if there is a *change* in the usual environment, the conscious mind re-attends to the task.

“The key to keeping people’s minds on the job of driving,” I told Mrs Q, “is to *create change* — hence, a blinking light wakes up a dozy driver. Hence, those red flashing bike-lights are significantly safer because they create alertness in people. In fact, it is possible to eliminate or reduce the risk of dozy drivers behind you rear-ending your car by a similar method. Would you like to know how? As you pull to a stop, or as you sit at the traffic lights, you can *tap your brake lights*. So, instead of seeing and habituating to a constant red brake light as they approach you, the dozy driver behind you is automatically jolted into alertness, because they see the *change*, the blinking light ahead of them. So can you understand that unless their eyes are totally closed they can’t miss it?” I then invited Mrs Q to mentally rehearse doing so right now. Briefly closing her eyes, I suggested she see herself sitting in her car, slowing down, almost stopped, tapping the brake pedal three or four times, resting at an intersection, breathing diaphragmatically, feeling calm as she looked in the rear-vision mirror, tapping her brakes again, cars behind her slowing, and driving off again feeling calm and relaxed.

### **Session 3**

Mrs Q reported a small but noticeable reduction in driving anxiety using the breathing technique plus the brake-tapping strategy. Session 3 proceeded with a recap of the events in her life since the last consultation, a summary and reinforcement of the two techniques learned, and a review of pain and panic symptoms. A list of the least to most stressful driving situations was established, and initial goals set. I explained again the process of transferring her skill in controlling and reducing anxiety, in the safety and comfort of the imagination, so that this could be successfully used in reality, “in just the same way the world’s top athletes all now routinely use as part of their training regimen.” Formal hypnotherapy was then begun; my standard progressive relaxation technique (similar to Hammond, 1990, p. 156) was used to enter trance, and post-hypnotic suggestions that this relaxation technique could be used at any time that Mrs Q wished to reduce tension and create a sense of calm. Then we worked through the hierarchy of aversive driving situations which we had

just established. Beginning with the back streets and the roads to her daughter's school and to the local shopping centre, with visualisations of feeling relaxed and secure, suggestions were made to use the breathing and brake-tapping technique as she stopped at intersections.

Mrs Q was a willing and talented hypnotic subject, and appeared to enter trance deeply. She is also a highly intelligent woman, and even with the obstacle of English as her second language was able to assimilate new concepts rapidly. The remainder of the session was used by Mrs Q to complain of her pain symptoms, and to seek some explanation and reassurance that it was not all "in my head." I explained to her that "all pain is real" and finished with ego-strengthening suggestions.

#### **Session 4**

Mrs Q reported only a very modest reduction in anxiety levels when driving since the last session. She was diligently using the breathing and brake-tapping methods, and had control enough to manage her needs, but the reduction was much less than I expected. Evans and Coman (2003) state that the SUD should drop by about 50% after each treatment session, and this had not happened. Mrs Q also complained that she was still checking the rear-vision mirror constantly, more than the road ahead, and this was an obvious safety hazard. This driving anxiety was in addition to the distressing levels of whiplash pain. Additionally, as the review of the past fortnight and her current situation unfolded, Mrs Q reported a distressingly high sense of guilt at her inability to support other people, as she had done prior to her injuries.

I was alert to two trends in this situation. When I treat a client with panic attacks, after teaching them the basics of diaphragmatic breathing I frequently find it useful to go looking for unexpressed anger. Second, I was alert to the trend noted by Barnett (1981), namely that "guilt is always an element [which] is never more intense than in the phobias." After Mrs Q's comment, I followed up on her previous statements that she was unable to help others. Mrs Q was apparently distressed by the effect her injuries were having on her daughter, although from her descriptions she appeared in fact to be coping with this. I then probed the security of her relationship with her husband; this also seemed supportive and satisfactory. However, alert to Mrs Q's possible social isolation as an immigrant, upon further questioning I discovered that her female friend in the area, to whom Mrs Q had given significant emotional support in the past, was still not reciprocating to Mrs Q in Mrs Q's hour of need.

Upon analysing the balance of generosity between them, it was clear that Mrs Q was overly compliant, easily dominated, and rather used by this “friend.” Mrs Q expressed no anger at the lack of reciprocity; indeed, she only felt fear that she would lose her friend if she did not do as her friend asked. We explored the likely benefits if Mrs Q was to stop the one-way flow of favours and concern. I made no suggestion or direction for her further actions, however, and we then proceeded to the formal hypnotherapeutic session for the reduction of pain which I had led Mrs Q to expect in this session.

I was aware that Mrs Q was facing an existential moment of “aloneness” in her present life-situation. To use Yalom’s (1980) term, the continual giving in spite of the absence of return of that generosity is an unconscious “ultimate rescuer” myth, by which a person denies their fears of aloneness by being a continuously “good” friend/person/spouse. Mrs Q’s unconscious assumption was that if she was “selfish” she would invite further disaster and abandonment; Mrs Q agreed that this assumption needed to be reality-tested, and we did so in a standard CBT/Glasser (1965)/Socratic manner. The logical conclusion of this examination was that she would, in fact, have considerably more reserves of energy and tolerance for her daughter and husband if she stopped “bleeding” for this demanding friend. Ego-strengthening would be necessary in order to allow her to say No to future demands by this friend.

The formal hypnotic treatment in this session began with my standard progression relaxation described above and, once in trance, a reminder of the breathing and anxiety management technique. I then built on this story with a variation that I have incorporated from my experiences with Alexander therapy (Brennan, 1999), which is a therapeutic mode of teaching awareness and control of internal body states. To this, I added suggestions for breathing out excess emotion and energy, and releasing excess tension, “perhaps even radiating off excess energy and emotion,” as noted in the Mrs P history above. I then began a “healing” visualisation; beginning from the intake of air and oxygen into the lungs, I gave suggestions for noticing the “refreshing, restoring, regenerating and rejuvenating” sense of freshly oxygenated blood travelling to remote and neglected parts of the body, suggesting, as the body relaxes, that the flow of this “smooth, soothing, healing liquid” is moving down channels of the body which are expanding, allowing more and more of the “silky, milky, golden liquid” to encourage more and more healing, and to take away “all of the spent chemicals and toxins and emotions, which have served you well, but which are now no longer needed, and which need to be dissolved and radiated and breathed away.”<sup>21</sup>

As noted, Mrs Q had a genuine and a fairly severe case of whiplash; I had already provided psycho-education regarding pain and anxiety, and so I incorporated some of the suggestions of Garver (1990, p. 61) regarding this. I added the following: “And as well as being afraid of the pain — which we now know we don’t need to be — we can be angry with the body for letting us down, for giving us pain. And this anger is a perfectly natural and understandable consequence of an injury. You are allowed to feel a sense of betrayal, it is normal. But eventually — and *I don’t know when this will happen for you* — your body and your mind, which have lost trust in each other as a result of the accident, will come to understand, and respect, and *love* each other again. Really, your body is a little baby, it doesn’t understand why you are so angry at it. Your body, despite the pain it gives you, always is, was and will be your best friend. It is like a little child, it is like your daughter [name]. She doesn’t heal or learn or grow when she is being yelled at or scolded. She only grows and learns when she feels safe and loved. And so why shouldn’t you treat your body as precious as you treat your own daughter?<sup>22</sup> And can you understand that you won’t be physically able to do the loving things you wish for your daughter unless you allow yourself to love your own body as much as you love her, and allow it also to heal and grow? And so you can allow the flow of the healing, golden, silky, milky liquid to get in even *deeper*, to restore and regenerate and rejuvenate your body ... Also, your body, which continues to send pain messages to the brain and the mind, can learn to tell the difference when the pain is there because there is ‘harm’ being done, or when it is just ‘hurt’ without damage happening to the tissues and cells of the body there. And so the innate wisdom of the body doesn’t have to keep telling the mind, ‘Look! I’m hurting!’ and the pain fades in the background, and does not distract you from the things you want and need to do.’<sup>23</sup>

From this sequence of metaphors, I addressed the issues regarding Mrs Q’s demanding friend; my suggestions invoked the care and protection of herself as if she were her own daughter, of feeling a sense of love for herself. I proceeded: “And when your friend, or anyone at all, asks you to do things for

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21 I acquired this imagery from an Alexander therapist I had observed treating a colleague several years ago. However, compare with, for example, Fredericks (1990, p.72).

22 As I had already witnessed the mother–daughter interaction, and it was clearly a very loving relationship, I felt fairly confident that I was not inviting any sense of ambivalence in making such a suggestion.

them, you are still able to feel this feeling as you say to them, ‘I’m so sorry, I wish I could help, but I’m unable to do so right now’; and even if the friend were to become insistent, persistent, threw a tantrum, or became aggressive you can still feel that golden, healing feeling inside of yourself. Those angry feelings are *her* feelings, not your feelings. You can notice when this happens and simply say No, or even just walk away.” This was a necessary ego-strengthening technique, building directly upon the healing metaphor. After the trance work had finished, Mrs Q was very happy with the visualisation, and explicitly stated that she had never realised that she could feel that way about saying No to people.

### **Session 5**

Mrs Q was significantly better three weeks later, when the fifth session was held. She explicitly reported noticing the efficacy of the treatment — with relaxation and pain reduction, but most significantly with a sense of inner confidence which she had not had before, and cutting herself off from negative thoughts and from draining people. She also reported a significant reduction in driving anxiety. Although she was still checking her rear-vision mirror frequently, she stated that she felt safe when watching the road ahead, and had only had one panic attack when driving, which passed quickly and she reported that she had not needed to pull over. I followed up with a brief recap of the previous session’s script, and I furthered her preparation for future goals, when healing was complete, but took care to instil permission to rest and relax whenever the body felt the need.

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23 Again, see Garver (1990).

## **Session 6**

At Session 6, Mrs Q reported that she had maintained and continued her gains with driving phobia, pain, and boundaries against people using her. She had been asked by her friend to do babysitting for her, and Mrs Q declined; the friend became insistent but Mrs Q resisted, reporting a sense of anger but able to be calm while refusing to help.

Mrs Q was interested to understand at a conscious level the transformation process that she had experienced in the previous session. In my explanation, I took care to reinforce the hypnotic, unconscious work with the conscious intellectual explanation by repeating the phrases in the same tone, as I had done in the hypnotic treatment. There was then further discussion about existential and mortality issues; in this, I reified the ego-strengthening and added that, “What doesn’t kill you might hurt a lot for a while, but it will make you smarter and therefore stronger.” We then discussed her recent enrolment in a TAFE course, which was due to begin in two weeks. As her progress to that date was excellent, we did not arrange any further consults.

## **Session 7**

One month later Mrs Q returned to me in tears and distress. After two weeks of the TAFE course she was in severe pain from the whiplash injury, which had not been able to cope with the full-time study load, involving much computer use which was causing neck strain, in addition to her normal home duties. She was devastated and believed she would have to give up the TAFE course. I inquired about the possibilities of part-time study, the deadline for withdrawal, and other options. We then had a hypnotic treatment session which “topped up” the hypnotic suggestions of relaxation, self-pacing activities, ego-strengthening, and pain reduction. I had by this time also managed to record a similar version and burn this to CD, which I gave to Mrs Q to take home. I took particular care to remind her that the upward trajectory of recovery is not a straight line but is a saw-tooth graph — a downwards dip is *not* a return to square one, merely a predictable dip on the road to healing.

## **Session 8**

Three weeks later Mrs Q told me that she had remained full-time in the TAFE course; she had bought a home computer and was able to self-pace her study in a way that successfully managed her neck pain and flare-ups. She had not

catastrophised her situation and had spoken with her lecturers about this. She had used the CD and was happy with the results. Mrs Q reported some continuing driving phobia, especially with PTSD triggers such as screeching tyres or seeing smashed cars, with cars approaching rapidly from behind being the worst. She described both psychological and physiological anxiety symptoms on these occasions, but she had not reached panic attack level. She was able to manage all necessary driving tasks, although she still felt reluctant to face peak-hour city driving.

I have not seen Mrs Q since this session.

## DISCUSSION

As is very common, especially with younger clients, Mrs Q had significant anger *at her own body* for the constant pain, tension, and inability to function as before. To elucidate this emotion has become almost a standard practice in my treatment of persons with pain — be it chronic or acute. Using Mrs Q's love for her daughter as a source of love for herself was quite effective as an ego-strengthening technique and it permitted the best possible rate of healing. The hypnotic treatment did not change Mrs Q's injuries *per se*, of course, as whiplash is a painful and long-term condition. It did help her, however, with her acceptance of the reality of the condition. This in turn helped her in the necessary maintenance regimen of stretches, heat treatment, and hydrotherapy, and to make intelligent adaptations to her circumstances.

Unlike Evans (2003), I do not use any trauma re-exposure technique with MVAs. This is for three reasons. First, an MVA is a very short single event, not analogous to war experiences, rape, or long-term childhood sexual abuse. The need for abreaction in these circumstances is generally much less. Second, my sense with the clients of my practice is that they would find this re-traumatising, and underline the more important process of regaining comfort and control. PTSD, very much in the MVA situation, is a disorder of forgetting; I wish to *assist* the forgetting, and *remember* a sense of safety. Third, there is a remote chance that a trial judge may disqualify testimony by a client if they have had hypnotherapeutic treatment (see Australian Society of Hypnosis, 1994). While extremely unlikely in an individual case, and while it is also arguably poor practice to refuse to offer a potentially beneficial treatment to a client, it is at least prudent to eschew those therapeutic techniques which may cause "enhanced memory." I have used abreaction techniques with veterans and adult survivors of childhood abuse; however, the context of an MVA is



considerably different, and I have observed that in the majority of MVA cases the memory is likely to dissipate through ordinary processes if the subjects can re-learn to drive comfortably. If it does not, I use the “flashing brake light” story to integrate the client’s narrative of the accident (see van der Kolk, McFarlane, & Weisaeth, 1996) and supply them with a practical behavioural strategy to restore control, and then hypnosis and imagery conditioning to re-learn this. However, I believe that it is ethical and appropriate to offer clients abreactive hypnotic treatment for PTSD if they find that the traumatic MVA memories continue to intrude and cause disturbance after the compensation claim has been settled.

I do not use any formal scale of hypnotic ability in my practice. This is largely because, as Barnett states (1981, p. 50): “scales for hypnosis ... are too cumbersome and time-consuming for the busy clinician.” For a brief time in 2002, after being introduced to formal hypnotisability scales, I did try to incorporate Spiegel’s eye-roll technique (Stern, Spiegel, & Nee, 1979) into my progressive relaxation script. However, I always felt it was rather procrustean, and I eventually abandoned it, as it was obvious to several of my clients that the complex instructions and awkward eye-muscle movement ran counter to the goal of relaxation, and it was clearly for my benefit and curiosity only. My continuing sense with my clientele is that the ostentatious display of hypnotic procedure involved in scales such as the Stanford Hypnotic Clinical Scales, Creative Imagination Scale or Hypnotic Induction Profile only causes a decrease in relaxation and comfort at best, and at worst raises rapport-destroying issues of power in the delicate psycho-legal context.<sup>24</sup> Unless a client explicitly expresses enthusiasm for formal hypnotherapy, I do not use any method to estimate hypnotic capacity.

There is one other use of hypnotic method that I use in my practice which is worthy of note. One of the most important tasks in the psycho-legal context is to provide assurance to clients that the pain is not “all in my head.” This is a very frequent comment after assessments by medico-legal experts for the insurer, and is frequent even after assessments by experts for the plaintiff.

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24 Let alone the awkward Amnesia Capacity Estimation of Barnett (1981, pp. 52-59). For an exposition and review of hypnotisability scales, see *American Journal of Clinical Hypnosis* (1979) Vol. 21, which examines the Stanford Hypnotic Susceptibility Scale (Hilgard, 1979), the Stanford Hypnotic Clinic Scale for Adults (Morgan & Hilgard, 1979a), the Stanford Hypnotic Clinic Scale for Children (Morgan & Hilgard, 1979b), and Hypnotic Induction Profile (Stern et al., 1978). See also Wilson and Barber (1978).

Where possible, I offer translations of the medico-legal reports, and contextualise the experience of the accident, recovery, and stressful experience of litigation as they prosecute their case for compensation. My role as psychologist is essential in this regard, as frequently neither the doctors nor lawyers, whether for the defendant or plaintiff, appear to have time or requisite skill in explaining the medical or legal phenomena. Receiving reports from doctors for the other side (i.e., insurer) is often a devastating experience, and to ameliorate the impact of these I offer a description of the complete medico-legal process. So, to assist clients endure this with a minimum of distress I utilise a series of indirect hypnotic stories at appropriate stages in the litigation process.<sup>25</sup> These stories also frame the experience in a way which is intended to limit the psychologically destructive aspects of the litigation experience, and to orient clients for future growth, once the experience is behind them.

Some clinicians and commentators (e.g., Patterson, 1996) will treat patients hypnotically, despite actual or potential litigation arising from their injury. Others (e.g., Barber, 1996) are extremely sceptical regarding the efficacy of hypnotherapy in treating pain under the shadow of litigation. Barber proposes a general rule that no hypnotherapy be provided until the litigation ends, saying that the patients are actually seeking the application of a “green poultice” (money) for their relief. To choose to treat a particular patient in such circumstances should, arguably, be the treating practitioner’s choice; however, a blanket rule of no-treatment, or even a “strong” presumption of non-treatment (Barber, 1996, p. 57), does not seem supported by the view of experts such as Rogers (1997), who states, “The literature does not support ... the view that such patients invariably become symptom-free and resume work within months of the finalisation of their claims. On the contrary, up to 75% of those injured in compensable accidents may fail to return to gainful employment two years after legal settlement.” This view is supported by many other experts and researchers, including Hutchinson (2001). Barber’s alternative recommendation is that hypnotherapy be given a “treatment trial.” This is my method; if a client does not respond within a few sessions, or is not willing to attempt the homework exercises and recording, the treatment is stopped.

The final story a client will usually hear from me occurs around the time of reaching a settlement. The story goes: “And now, I don’t know how you will

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25 Again, there is insufficient space for these here; future articles by this author will illustrate these techniques.

feel after this case is all over. You may feel like celebrating, or you may simply feel relief. Many people actually get even more depressed once it is all over. It is as though they have struggled to hang on tight through the whole legal process, and once it is over, sometimes — bam, they collapse. Would you like to hear a story? There was one really nice lady who I saw, for several years, who lived on a social security benefit of only \$150 per week for four years, with painful knee and back injuries, and who won't work again. She was so down, she had suicidal ideation for a long time, and she truly believed she would never be happy ever again. Then they finally settled her case, for a six-figure sum. I had warned her about the post-settlement emotions, and that she would have to grieve for the months and years that she had lost while her life was on hold in this lawsuit. Three months passed, and then one day she came in to see me. And do you know what she said? She said, 'Paul, after it finished, I spent a whole month in bed. I didn't leave the house except to buy groceries. I didn't get out of my pyjamas most days. I stayed under the blankets, I was exhausted. But then I went outside one day, and I was so surprised — I could feel the sunlight on my face. It was lovely, it was so warm — I had forgotten all about the sunlight! And I looked and I saw my little garden. And do you know what I did? I walked barefoot in the grass. Yes, I just walked across my lawn, I felt the dewdrops on my toes as I walked barefoot in the grass ...' And you know, that was the first time I had ever really seen her smile. She hadn't really forgotten how to be happy after all, and her life was beginning again."

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## ANXIETY, MEMORY ENHANCEMENT, AND HYPNOSIS: A CASE STUDY

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*This article reports on the issues relating to memory enhancement in hypnosis. A practical case is put forward for discussion, and aspects of veracity and distortion of memories obtained in such circumstances are debated. Readers are left to draw their own conclusions about what to do when clients request hypnosis for such purposes.*

“Memory is a complex and labile phenomenon with inherent plasticity” (Sheehan, Green, & Truesdale, 1992, p. 690). Accordingly, the use of hypnosis as a means to enhance memory has attracted controversy and debate within the literature (Barnier & McConkey, 1992; Dinges et al., 1992; Fisher, 1995; Gow, 1999; Kandyba, 2002; Milne, 1995; Murrey, Cross, & Whipple, 1992; Scoboria, Mazzoni, Kirsch, & Milling, 2002; Sheehan, 1997; Sheehan & Statham, 1989; Weekes, Lynn, Green, & Brentar, 1992; and Whitehouse, Dinges, Orne, & Orne, 1988). Sheehan and Statham (1989) were particularly cautionary in their views and contended that “hypnosis produces memory distortion more often than not; evidences memory enhancement infrequently; is associated often with increased verbal productivity; and at times appears to significantly increase the confidence expressed in memory reports of highly susceptible subjects in hypnosis” (p. 170).

Other authors (Green, Lynn, & Malinoski, 1999; Labelle, Laurence, Nadon, & Perry, 1990; Murrey et al., 1989; Orne, 1979; Waxman, 1989; and Weekes et al., 1992) have also documented their concerns regarding the use of hypnosis as a means to enhance memory. These concerns included pseudo-memory manifestation and memory distortion. In relation to memory and hypnosis,

Gow (1999) reported on research that demonstrated that hypnotic techniques can produce more information, but that information is both accurate and inaccurate. Similarly, Scoboria et al. (2002) found that “it [hypnosis] results in increased error rates and enhanced confidence in the accuracy of both true and false retrieved details” (p. 26). Nevertheless, Pinizzotto (1989) suggested that there is a place for hypnosis in the forensic setting and highlighted several high profile (American) cases where hypnosis had been used and “impressive” results obtained. Nonetheless, he was also cautious in advocating the use of hypnosis as a tool for memory enhancement.

Whitehouse et al. (1988) suggested that improved recall may not be a factor of “hypnotic augmentation upon memory retrieval processes” (p. 290), but may result from individuals being less critical of information about which they had been uncertain of previously. Consequently, individuals may be more prepared to report information (previously known to them) as memories. Whitehouse et al. (1988) postulated that in hypnotically responsive individuals that the responses evinced through hypnosis may take on greater plausibility, thereby increasing subsequent acceptance.

Given this diverse body of research, it could be assumed that the validity of any information that is derived under hypnosis warrants authentication or independent corroboration (Perry, 2000). It is prudent to advise clients of the risks associated with (hypnotic) regression techniques (particularly when involving possible litigation); and not to use or advocate hypnosis as a tool to assist memory enhancement.

## **CASE STUDY**

However, for the sanity of a client who presented in highly distressed and anxious state, I recently agreed to hypnotise a man (Claude), who requested memory enhancement.

This gentleman presented in a very agitated and distressed state. He had borrowed work equipment (two laptops and a light camera) to conduct a work-related presentation. When the warehouse supervisor audited and reconciled his equipment, there was a record of only one laptop being returned. The client “believed” that he had returned all items but could not “remember” specific details of the event. In this instance, this gentleman was describing the process of “normal forgetting” or the “natural decay of memory as a result of time and interference from subsequent events” (Bryant, 2000, p.

22). Presumably, Claude did not expect that he would have to remember this event and thus would not have rehearsed this material to memory. Accordingly, Claude hoped that hypnosis would enhance memory or his recall of this event. It was the client's highly anxious state that prompted my use of hypnosis, not an expectation that memory enhancement would result.

For those prepared to accept the premise that hypnosis assists memory enhancement, the client's subsequent assertions of his "recall of facts not previously accessed" may support a contention that hypnosis can aid memory recall. The client was seemingly appreciative of my apparent ability (through the use of hypnosis) to enhance memory recall. Despite my repeated protestations and scientific argument, Claude remained convinced that hypnosis improved his recall of previously forgotten facts. Accordingly, I feel compelled "to set the record straight" and promote this case as an example of "hypermnnesia" (i.e., the recollection of more information after repeated testing") (Pinizzotto, 1989). Readers are advised to keep in mind the wider definitions of hypermnnesia, as indicating any evidence of increased recollection of material.

### **Client Background**

Claude had had a 35-year association with his employer and there was no prior history of misconduct within the organisation. He presented at the three appointments (with me) in a highly distressed and agitated state. He was very upset about the missing equipment and his inability to recall a distinct memory of returning the goods (i.e., a memory that involved placing the three items on the counter at the warehouse and having them registered as returned).

As indicated within the introduction, I had never utilised hypnosis as a means of memory enhancement and was highly skeptical of its use in this area. However, this gentleman had constructed a sequence of events through his own investigation which led him to the conclusion that he did not take the items, but in fact had returned them. In fact, all corroborating evidence he had collected (recall from other witnesses, independent reconstruction of events, etc.) supported this conclusion. Unfortunately, his level of anxiety made him question this probable "truth." I therefore felt that hypnosis would benefit Claude as a means of reducing anxiety levels, which I felt interfered with his reasoning processes. There is sufficient research to suggest that high levels of anxiety can produce an adverse effect upon working memory (Ashcraft and Kirk, 2001; Darke, 1988; Eyesenck, Mogg, May, Richards, & Matthews, 1991).



Seemingly, this event (the missing work equipment) had become a preoccupation with the client. He indicated that he had “searched his house” several times for the missing equipment. These searches involved emptying all cupboards and rearrangement of furniture. (The imposts of these searches to the family were estimated as considerable.) The client also questioned individuals who he knew to be involved with the presentation (including his co-presenter and several participants) as well as the warehouse supervisor (who was in charge of the equipment) as to whether they had any recall of his returning the equipment. Evidently, these individuals were unable to allay the client’s concerns, but with the passage of time (approximately nine months) the client had constructed a sequence of events with one critical omission — a memory that contained him handing over the equipment to the warehouse employee. Seemingly, this was the memory that he wished to access.

The event had occurred approximately nine months preceding the initial appointment with me and a formal (workplace) investigation was to proceed in relation to the missing stores. Claude hoped that he would be able to sign a statutory declaration indicating that he had returned the goods, and he felt that he needed to have a clear memory of the event so that he could do so. Otherwise, as indicated to me, Claude would feel compelled to provide monies for the replacement of the equipment.

As stated, I met with the client on three occasions in relation to this matter. I agreed to undertake the hypnosis because I felt that the hypnosis would be beneficial in alleviating anxiety and considered that it would not have a confounding impact upon memory recall in this particular instance.

## **Session 1**

At the initial session, I found out as much background as possible and why the client was insistent on the use of hypnosis. He stated that he had gone to exhaustive lengths (as indicated within the client background) in order to “remember.” As he had been unable to achieve a distinct memory, he felt that hypnosis might provide the necessary framework.

In response, I explained my concerns (which largely reflected the introductory paragraphs of this case study). I explained to Claude that I did not believe that hypnosis would assist his memory and that I would have to be careful in my approach, as I did not want to inadvertently say something that would contaminate or create false memory. As Perry (2000) indicated, “memory is reconstructive, that it is subject to alteration as a result of fresh

sensory inputs” (p. 8). I also explained how information, derived from hypnosis, is questionable from a legal perspective and that other corroborative evidence would need to be located. I explained that I would ensure that the hypnosis would be undertaken in such a way as to prevent these potential risks from occurring.

Another appointment was arranged (a week later). In the intervening period, the client was to consider the option of hypnosis and tell me of his decision at our next meeting.

## **Session 2**

The client acknowledged my concerns in relation to the use of hypnosis, but nonetheless felt that it was an option worth pursuing. He felt that he had exhausted all other avenues that would assist him in the recall of this event.

Given the client’s highly anxious state, I decided to use an induction involving progressive muscle relaxation (so as to reduce the physical symptoms related to his anxiety). Claude appeared to respond well to this technique. Although he had no previous experience with hypnosis, Claude had worked as a physical training instructor and, as such, knew the physical benefits associated with reducing muscle tension.

A modification of the “Memory Bank” (see Gregg in Hammond, 1990, pp 437–439) was utilised. Ego strengthening was used to enable the client to have more confidence in his ability to remember. In fact, Sheehan and Statham (1989) indicated that “confidence may be affected appreciably when hypnosis is introduced.” This session also involved having the client “retrace his steps” (Hammond, 1990, p. 438) of the day that he returned the laptops. Claude had some independent recall of this day, which was discussed at our initial session. As noted, he had already largely constructed a sequence of events (pertaining to this day) which had been corroborated by others who also had involvement in the event. These independent memories and corroborated events were worked into the script that involved retracing the day’s events. Every attempt was made by me not to introduce (or interpret) information that had not already been provided to me by the client. Research indicates that misleading questions or false information given to clients during hypnosis can permanently affect original memory of an event (Murrey et al., 1992; Orne, 1979; Perry, 2000; and Scoboria et al., 2002). Fisher (1995) also indicated that uninfluenced recollection is generally more accurate.

As such, the resultant script enabled the client an opportunity to explore

each facet of the past event in a relaxed state. Ideomotor signaling was used so that I would have some indication as to when it was an appropriate time to move on.

When coming out of hypnosis, the client indicated that he had retrieved additional information (including other persons who were in the warehouse at the time he was returning the stores). Claude was disappointed, however, that he did not have a physical memory of returning the goods. "I still cannot see me placing the computers and light on the counter," he lamented.

The client appeared physically exhausted from the session, but was not in trance. He stated that he wanted one more session to see whether other information could be found. An appointment was arranged for two days later.

### **Session 3**

Claude had spoken with the other persons (who he had "recalled" from the previous session), who were in the warehouse. These individuals apparently remembered him, but were unable to recall what specific items he had with him on the day in question. Given the apparent success of the preceding session, as perceived by the client (i.e., an additional memory from that day), Claude was keen to be hypnotised again.

A similar induction was attempted, as well as the modified suggestion (as promoted by Gregg in Hammond, 1990). However, rather than rely on visual memory, I encouraged the client to consider his movements and the sounds (language) that he could remember from the event. Pinizzotto (1989) indicated that "even the physical conditions of the environment in which the learning occurred (e.g., odours, sounds, sights and temperature) assist the individual's ability to remember the information learned" (p. 325). Fisher (1995) also supported the strategy of "recreation of the original context" (p. 745). Thus if you cannot physically return to the original scene, visualisation of the scene may be another option to be used in memory retrieval. Again, every attempt was made by me not to introduce (or interpret) information or introduce language that had not been directly provided to me by the client. Kinaesthetic memory did not provide additional information. However, the client maintains that he remembers saying to the warehouse employee, "Here they are. I have returned them." Thus while he was unable to access any visual memory of the items being returned, Claude claims he was able to access an auditory memory of what he said to the warehouse staff member. On the basis

of this auditory memory, Claude felt that he could sign a statutory declaration indicating that he had returned all items.

This was an unusual clinical request for me and one that, because of my previous reading and studies, I felt some concern about. I did not want to inadvertently contaminate this gentleman's memory. While he believed himself to be honest (i.e., that he had returned the equipment), he wanted a specific memory which would corroborate this belief in himself. At the time of the initial session, he did not have such a specific memory and presented to me in a highly agitated and distressed state. Prior to these sessions, Claude had already recalled general events which provided a probable truth, but because of his highly agitated state he was unable to relax sufficiently to set down these memories logically.

## **DISCUSSION**

This case raises a number of interesting discussion points. Claude possessed the belief that hypnosis would help him and so "recalled events" may have taken on greater significance because of this pre-hypnotic expectancy. However, a study undertaken Lynn, Milano, and Weekes (1991) suggested that pre-hypnotic expectancies, in fact, do not affect the pseudo-memory rate. In fact subjects' confidence in the accuracy of their reports is apparently not affected by pre-hypnotic expectancy (Lynn et al., 1991).

"Social demand" does not appear to be a factor that would have influenced this case, either. Research conducted by Murrey et al. (1992) as well as Weekes et al. (1992) indicates that social demand (or response bias) can influence the manifestation of pseudo memories. While Claude had an overwhelming desire to feel that he was being honest when he signed the statutory declaration indicating that he returned the goods, there was already evidence to suggest that the goods had been returned, but simply not registered by warehouse staff. Claude's prior investigations had indicated that the warehouse was manned by casual staff on the day in question, and that there was a great deal of confusion within the warehouse regarding the registration of returned items. Hence, the client could have signed a statutory declaration with reasonable certainty that he had returned the goods, but the items were misplaced by warehouse staff. Further, every attempt was made by the therapist to minimise memory distortion (including non-interpretation of events, care in the language that was used, and the use of a "script" that had largely been provided to me by the client before any hypnotic intervention). Accordingly, I do not believe that

pseudo memory would have resulted through inadvertent or deliberate action by the therapist.

Accordingly, individuals who advocate the use of hypnosis as a means to enhance memory might contend that, through the use of hypnosis, Claude was able to access information that may otherwise have remained unavailable to him (including other potential witnesses and an auditory memory), particularly given the basis of the preceding discussion points.

In the case of Claude, I believe that the explanation of hypermnnesia has some merit. I feel that the new memories apparently elicited from hypnosis were postulations already surmised by the client. Claude had ruminated on this event for nine months and had “repeatedly questioned” himself about the probable sequence of events. He had also collected substantial corroborating information. In the case of Claude, hypnosis probably reduced the anxiety, thereby increasing the confidence and possibly the client’s willingness to accept information and reinterpret this information as “memories.”

I do not believe that I would have attempted regression techniques with this client had there not been the level of independent corroboration. Moreover, in retrospect, this case only highlighted for me the potential risks involved in the belief that hypnosis can enhance memory. While some may argue that memory enhancement, as opposed to memory recall, resulted in the case of Claude, I am unconvinced. The hypnosis did not touch on “new territory,” and I don’t believe that any new information was elicited or uncovered by the hypnotic process. This gentleman had ruminated on this event for some nine months before I met him. Seemingly, anxiety had prevented him from having confidence in the sequence of events that he had already surmised. Apparently, hypnosis allowed Claude to reduce his anxiety and to clear his mind, thereby allowing him to assess the sequence of events that he had already established prior to any hypnosis being attempted.

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## THE USE OF HYPNOSIS IN THE TREATMENT OF POST-TRAUMATIC STRESS DISORDER IN A FEMALE CORRECTIONAL SETTING

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*This article reports on a therapeutic program, conducted in a correctional centre, which included the use of hypnosis with women who had been diagnosed with PTSD. It discusses the logistical and process issues of implementing the program within this treatment setting, focusing on “what works” and specifically how applied clinical hypnosis can best be utilised in this context with other techniques, and outlines some strategies to employ to overcome therapeutic obstacles.*

### OVERVIEW

This article describes a post-traumatic stress disorder therapeutic program concluded in 1999 at a female correctional centre, to assist female offenders by applying a broad array of cognitive, behavioural, and applied clinical hypnosis strategies to reframe behaviour and decrease the symptoms of post-traumatic stress disorder (PTSD). The modules of the program emphasise validation of the offender’s current emotional, cognitive, and behavioural responses, and provide psycho-education on PTSD and solution-focused skills in managing daily distressing situations, negative emotions, and interpersonal relationships.

The dynamic interaction between the prison environment, offender psychopathology, and individual coping styles elevates the risk for chronic PTSD, suicide, and self-harm in the female custodial correctional setting. The relationship between experiences of abuse, current trauma symptoms (as assessed by the Posttraumatic Stress Diagnostic Scale [PDS]: Foa, 1995) and the coping skills of the six female prisoners who completed the program



demonstrated that a strong correlation exists between the effects of trauma on the functioning and coping skills of these women and childhood abuse, poor coping, and the prevalence of psychiatric diagnoses amongst the female offender population.

## **METHOD**

### **Participants**

The participants in the program consisted of a sample of six women who had served more than six months of a custodial sentence. The sample ranged in age from 20 to 64 years, with a mean age of 22 years. Referrals were generated from staff members. Once referrals were established, an information session and individual assessments were conducted to inform potential participants about the program content and assess suitability. Inclusion criteria consisted of a diagnosis of PTSD. Exclusion criteria included inadequate verbal skills, florid psychotic symptomatology, alcohol/drug intoxication or withdrawal, and acquired brain injury. The program engaged one group facilitator. It would have been preferable to have two facilitators; however, due to staffing resource constraints, this was not possible at the time.

Personal history information revealed that women prisoners often came from disturbed family backgrounds with significant levels of family breakdown, parental drug and alcohol use, and violence. The women in the group reported comparatively high levels of childhood trauma and abuse, with four of the six women reporting having been physically abused, and all six reporting both emotional and sexual abuse. The women reported significant levels of psychological disturbance commencing in childhood and continuing into adulthood. In adolescence, two of the women reported that they had an eating disorder, four of the six reported attempted suicide, and two reported self-harming behaviour. These rates of disturbance continued into adulthood and all of the women believed that they had psychological problems. The majority reported drug or alcohol use. Their drug use generally commenced at an early age with the use of marijuana progressing to opiates by the average age of 15. The high rates of medication prescribed by the visiting consultant psychiatrist, and used by these women, was also evidence of the high levels of trauma and poor coping skills within this population.

## **Intervention Program**

The program consisted of two-hour sessions, conducted once per week for 10 weeks. The first half was devoted to reviewing homework tasks, which allowed group members to demonstrate utilisation of skills taught in previous sessions. Following a break, the second half of the session was devoted to presentation and discussion of new skills. The format was open, to help participants learn to cope with change and allow the focus of the group to remain on the task of skills training, rather than getting caught up in day-to-day organisational issues. Each group member was invited to engage in individual counselling on a needs basis, particularly when an issue became evident that seemed inappropriate for discussion within the group. In order to ensure a clear delineation of therapist roles, supportive counselling was offered by a counsellor outside of the program.

## **Measures**

The Posttraumatic Stress Diagnostic Scale (PDS) was chosen as a screening and pre- and post-test for the PTSD group. The scale is a 49-item self-report instrument designed to aid the diagnosis of the disorder. The structure and content of the PDS mirror the DSM-IV diagnostic criteria for PTSD. The PDS was developed specifically to fill the need for a brief self-report instrument that would help provide a reliable diagnosis of PTSD. In addition, the PDS provides recommendations for quantifying severity of PTSD symptomatology.

## **Therapeutic Tools and Techniques**

Hypnosis was used initially for tension reduction with post-hypnotic suggestion for relaxation. In subsequent sessions, hypnotic regression was used to recall and revivify the traumatic incident, vent emotions, and gradually reintegrate the experience with improved coping skills. Since hypnosis can also be useful to help clients deal with nightmares, intrusive thoughts, and flashbacks relating to abuse, it was included within the broader objectives of the program to support adaptive coping skills, normalise the abnormal, decrease intrusive thoughts, decrease avoidance, and alter attribution of meaning of the trauma. The specific therapeutic strategies used were considered with respect to the women's cultural origins, their existing trance state, and their multiple resistances to treatment. The decision made was that some

behavioural and cognitive approaches would be included in the group content. However, it was seen that the provision of hypnosis would allow for a more rapid and less traumatic recovery.

Therefore guided imagery, self-hypnosis, and anxiety resolution were used in the group content. The aim of the content of the program was to utilise therapeutic techniques that promoted the integration and resolution of trauma. Coping-skills training for the most part was concluded during the course of therapy, although several coping skills were taught that could be used at a later time.

Given the proven effectiveness of cognitive-behavioural therapy (CBT), applied clinical hypnosis, and dialectical behaviour therapy (DBT) with clinical populations (Linehan, 1993c, 1993d), and the prevalence of borderline symptomatology in offenders, Linehan's (1993a, 1993b) work with offenders informed some of the content of the program.

Suggested therapeutic tasks for each phase of treatment of trauma victims may vary between ideomotor signals, safe place, affect modulation and toleration, containment techniques, age progression and age regression, hypnotic time distortion, and hypnotic distancing techniques. Also, the more advanced hypnotic techniques such as advanced signalling, fractionation, deepening of trance, mobilisation of effect in cognition, age regression, penetrating or creating barriers in dissociative identity disorders, and contracting for safety. The more complex hypnotic techniques, such as processing the memory in reverse, combining memories, working with "decision makers," or dividing a memory through several therapy sessions, are all techniques found helpful in processing the existential crisis and promoting cognitive restructuring for women who have been trauma survivors in and during the processing of a memory.

Marsha Linehan's original program material was modified to be more applicable to an offender population. First, the module names were simplified to capture more specifically the aims and skills taught in each module and connect these to the goal of alleviating distressing symptoms of PTSD. Second, given the level of distress in a prison environment, it was important to alter Linehan's ordering of module delivery and teach offenders distress management before targeting other skills, such as emotion regulation and interpersonal effectiveness. Third, handouts were simplified to assist acquisition and retention of program material. To further engage group participants, warm-up and closure exercises, such as those listed below, were used.

*Healthy Mind, Healthy Body (Linehan's Core Mindfulness, 1993a, 1993b)* Vulnerable offenders often have a poorly developed sense of self. This module teaches participants how to observe themselves consciously and interact more effectively in their environment to enhance their self-perception. Given that these skills also apply to the remaining three modules, they were introduced first and continually integrated throughout the program. A key concept of this module is Linehan's three states of mind (logical, emotional, and wise) — the ultimate aim being to access “wise mind.” Offenders could relate more to these concepts when everyday analogies, such as attaching a character to each state of mind, were used. Introducing basic cognitive-behavioural concepts also assisted in demonstrating efficient ways of moving into wise mind and achieving a healthier mind and body. Hypnotic techniques were introduced in this module and focused on induction into trance.

*Dealing With Distress (Linehan's Distress Tolerance, 1993a, 1993b)* Vulnerable offenders exhibit patterns of behavioural dysregulation often expressed as attempts to injure, mutilate, or kill themselves. This is often a function of an individual's inability to tolerate emotional distress long enough to pursue more effective solutions. This module focuses on ways to manage distress. Given offenders often find this difficult, a more extensive array of practical exercises was required. For example, participants were encouraged to explore pleasurable sensations through guided imagery, to use stress reduction techniques through self-hypnosis, and to participate in progressive muscular relaxation exercises delivered at the end of each session.

*Looking After Number One (Linehan's Emotion Regulation, 1993a, 1993b)* Vulnerable offenders generally experience extreme emotional dysregulation, typically responding inappropriately to environmental stressors. This module focuses on recognising and managing these unhealthy emotions, with aspects of Linehan's original material significantly altered. For example, a simplified CBT version of Linehan's model for recognising emotions provided offender-specific examples of cognitive myths to assist offenders in identifying and challenging their cognitive distortions. Linehan also uses various acronyms to assist participants to grasp key concepts. Some of these were not suitable for an offender population and therefore altered to better assist skill acquisition. At this point in the program, hypnotic deepening techniques were introduced to enhance the effects of the experience of trance.

*Making Friends Not Enemies* (Linehan's *Interpersonal Effectiveness*, 1993a, 1993b) Vulnerable offenders experience interpersonal dysregulation, finding it extremely difficult to form and maintain healthy relationships, and this subsequently impacts upon their perceived sense of self. This module explored the development and management of dysfunctional versus healthy relationships by focusing on issues such as assertiveness, conflict resolution skills, self-respect, and self-esteem. Within Linehan's original material, there appears to be blurring between these key aspects. The aim was to simplify the material by focusing separately on each of these aspects, as well as further exploring their interrelatedness, to help offenders use their assertiveness and conflict management skills to build better relationships, and ultimately develop a healthier self-worth.

### **Obstacles Encountered in Researching Program Effectiveness**

In terms of implementation, the program has been conducted in one high-risk unit where offenders require either long-term management or strict segregation from mainstream units. Throughout the delivery of the program, numerous therapeutic obstacles were encountered. These included external influences — such as prison lockdowns, unit fights, and difficulties with officers — which often created difficulties as group members wanted to focus discussion on these issues rather than focusing on group content. To tackle this, some time was allowed for participants to vent and validate their feelings, after which the manner in which the program's skills could be implemented to deal more effectively with these situations was discussed.

Another obstacle was that participants found it difficult to grasp certain concepts. To tackle this, analogies, role-plays, poetry reading and drawing/visual exercises pertinent to personal experiences were used. Hostility and belligerence disrupted group cohesion at times. For example, initially one group member consistently sat outside the group circle near the door and at times would leave the room. To deal with this, she was encouraged to sit in the circle and her motivation to attend the group was challenged. Other group members who had complained about her disruptive behaviour were encouraged to challenge her, which increased ownership of group issues.

Other issues that emerged strayed from original program content. Amongst them were day-to-day unit issues, cultural issues, stereotypical attitudes, the use of violence, difficulties adjusting to a "normal" life upon release, employment,

and relationships. It was important to validate participants' emotions and experiences in these difficult situations, but also to work through these examples and link them back to the program concepts. Sometimes it was difficult to get participants motivated to discuss homework. This was overcome somewhat by using stimulating, relevant warm-up exercises, which were useful to focus group members on specific homework skills. Boundary issues were at times challenged as group members constantly wanted to know the facilitator's personal details, which was apparently used as a delaying tactic to avoid exploration of new skills. This disrupted group process, but was handled by reinforcing that the purpose of the group was to teach new skills.

## **OUTCOMES**

An attempt to conduct both quantitative and qualitative evaluations was made. Given the small number of participants completing both pre- and post-tests, the significance levels cannot be reported; however, discussion of preliminary trends, suggested by the data, is possible. Over time, a larger sample size pre- and post-treatment will assist in increasing the validity of these findings, so that more firm conclusions can be made.

Group cohesion was quickly established and solidified by midway through the program, a useful indicator of an "effective group" suggesting that more intensive therapeutic programs are beneficial in facilitating disclosure and developing insight. This was clearly demonstrated by group members being extremely comfortable in sharing personal information (e.g., poems written to them by family members, their own letters to family and friends, and by sharing painful experiences). Several participants actively demonstrated coping and conflict-resolution skills. For example, two group members, who had unresolved past conflict and animosity towards each other, managed to resolve their differences using the skills to ensure both could complete the program. On several occasions, participants used their initiative to speak informally about their perception of the usefulness of the group, particularly after a difficult session. Participants with extensive group experience also commented that the program content was innovative and stimulating, surpassing skill usefulness taught in other programs. Finally, formal feedback was obtained using qualitative evaluation questionnaires.

Certain themes were found throughout the program, extracted from facilitator therapy notes, to summarise the qualitative evaluation. Most participants involved in the program demonstrated high levels of motivation and commitment to the group.

Participants provided positive feedback overall and emphasised the meaningfulness of this particular program, in that it differed from standard prison-based core programs.

## **CONCLUSION**

While it is difficult to separate the efficacious component of the provision of hypnotic techniques as outlined in the article, as distinct from the other therapeutic techniques, group support, and individual counselling, there is no doubt in the minds of the participants and group leader that the utilisation of hypnosis in the early part of the program and as a means to reduce traumatic impact was efficacious for the whole treatment program.

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## THE USE OF HYPNOSIS IN THE TREATMENT OF PTSD

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*This study describes the application of hypnosis in the treatment of a woman, Jackie, with post-traumatic stress disorder resulting from her experience of having large glass doors collapse and shatter on top of her at work on two separate occasions. She was referred by her general practitioner and through the use of hypnosis achieved her goals of returning to work and abolishing distressing flashbacks, feelings of not being safe, inability to leave her home, loss of appetite, panic attacks, and sleep disturbance which she had been experiencing. The doctor had not prescribed any medication at the time of referral, but was waiting to see how the counselling treatment progressed. The implications of using hypnosis, should Julie wish to seek legal action in the future, were discussed. She stated adamantly that she did not wish to pursue the matter legally and signed a disclaimer stating that she understood the implications.*

### SESSION 1: FULL HISTORY AND ADMINISTRATION OF THE CREATIVE IMAGINATION SCALE

#### **Presenting Problem**

Julie was a 50 year-old-woman who was referred by her general practitioner for treatment of post-traumatic stress disorder (PTSD) following the collapse and shattering of glass double doors at her place of work. The doors (very large and heavy) fell upon her, and although she sustained only superficial lacerations to the forearms and chin, she experienced extreme shock. The situation was complicated by the fact that almost exactly one year previously (only four days separated the dates) the client was in a similar but more severe accident involving the collapse of glass doors at the workplace.



The first incident occurred during an annual festival held in her city. During the two-week festival, large glass doors were opened up to create a space for patrons. Julie was going about her normal duties to prepare for the opening time, but when she went to open the “very high and thick” glass doors she heard a grinding sound. Moments later, the doors began to collapse. Julie described it as feeling “like an eternity ... as if my life went through me.” The wooden doorframe had broken and was the first thing to strike Julie, followed by the shattered glass. She felt “entombed” by the glass, which was in her hair. She was cut and bleeding. A fellow employee ran to her aid, lifting her from the glass. Julie reported losing her memory for a short time and could only recall being worried about how patrons would be able to make their way through the area. An ambulance was called and Julie was taken to hospital. She was allowed to go home the following day.

Julie described her recovery from that incident as slow. She did not seek any professional help, as she was able to continue going to work. She reported that it was quite some time before she could talk about the incident or to joke about it, which seemed to be how other employees were coping. Julie confided that “they don’t know what it’s like,” explaining that only she knew the fear of being underneath all the broken glass; “I thought I was going to die,” she told me tearfully. Julie also said that she had not told her brother, who was her only close relative, about the incident.

The second incident had happened almost a year later. Again Julie was opening the doors, when this time the glass began to shatter from the top sections. The frame broke and showered her with glass. Julie described herself as “being frozen, terrified ... I just couldn’t believe it.” She began to scream, “Oh no, it’s happening again!” She then began to cry and apologised to the people around her, believing that it must have been her fault for the doors to have collapsed twice. Julie’s injuries were not as severe as on the previous occasion, but the shock and disbelief that it could happen again proved to be very traumatic for her. Julie lost her confidence. She left work that day and had not returned by the time of her first visit. Furthermore, she was locking herself in her house, only leaving to buy groceries. Julie could not face people, she felt guilty and was sure that her employers were blaming her for the incidents, even though they had apologised and reassured her to the contrary. Her employers had explained that the doors were faulty and had not been properly repaired after the first incident. Insurance photographs were being taken. Despite the evidence that she was not at fault, Julie continued to lose her confidence and self-esteem. She spoke warmly of the company, saying that

they had been good to her throughout an illness that she had had some years earlier. She repeated many times that she was not interested in seeking compensation, but just wanted to get back to work as soon as possible, as her job and her independence meant a great deal to her. Julie's doctor had given her two weeks off work with a gradual return recommended.

### **Social History**

Julie had been married for 10 years to a man she described as mentally and physically abusive. They separated five years earlier and she had lived alone since. There were no children. Julie was the elder of two children, both born in Australia. Her father was born in the U.K., arriving in Australia in 1951, and her mother was born in Australia. Her parents had had a difficult relationship with frequent fights. Julie described her father as dominant and violent at times. He drank a great deal and would throw his food across the room if it was not to his liking. He used physical punishment with the children and used to call them names, particularly when he was drunk. Her mother did not work outside the home and was a "quiet, nervous woman" who was frightened of her husband. Julie did not feel close to her father and tended to stay in her room to avoid him. She was closer to her mother, and felt anxious and frightened for her mother's safety when her parents fought. Julie described herself as a nervous child who found it hard to make friends. She tended to be a loner and did not like bringing children home to her house. During her teenage years, Julie tended to stay at home and keep to herself rather than risking making her father angry by expressing a desire to go out with friends. Her relationship with her brother was not close; she felt that he did not understand her and was not supportive during a time when she was sick. Julie's father had died five years earlier from heart disease, and her mother three years before that as the result of a stroke. Julie was involved in her father's care for 12 months before his death, but said she had looked after him from a sense of duty rather than from love. Her mother's death was sudden and had had a greater impact on her.

Julie tended to rely upon her workmates for social interaction, occasionally attending functions with them, but she did not have a group of friends outside the workplace. Her hobbies included reading and gardening.

## **Academic History**

Julie struggled academically, particularly with language skills, from an early age. This contributed to her lack of confidence and she tended to “go into” herself to avoid drawing attention to her difficulties. Her father told her it was her fault that she was having trouble, that she was lazy and stupid. Julie left school after failing to pass Year 9.

## **Employment History**

After leaving school Julie worked at a local supermarket for many years, where she enjoyed the routine and a developing sense of purpose. She then began working with her current employer, attending to patrons at festival events. Julie regarded her job as the most important thing in her life. She found the structure and routine reassuring, and felt proud of her ability to interact in a cheerful way with patrons and to do her job competently.

## **Medical History**

As a child, Julie had suffered from tonsillitis. She was healthy otherwise, until 1995, when cancer of the bowel was diagnosed. Julie underwent chemotherapy, but became very anxious about the treatment. She required medication to ease the anxiety, but recovered well physically and mentally. A considerable amount of time was spent away from work during treatment and recovery. Julie stated that her employer was very good to her during this difficult time and that she felt a great sense of loyalty towards the company. Julie was a non-smoker and consumed alcohol rarely.

## **Diagnosis**

The diagnosis of post-traumatic stress disorder was made before treatment began. A pre-existing predisposition to anxiety, separate from the workplace incidents, was considered likely.

## **Treatment Goals**

Goals were centred on there being a significant decrease in or elimination of symptoms (flashbacks, anxiety, feelings of not being safe, inability to leave her home, loss of appetite, sleep disturbance, inability to attend work). Hypnosis has been used successfully in the past to treat PTSD (Moore, 2001) and would

be used in this case to address all worrying symptoms, to increase relaxation, and to teach new skills.

### **Assessment of Suitability for Hypnosis**

A Beck Depression Inventory was administered, not just to check Julie's levels of depression, which if severe may have made hypnosis an unsuitable choice, but particularly to assess levels of suicidal ideation. In this case, Julie scored 19, which was within the average range, and had no suicidal thoughts. To assess hypnotic ability, the Creative Imagination Scale was administered. Julie scored 25, which placed her in the medium high category. With a combination of medium to good creative imagination and a lack of depressive symptoms, Julie was considered a suitable candidate for hypnosis.

### **Homework**

Julie was shown how to use controlled breathing and was instructed to practise this three times per day and at any time that she felt anxious. She was given a chart to record her level of anxiety on a 1–10 scale before and after using her breathing. Information on PTSD was also provided, in order to reassure her that she was not going crazy (she had asked if this was the case)

## **SESSION 2**

Julie was asked how her week had been and how she had found the breathing technique. She reported that the different method of breathing helped slightly, and in most cases lowered her anxiety level by one to two points.

### **Preparation for Hypnosis**

The benefits and limits of hypnosis were discussed; specifically that hypnosis was not a “magic wand,” but rather a useful strategy to achieve symptom reduction in an overall treatment plan. Julie asked if she would be unconscious and if I would be in control of her mind. These common misconceptions were dispelled by reassuring the client that my role was that of a guide not a controller, that she would be able to choose whether or not to follow any suggestions made, and that she would not be unconscious or asleep, but rather in an altered state of consciousness, rather like that of watching a movie and becoming immersed in the story. Julie was happy to continue.

She was then asked about a place where she felt most relaxed, comfortable, and happy. She identified her garden as such a place. Some time was spent enquiring about what sort of day would be the most relaxing, what she would be able to see, hear, feel, and smell. Care was taken to capture Julie's language, which was simple and at times childlike. Her words would be used in the induction process to build rapport.

Julie was then asked to take a seat in the "hypnosis chair" — a comfortable armchair with a footrest and neck support. Setting aside a specific chair for this purpose has been reported as increasing client expectation that trance will occur (Hartland, 1989). An eye closure technique was used to induce trance, as anxious subjects who find it difficult to suspend critical self-awareness may benefit more from this, rather than voluntary eye closure (Walker, 2001). Also, a tape was being made for use at home, so this provided another reason for a more direct approach being appropriate. Julie was told that I would put a double ending on her tape, one for use in bed at night to aid in relaxation and to assist in undisturbed sleep, and the other for use today, whereby I would use a counting technique to bring her out of trance.

The induction phase took 10 to 15 minutes and involved relaxation through breathing, deepening by means of a counting technique, and taking Julie to her safe place. While in her garden, Julie was encouraged to use all of her senses to fully experience pleasure, comfort, safety, and relaxation. She was asked to indicate to me when she felt she was "there," and she did this by nodding her head slightly. Suggestions were then made to Julie that her mind was becoming aware of a growing sense of peace and calm, like a beautiful flourishing garden, and was at one with nature. She would experience a feeling of having lots of time, more and more time, to just relax and to be free of the outside world. Also she would be able to experience this feeling any time that she felt anxious by hearing the words quite clearly in the back of her mind: "I can be calm and I can be relaxed." (Repetitions have not been included but at least four were used.) Suggestions were then made that Julie could go off to sleep, first turning off her tape before going off to sleep — a deep relaxing sleep — and waking when it was appropriate to wake ("or you can listen now, as I count from 20 back to 1, becoming more alert with each count," etc.)

Julie's muscle tone, particularly in the face and neck, were observed to be loose, her skin tone lightened, and her breathing deepened and slowed. These signs, combined with the feedback provided by Julie of feeling heavy, warm, and relaxed, indicated a moderate trance depth.

Julie was given the tape and told to listen to it each night before bed to aid with relaxation and sleep. She was also asked to use her breathing exercises, to use her garden imagery to control anxiety, and to record, as before, the levels of anxiety.

### **SESSION 3**

Julie was asked how her sleep and levels of anxiety had been. She had used the tape each night and said that she “felt good knowing there was something that she could use.” She had managed to go off to sleep each night successfully, but had woken on four of the seven nights due to a recurring nightmare.

The nightmare had involved giant glass doors breaking and injuring patrons. Julie was in the dream, but was watching a young boy who was trapped beneath the glass. The boy’s father was calling to her for help. Julie felt the dream indicated her feelings of responsibility for the safety of others near the glass doors and her fears that other people, perhaps children, would be hurt.

#### **Cognitive Behaviour Component**

Some time was spent explaining how the way we think creates the way we feel, after the style of Beck and Ellis. Many examples were given to Julie to ensure that she understood the connection. The example of her feeling of responsibility regarding the doors was then examined, using a Socratic questioning style. Julie was then asked to challenge and change her thoughts of “I’m responsible for the safety of others” and “It was my fault the doors broke” to “It is not my responsibility to ensure the doors are safe for everyone” and “According to the company, the doors were faulty; that’s why they broke.”

Julie was then told that during this session she would be imagining parts of her experience of having the doors collapse, that she would “see” it happen as on a movie screen, and that she would use her breathing and relaxation to calm herself down. She would be able to assess her level of distress out of 10, and to indicate this to me.

Hypnosis was induced as before (10 to 15 minutes) with Julie’s garden being used as her safe place. While in her garden, it was suggested that her mind was becoming very calm and clear and relaxed, and that any time she felt responsible for the doors breaking she would be able to hear very clearly in her mind a firm voice stating that the doors were faulty, that’s why they broke, and that it was not her responsibility to fix them. (Again, repetition was used.)

Julie was then invited to imagine herself leaving her garden and walking along a path to an outdoor theatre. She was asked to enter the building, walk down the aisle to the front row, and take a seat. She would feel very relaxed and perhaps curious as to what might appear on the screen. She would also notice a remote control on the arm of her chair, which would enable her to “freeze frame or slow motion” the film at any time. As the curtains opened, Julie was invited to see herself on the screen one year ago, at the time of the first incident, going about her duties of opening the doors. It was observed that Julie’s breathing became quite rapid and shallow; she began to move her head from side to side. It was suggested that the movie go into “freeze frame” for a moment before the breaking of the glass. Julie was asked for a number, out of 10, as to how distressed she felt, and she reported an 8.

Julie was then instructed to use her breathing technique and to return to her garden until she felt her anxiety reduce to less than 5. Julie indicated by raising her finger when she was ready to return to the theatre. She was then asked to run the movie frame by frame ... the breaking of the glass, herself being struck and injured. She would be able to stop the movie at any time, using her breathing and garden to calm down, before returning to the film. She was reminded that she was quite safe sitting in the front row of the theatre. When she had returned she was to indicate this to me by raising her finger. Julie was observed to undergo changes in her anxiety levels, first with a heightening, then a period of calming and return to steady breathing patterns. After a period of approximately five minutes, she indicated to me that she was finished. I enquired as to her levels of anxiety, which she rated at 4. I then brought her out of trance in the usual way.

Feedback indicated that Julie had experienced moderate to strong levels of anxiety throughout this process, but had felt in control because she was able to stop or slow down the picture. She had been worried that the breathing would not help, but found the combination of breathing and her garden imagery had lowered her anxiety before she returned to the movie. She had felt reassured that I was there if she “got into trouble,” which gave her confidence to return to the events of the first (and more traumatic) incident. She reported feeling relieved that she had “done it.”

Julie was reinforced that she had done a very good job and had made important progress. She was instructed to practise the desensitisation effect once each day by relaxing herself and imagining the glass doors breaking, while being in control of the speed and of stopping the “film” if necessary. Julie was due to begin a graduated return to work in three days time, which would

give her another three exposures. Strategies had been discussed and put into place by myself and her employer to ensure that she felt safe and supported.

#### **SESSION 4**

Julie reported that she had been to work (reduced hours) each day she was required, and planned to return to normal hours. She had felt a great deal of concern when it came time to open the doors, but had stood back, used her breathing, and repeated to herself that the doors had been fixed and she was safe. She had a companion to perform this task, and she was only required to accompany that person on the first few days. This procedure was put into place to build her confidence in the safety of the doors and to provide gradual exposure.

Julie's workmates had been very supportive and she was relieved to be back at work. She said that she had been surprised by the emergence of strong feelings of anger toward their employers. She had begun to realise their failure to provide a safe workplace for herself and others, questioning repeatedly why they had failed to repair the doors properly after the first incident. Julie had moved away from the strong feelings of guilt and responsibility she had been shouldering and had placed them where they appropriately belonged. Having done this, she reported feeling relieved that it was not her fault after all. She connected the feelings she had had as a child of "always being blamed for things" with her prior feelings of being at fault. She had separated herself from these early feelings and had looked at the situation in a more balanced way.

Julie reported that her sleeping had improved and that there were no longer any nightmares. She had practised her imagined exposure on three of the seven days, but felt it drained her too much emotionally to perform each day. Flashbacks were still present, but greatly reduced in frequency. Julie's eating was pretty much back to normal and she told me proudly that she had been invited out with some workmates to have a meal and was looking forward to going.

#### **SESSION 5**

Induction occurred in the usual manner, with Julie being invited to enter the "theatre of the mind" as before. This time, as she took her seat and the curtain opened, she would see herself on the screen preparing for work, travelling on the train, and arriving in her usual manner. She would perform her usual duties until it was time to open the doors, whereupon she would see herself



approaching the doors in a calm, confident, and matter of fact way. She might even be pleasantly surprised by how competently and efficiently she carried out her duties. She would feel a sense of pride in how she appeared to others in the workplace and how indeed she is. Throughout this session Julie's body appeared relaxed and comfortably heavy in the chair.

Julie was given this tape to listen to three times during the week. She was continuing to use her sleep tape and enjoyed the routine of relaxing each night.

## **SESSION 6**

Julie told me that she had been out to dinner and had enjoyed the company, although she did not stay late. She confided that she had almost pulled out, but had used calming and coaching self-talk to reassure herself. She said she had been relaxing more, using classical music and a hammock slung in her garden. At work, she felt she was pretty much back to her old self, able to share a joke with patrons and fellow workers, although she still avoided talking about what had happened with the doors.

Induction was followed by ego enhancement, using imagery of a waterfall washing away all previous worries and feelings of hurt. A white healing light was introduced, and Julie was invited to step inside and feel the light protecting her from the stresses of the outside world. Suggestions were made to reinforce the gains already achieved and to promote pride in her achievements. Julie was reminded of all the strategies she had learned and that she could effortlessly put these into practice at any time.

At the end of this session, Julie said that she would like to see me once more, but perhaps that would be all she needed. This was agreed.

## **SESSION 7**

Julie had returned to normal working hours and no longer needed anyone to accompany her while opening the doors, "but I know they keep an eye on me anyway," she said, smiling. Her employers had informed her that there had been a design fault in the doors, which had been rectified. Julie said she felt relieved when told this, but had stopped feeling guilty beforehand. She had felt a lessening of guilt in other areas of her life also. Her symptoms from the workplace incidents were significantly reduced and she felt comfortable to end her sessions with me, knowing that she had strategies at hand should she need them. I left it with Julie to contact me at any time.

The use of a combination of hypnosis, cognitive behaviour strategies, exposure techniques, and relaxation hypnosis in the treatment of PTSD has been well documented, and appeared to work well in the case of Julie, reinforcing and enhancing an overall treatment approach. Additionally, Julie felt that she was much better equipped to deal with any distressing events in the future.

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## POST-TRAUMATIC STRESS DISORDER, CRIME, AND TRANCE

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In late 1991, I was employed as the psychologist at a correctional centre in Queensland which housed a relatively large number of “lifers” — prisoners who had been given a mandatory life sentence after pleading guilty to, or being found guilty of, murder. Many of the lifers were approaching the date at which they would be eligible to apply for parole. After serving thirteen years in prison, they would be considered for parole, which if granted would continue for the rest of their lives.

The task was assigned to me to interview each of the lifers and to make an assessment as to whether they were suitable for parole. This assessment was to be based on such factors as their addressing the issues that led to the offending behaviour, the presence or absence of remorse in their presentation, and their ability to demonstrate empathy with the victim.

Throughout this short article, the word “the” is used rather than “his,” “her,” or “my” when referring to the victim or the crime. It seems singularly inappropriate to refer to “my victim” or “my abuser,” as is common practice. The “two people” do not belong together in any way. Those cases which are described in detail are taken from the notes of people who gave permission at the time for the material to be published. The pronoun “he” is used as the offenders are predominantly male.

### **Trauma and Dissociation**

It was interesting to note that many of the lifers did not remember committing the crime. At first, it was thought that perhaps they were simply lying, but after much discussion with them, it seemed that they may genuinely have been

unable to recall the offence. Some, but by no means all, were intoxicated at the time. Mostly, they were very confused about how they were to go about “addressing the issues that resulted in their offending behaviour.” They did not understand why they had done what they had done, so much so that they tended to talk about “when it happened” rather than “when I did it.”

One of the lifers was “a real gentleman,” a person who seemed to be completely out of place in prison. It turned out that he was a war veteran who had killed a drinking companion for no apparent reason, could not remember it, and had pleaded guilty to murder. This meant that there was no trial and that he had received the mandatory life sentence. His history made it very clear that he was suffering from a classic combat-related post-traumatic stress disorder (PTSD). Anyone who had studied an elementary textbook in psychiatry or clinical psychology would have seen it at once. Dissociation, or going into an altered state of consciousness, is a major symptom of PTSD, and so is the inability to recall important aspects of traumatic events.

Clinicians, familiar with trance states, will see dissociation as nothing more or less than trance. The victim of major, or ongoing, trauma will dissociate during the actual trauma and then dissociate again when some cue in the environment reminds them of the trauma.

Having been alerted to the possibility of dissociative, or trance, states at the time a crime is being committed, I noticed many of the other Lifers had suffered major trauma. One man, who had killed his wife, disclosed that he had been sexually abused by his teacher after school and then beaten by his parents for coming home late. He was in his fifties at the time of assessment and it was the first time he had ever told anybody what had happened.

Another man, who had panicked while committing an armed robbery and shot a number of people, had been beaten almost every day at his Catholic boys school. A man who had killed a little girl had been gang raped at the age of eight.

There was one very bizarre case, where the perpetrator did not remember the crime. The victim had had her throat viciously cut during a break and enter. The murderer had grown up in a home where there was extreme domestic violence. As a very young child, he had apparently watched his mother knocked down and left on the floor, unconscious and bleeding.

One particularly violent murderer, who also did not remember committing the offence but agreed that he must have done it, had been brought up in boys homes. He remembered being forced to perform oral sex on a whole dormitory of older boys and lying face down on a mattress while a large

number of them sodomised him. He said that he deliberately adopted a policy of becoming more violent than those who were being violent towards him, and that included the physically abusive staff.

It seemed possible that, as these people had suffered severe trauma as children and teenagers, they were adept at moving into a dissociative or trance state.

Adopting another unusual and unproven perspective, it also seemed possible that committing a violent offence, such as cutting a woman's throat or killing a small child, might be experienced by them as traumatic. The eyes that see the violent death and the brain that processes the experience would be expected to react in the usual human way, even if the hands that performed the killing were part of the same person.

So imagine now that we have a scenario where a man cuts a woman's throat and his brain is traumatized by the sights and sounds that he creates himself. This would mean that he may well be unable to recall an important aspect of the trauma to cite the DSM IV (APA, 1994). The alternative explanation is that he is already in a trance state when he commits the crime and the trauma of the offence deepens the trance, so that he does not recall it.

The case of Jeffery Dahmer (Britannica, 2004) is very interesting. This man killed and cut up a number of men whom he had lured into his apartment for sex. He had started his sexual activities as a teenager masturbating to gay pornography and killed his first victim when a presumably straight hitchhiker refused his sexual advances. Many years later, he began to drug his victims and had sex with, or masturbated over, their unconscious bodies. Later still, he killed them first and then kept pieces of their bodies in his refrigerator.

Reading about this man and the analyses of his behaviour, there is one thing that the commentators do not seem to have noticed. His mother was depressed, rejecting and abusive, and the only time that the little boy at the age of three or four was able to cuddle up to his mother's warm body was when she was sedated on valium and other drugs. The sleepy trance-like state that he may have entered at these times may be the explanation for his preference for inert sexual partners, rather than the passive bodies in the pornographic images.

## **Post-Traumatic Stress Disorder and Crime**

There appears to be a definite link between PTSD and dissociative states and crime. At one end of the scale, there is the man who loses his temper in an "outburst of anger" (to quote DSM IV again) and punches the walls,

frightening his wife and children. At the other end, there are those people who have a dissociative identity disorder and are completely unaware of their violent behaviour. In between, there is every shade and hue.

An article in the *Sunday Mail* (10 October 2004), describing the suffering of the wife of a paedophile, mentions a dissociative state. The husband told his wife that he always felt like a child pretending to be an adult and that while he was molesting children he felt that he too was a child. Because he felt this way, he reasoned that he was not really doing anything wrong.

It is very interesting to see how different offenders are when they are in prison. One prison officer was heard to say, "I can't understand why they are so violent out there and such sooks in here." Mostly, they are remorseful and confused, unable to explain why they did the things they did and yet certain that what they did was wrong. They are afraid of the consequences of their offending for themselves and others, and terrified of the bully boys in the prison. There are the ones who are even more dissociated, unable to admit to their offending behaviour and defending themselves by adopting the violent persona.

It was Sigmund Freud's disciple, Sandor Ferenczi (DesGroseillers, 2004), who suggested that the victim might identify with the aggressor, in order to feel safe. Perhaps this is the dissociative link between PTSD and crime. The erstwhile victim enters a trance state, whereby he is enabled to act out the abuse which was perpetrated on him. The violence that he witnesses at his own hands then deepens the trance and he cannot recall it clearly, if at all. As the trance state is triggered again, perhaps assisted by alcohol or other drugs, so he repeats his offending behaviour.

In 1991, the idea that offenders might be suffering from PTSD and other anxiety disorders was dismissed as the "abuse excuse." Research studies now suggest that offenders have in fact suffered significant trauma (Baker, 2004). There is a role here for hypnosis researchers to determine at what point the trance states commence and how they are activated in terms of offender rehabilitation programs. Perhaps also trauma therapy for first offenders may prevent further acts of crime for these victims. In addition, hypnosis may have a major role to play as an adjunct to this trauma therapy, once the research has identified the triggers in and out of the "criminal activity mode" trance states.

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## THE RIGHT WAY TO SCRATCH HOGS! REFLECTIONS OF AN APPRENTICE HYPNOTIST

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*Hypnosis education in Australia has been conducted by such organisations as the Australian Society of Hypnosis state branches. In the last decade, universities in three Australian states undertook to provide postgraduate courses for psychologists, doctors, and dentists. There is only a small literature devoted to hypnosis training, but such articles are generally written by those who provide the hypnosis education. An identified gap in the literature, which this article addresses, is the critical assessment of such programs by the students. One such program was conducted by the School of Psychology and Counselling at the Queensland University of Technology (Carseldine campus). Major strengths identified in this program included the use of group dynamics to facilitate the training process; the diversity of backgrounds and wide practical experience of the trainers; the emphasis on practical skills and reflective practice, combined with a thorough grounding in background theory; and, above all, the approach of the coordinator who both challenged group members and encouraged individual talents and proclivities in a manner decidedly Ericksonian.*

*This article is framed as an Ericksonian metaphor about personal experiences about teaching processes while learning about hypnosis practice and research, and is in no way intended to be an analysis of different courses in hypnosis in Australia.*

Once upon a time, in a fair and prosperous land, there lived a beautiful goatherd. Had she been in charge of sheep, she would have been called a shepherdess, with all its attendant romantic connotations. However, such was not her fate. Nor did it concern her greatly, because she was very fulfilled looking after her goats. Her job was to take the goats to the best pasture on the top of the mountain, from whence they looked out over the magical countryside as they thoughtfully digested the choice morsels on



offer and enjoyed the mixed scents of the alpine flowers. Each goat wore a little bell which gave off its unique note, marking its identity, and the little goatherd was familiar with each tone and its owner. And the goatherd cared for them all equally — the boisterous and the gentle; the serious and the whimsical. Part of her prowess lay in her appreciation of the likes and dislikes of each goat, and she allowed each one its own little foibles and preferences. Each had its preferred path to the top of the mountain, but she knew that they would all arrive and gather together at the summit as long as she was there to unite them. Every day she would spend time with each one of the goats, finding them special treats or telling them interesting and surprising stories to pass the time pleasantly. From such a motley and idiosyncratic group, she developed a fine herd, because she had nurtured each one from infancy to adulthood. She was proud of them — and knew this was the best herd of goats within the borders of that wondrous land! Their milk and cheese were famed from border to border for their unique flavour and their abundance, and were in great demand by the citizenry who craved only the finest.

The Graduate Diploma in Social Science (Clinical Hypnosis) was offered at the Queensland University of Technology between 1998 and 2004. It combined a first-year, part-time graduate certificate course, which focused on basic clinical hypnosis training, and a second-year research component involving coursework and a literature review. The completion of both streams earned the diploma and eligibility to apply for full membership of the Australian Society of Hypnosis (ASH). It was possible to complete the entire diploma in a year of full-time study.

The curriculum was fairly standard for a hypnosis training course at tertiary level, but the manner of presentation was novel, accessing community resources to ensure a wide exposure to different approaches and practices, rather than relying on university staff alone to provide input. Students were expected to attend local ASH (Qld) workshops which access better known (and more expensive) presenters. Coordination of the course was provided by an experienced clinician and member of the academic staff.

As a member of the second group to take advantage of this course, I would like to offer some reflections on that experience. It was one of the most enjoyable and growth-facilitating courses I have undertaken at any university, including other postgraduate work, and I would like to analyse what made it such an inspiring, unique, and extremely enjoyable experience.

## **Group Processes**

The group which undertook the first-year course was a small one, mostly of psychologists and one dentist. Our backgrounds were vastly different in terms of work milieus, and included:

- three private practitioners, two of whom carried a considerable pediatric case load and one of whom specialised in trauma work;
- one retired academic who engaged in voluntary work in the palliative care area;
- one who worked in the prison system;
- another who worked extensively with Vietnam veterans;
- one whose work was with intellectually handicapped persons; and
- two recent graduates, one a sports psychologist and the other a generalist counselling intern working in the tertiary education system.

Ages ranged from early twenties to early seventies. This wide range of interests and huge wealth of experience contributed enormously to the learning environment, as each technique and strategy learned could be teased out over a number of professional situations.

Being a small group led to remarkable bonding in a relatively short time, aided by the fact that a great amount of practice of newly learned hypnotic techniques was facilitated by working with each other. As well, weekends spent with members of ASH (Qld) who, although they were initially unknown to us, helped weld us even tighter, particularly as the first of these workshops was residential.

At every stage, group members were willing to support and encourage each other, and in every way possible expedited the learning of new skills. The group harmony and mutual supportiveness was amazing, considering the competitiveness that can flower in academic settings, and was an integral and meaningful part of the experience, which emphasised the development of practical clinical skills.

Because every range of hypnotisability was represented in our group, we learned from practice what it meant to be high, medium, or low susceptible. And we learned that every degree of hypnotisability is useful clinically, and what might or might not be achieved with each level.

## **Tuition**

Unlike other university courses, but akin to the teaching wealth of the ASH courses, the tuition was provided by clinicians (mostly ASH members, although wider than ASH) who were usually involved in successful private practice and research. While the standard of teaching, in terms of group facilitation and presentation, was not always of the highest professional standard, the input was almost routinely excellent. We were taught by a large variety of people, many of whom specialised in particular areas, and several of whom were well known in the hypnosis community. In the main, the sessions included experiential exercises which capitalised on the potential for learning in *seeing*, *hearing*, and *doing* the new techniques about which we were taught. No area of practice was omitted — traditional hypnosis, Ericksonian methods, neuro-linguistic programming, cognitive-behaviour therapy with hypnosis, medicine with hypnosis — all were grist to our mill. And, of course, we all had our preferences.

I was lucky enough to add the ASH Australian Congress to my academic year, my attendance being facilitated by the fact that our coordinator negotiated reduced fees for the students.

For me, this event marked the peak of the steep learning curve that had been 1999, and brought together a great deal of what we had been experiencing on our campus and in the hotels of Brisbane and the Gold Coast which were the venues for the ASH (Qld) workshops. It was exciting to finally see the faces behind the articles and books I had studied for my various assignments — Peter Sheehan, Fred Evans, and Kevin McConkey. However, just as exciting was discovering that I was very much *au fait* with the matter of their presentations, and that I could capitalise on my coursework to gain new ideas from people, such as Patrick McCarthy. My experience of the wider hypnotic community was that they were just as enthusiastic and supportive as the group at the university of which I was a part. Such support for and acceptance, as equals, of mere students provided a rare and delightful atmosphere in which to learn and one that was unusual in professional associations.

Attendance at ASH workshops also had great benefits for students, in that we were mixing informally with more experienced practitioners who were willing and happy to share their skills with us. Thus we learned from the presenters, as well as from other workshop participants, especially during practice exercises.

## **Supervision**

The supervision experience was also marked by exposure to practitioners who were well established in the field, whose areas of expertise were varied, and who were often unique characters in their own right. We were allowed to choose our fields of interest and joined in groups of from three to six. In this fashion, we were able to tap the knowledge not only of the supervisor, but also of our student colleagues. Some lucky clients, who were the subjects of our case studies, had the benefit of many brains, the combined experience of many years, and the high degree of enthusiasm of all involved. We understood that the ASH training courses also utilised group supervision sessions, but the QUT sessions were different in objectives, preparation, processes, learning reflections, and measurable outcomes.

## **Ethos of the Course**

The general ethos of the course was very much set by the coordinator. She had obviously absorbed the moral of Milton Erickson's tale about allowing the horse its head, so it will find its way home. She was, in fact, someone who knew how to scratch hogs right!

We were all respected for our expertise as practitioners, and as the course progressed we were encouraged in the areas in which we were showing particular talent. However, we were also challenged to learn the things to which we did not take quite so automatically. Throughout the year we were paced, and at no time were we allowed to slacken off, although the pressure was never experienced as overwhelming.

In a fashion which allowed for maximum learning, our experiences with various tutors were processed in an informal and relaxed manner. Likewise, the required reading proceeded, guided by tutorial questions which were submitted by weekly emails. These submissions were handled at the student's individual pace, and those whose daytime practice was particularly time-consuming did not complete them all. This facility was extremely useful for me, as it provided a structure within which to learn. It helped encourage thinking beyond the words on the page, to the implications for practice in each thing I read. It was also an excellent preparation for the examinations which marked each semester end. Weekly feedback, although brief, usually helped correct misconceptions and added dimensions which were not yet obvious to this neophyte hypnotist. Interestingly, those who completed the structured learning processes always fared better in the exams than those who chose not to do so.

## Milestones

To shape my review of the year, I wrote down the events that I experienced as major milestones on the journey to the top of the learning curve to get some idea of what was most significant in this incredibly stimulating experience. Broadly speaking, I would have to say that possibly the most frustrating, and yet the most beneficial, aspect was my enrolment for the complete diploma (that is, two years). All the other students were enrolled in only the certificate course (that is, the first year only). Because I was trying to come to terms with theoretical and research issues for which I was ill-prepared, I felt envious of those who only needed to understand the clinical side of hypnosis. My first assignment on the hypnotic susceptibility scales almost overwhelmed me, as I had encountered so few of the hypnotic phenomena of which they spoke.

In the second-year class (designed for advanced practitioners) of which I was part, I found that I was the only person not already using hypnosis in therapy. I had the rather rare and humbling experience of feeling like the dunce of the class. What a challenge!

While my first-year colleagues were enjoying the sheer joy of clinical experiences, I was trying to reach some conclusions about just what hypnosis involved. I felt overwhelmed by neo-dissociationism, social-cognitive theorising, phenomenological viewpoints, and all the other theoretical writings prescribed for study. I was pressuring myself to make some decision about what hypnosis really was — based on the often confusing literature I was reading. My intellectual presumption and naivety later became apparent when I realized that even such brilliant researchers as Ernest and Josephine Hilgard, Nick Spanos, Helen Crawford, David Spiegel, Irving Kirsch and others could not reach definitive answers! Given that I came to the field with an Ericksonian background in solution-focused brief therapy, where influential communication is basic, and trance is not formally induced, I found these other ideas very difficult to integrate initially.

However, looking back on that year, I believe that subjecting the phenomena of hypnosis to painful and intense intellectual scrutiny has made me a much more aware practitioner of the art. The old saw, that from experiences which are difficult there comes wisdom, has been borne out in my experience in the first year after graduation from the graduate diploma.

Other aspects of the experience which stand out in my mental review include the cyclical nature of *experience*, gained through either workshops or

reading, followed by *reflection* on the implications of the experience, both for practice and for an understanding of what constitutes hypnosis. I was very lucky to be the “victim” for many of the workshop presenters, and learned at first hand what effect the particular technique or strategy would have on clients. In particular, one lecturer asked me to be the subject for an experiential analysis technique, and this experience, coming early in the year, was an important step for me.

I believe the practice of self-hypnosis, of which I am an avid proponent, has also introduced some needed life enhancing changes with which I am extremely satisfied. In the effort to become good at metaphor, and to be an effective hypnotic communicator, I have honed my observational skills with consequent added enjoyment to my life.

Actually producing case studies was another giant step in my metamorphosis from therapist to hypnotherapist. There is no doubt that clients teach us more about our practice than does anybody else, and I owe a great debt of gratitude to the young clients who helped me so much by enjoying our imagination exercises so enthusiastically and benefiting from this work.

Experience, reflection, personal and professional relevance, and the struggle to identify the essence of hypnosis have all contributed to effective and enjoyable learning.

## **Conclusion**

Our coordinator informed us that feedback from our supervisors indicated that we were a particularly competent group. Her conclusion regarding this result was that Ericksonian hypnosis had been introduced early in the year, which had given everyone real encouragement. This may have facilitated our competence. Certainly she had the experience of far more training, both generally and in this area, and was therefore in a better position to judge. However, from the point of view of a student in the class, a trained teacher as well as a psychologist, it seems that several important learning principles were observed in this educational process and the results can also be attributed to this fact.

The group was small and highly motivated. The group dynamic which was encouraged and nurtured was of cooperative endeavour and genuine respect, which approaches were spelt out by the coordinator again and again in the first few weeks. An attitude of mutual intellectual pursuit and enthusiasm for hypnosis was fostered and modelled, not only by the coordinator, but also by the tutors.

Input to the group was given by experienced practitioners, who not only

encouraged practice and experimentation with the skills they were helping us learn, but who were able to produce a wealth of therapeutic experience from which we could benefit. As Milton Erickson (Rossi, 1980) demonstrated so often, stories are the best way to learn effectively. Experiential learning, at both the conscious and unconscious levels, was obviously occurring. And because most of the practitioners made it fun, learning was relatively painless.

This approach was continued in the supervision sessions, where we lived our own stories about best practice in working with our clients. Again we were tapping into stories of the supervisors' clients and the methods used to encourage change and growth.

The combination of experiential learning and the reflective process which was vital to the learning experience was intrinsic to the structure of the course, and was encouraged on the extrinsic level through post-session debriefing by the coordinator, Kathryn Gow.

For me, the inclusion of the ASH Congress (in New South Wales) was a heightened continuation of this process, where for one week, 24 hours per day, I lived hypnosis. This conference at once confirmed for me the incredible amount of learning we had all done in the previous seven months, and gave me role models for the individual style of hypnotherapy that I was developing, as well as for excellence in research which has been modelled by people such as Peter Sheehan and Kevin McConkey.

That year was marked by presentations given by fascinating and well-known Australian hypnotherapists including Doris Brett, James Auld, Malcolm Desland, and Annette Brandle, as well as many others too numerous to mention here. Not only was their hypnotic input inspiring, but the stories they shared of how hypnosis had helped them in their own lives with the pain and suffering to which we are all exposed as members of the human race left their mark on the Queensland University of technology class of '99.

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## REVIEWS

### **The Highly Hypnotizable Person: Theoretical, Experimental and Clinical Issues**

*M. Heap, R. J. Brown, and D. A. Oakley (Eds.)*

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It has been over a decade since the publication of landmark collections on research and theory in the field of hypnosis such as Lynn and Rhue's *Theories of Hypnosis* or Fromm and Nash's *Contemporary Perspectives in Hypnosis Research*. In that time, both hypnosis and the psychological sciences have undergone (and continue to undergo) tremendous change. Most of the dominating intellectual figures of those earlier works have passed away and hypnosis research as an active topic within mainstream psychology has entered a period of decline. The "decade of the brain" has come and gone and the growing integration of psychological research with emerging neuroscience technologies is producing nothing less than a revolution in our understanding of human mental processes. It is against this background that the arrival of this latest volume on current hypnosis research has been an eagerly awaited event.

The editors use the theme of the highly hypnotisable person to organise the contributions and approach the theme from multiple perspectives illustrating the diversity of approaches within the domain of hypnosis. Contributors write from experimental and theoretical perspectives on developmental, social, neurophysiological, cognitive, and clinical aspects of high hypnotic susceptibility. Both state and non-state approaches are explored, as are a diversity of views within these broad camps and the possibility of building a constructive dialogue between them.

Chapter 1 by the "fab 3" (Heap, Brown, and Oakley) presents an overview of key issues in the theoretical and experimental landscape. The authors provide a clear, simple description of hypnotic procedures, induction, suggestion and core aspects of hypnotic responses, and the measurement of hypnotic ability. The framework of the state/non-state debate is described, along with clear, but brief, summaries of most of the major positions adopted

within that debate. It is a feature of this chapter that the important differences between major positions *within* each of these broad camps are highlighted, as much as the distinction between state and non-state approaches.

Next, Barnier and McConkey explore the measurement of hypnotic susceptibility and, in particular, the identification of highly susceptible individuals. They provide a clear overview of the nature and use of the major hypnotisability assessment instruments. Most importantly, they also explain the differences in the rationales underlying each scale's construction and how each scale has been used in clinical and experimental research. Debates around the psychometric properties of susceptibility measures — their factor structure, stability, and modifiability — and the debate around the correlates of susceptibility are broadly canvassed. This chapter is an important resource for anyone wishing to explore the complex of issues surrounding the assessment of hypnotic ability and its uses.

Barnier and McConkey also cover phenomenological assessment methods, such as Pekala's Phenomenology of Consciousness Inventory and Sheehan and McConkey's Experiential Analysis Technique (EAT), but this important topic does not appear to be covered in the same depth as the more orthodox behaviourally oriented approaches. However, the next chapter, by McConkey and Barnier, on individual differences in responsiveness amongst highly hypnotisables, draws heavily on evidence derived from the application of the EAT. With data drawn from studies in their lab at the University of New South Wales, the experience of a range of hypnotically suggested phenomena such as sex change, blindness, and anaesthesia are examined to demonstrate the diversity of experiences, strategies, and underlying cognitive processes present in the responses of equally susceptible highly hypnotisable individuals. The challenge of this diversity for building a unified theory of hypnotic responding is taken up by the authors in the final section. They propose no grand synthesis, but instead alert clinicians and researchers alike to the complexity of the hypnotic experience and the oversimplification of existing theoretical accounts.

Graham Wagstaff (who coined the term "sociocognitive" in hypnosis research) recounts the development of the social psychological non-state position. Along the way, he carefully distinguishes this position from the more cognitively based versions of response expectancy theory recently advocated by Kirsch and Lynn. Drawing on the work of Spanos, as well as his own, he argues that compliance is an essential component in explaining some of the behaviour of very highly susceptible or virtuoso hypnotic subjects. In places,

however, he appears to be explaining away (for the sake of explaining away), in others, the conclusion of compliance is hard to escape. Those who would angrily discount this possibility would do well to calmly read the evidence and arguments he presents and to set to work to devise and carry out experiments which would convincingly demonstrate alternative explanations. Wagstaff concludes by presenting a much needed and profoundly reasonable critique of simplistic state based arguments from studies of neurophysiological changes occurring in hypnosis. Alternative explanations which do not invoke a hypnotic state are often equally plausible. Any adequate account of the neuroscience of the hypnotic state (if such exists) must be tested against a well-developed neuroscience of human social psychological responses. That is not to say that all such arguments must be simplistic. Future work on the neuroscience of hypnosis will be greatly enriched by rational engagement with the hard problems raised by this social psychologist's critique.

Judith Rhue's chapter on the developmental antecedents of high hypnotisability will be of particular interest to anyone working with children. Rhue focuses primarily on fantasy and play as forerunners of adult hypnotisability and critically reviews the available evidence for the role of genetic and social determinants (such as punishment and isolation or active encouragement) in the development of these abilities. She also begins the important task of integrating existing findings into broader social and cognitive models of personal development. The extension of these efforts is an important task for future researchers. Methods of assessing hypnotic responsiveness in children are separately reviewed. The section on adapting hypnosis-based procedures into treatment protocols for children using imagination scenarios is particularly useful. One potential criticism of this overall approach is that it seems to implicitly endorse Wilson and Barber's position that hypnosis and imagination can be treated as virtually synonyms (though Rhue's own work suggests a more modest association in adulthood). If that is the case, then the concept of hypnosis is redundant. If it is not the case, then great care will be needed to untangle the role of imagination from that of other processes in the development of hypnotic responsiveness.

In the next chapter, Horton and Crawford review a large number of neurophysiological results correlated with hypnotic susceptibility. Indeed their reference list is almost as long as the chapter itself. This constitutes a useful resource for anyone wishing to read backwards into some of the relevant literature. A useful inclusion is the recent work on genetic polymorphisms linked to aspects of dopamine function in relation to hypnotic susceptibility.

However, the evidence presented is heavily weighted towards EEG studies. While there is some consideration of imaging results, this rapidly expanding literature is relatively neglected. The most important shortcoming is that the literature included is reviewed only from the standpoint of supporting the authors' position that hypnosis engages enhanced attentional processing and consequently that highly hypnotisable individuals possess a more efficient "fronto-limbic" executive control system. Alternative interpretations are not considered. Nor are the data subjected to critical scrutiny (including considerations of methodological adequacy and contradictory findings). As Graham Turpin observes in his final comments (Chapter 10), this approach in no way effectively rebuts Wagstaff's critique.

It has been some years since the publication of a major new theory of hypnotic phenomena. Brown and Oakley do just that in the next chapter, and the outcome is electric. Working within the framework of recent advances within cognitive psychology, they pick up from the recent debate between dissociated control theory and response-set theory. That debate was cast within the framework of Norman and Shallice's model of cognitive control based on the interplay of a supervisory attention system with lower level contention scheduling processes. Brown and Oakley propose a further division of the SAS into primary and secondary attentional systems and work out the implications of this model for response to hypnotic suggestion. Along the way, they provide a synthesis of key insights from previous sociocognitive and state-based frameworks and an account of two distinct pathways to high hypnotisability which they link to Sheehan and McConkey's EAT evidence of concentrative versus constructive styles of responding amongst high susceptibles. This chapter is a theoretical tour de force which cannot be ignored by anyone concerned with a scientifically based understanding of hypnotic phenomena. One disappointment, however, is the almost exclusively cognitive focus of the theory. This is all the more surprising, given the role of Oakley in recent ground-breaking neuroimaging studies of hypnosis and volition.

A feature of this book is that many contributions span the interests of researchers, clinicians, and students of hypnosis. This is clearly evident in the next two chapters. Lynn, Meyer, and Shindler provide a useful analysis of T. X. Barber's recent tripartite model of high hypnotisability (the positivity set, fantasy-prone, and amnesia-prone high) from the point of view of what an understanding of these differing features, amongst responsive subjects, may contribute to effective clinical interventions and to avoiding potential pitfalls associated in working with each. They then review a range of evidence for the

relevance of hypnotic susceptibility to psychopathology and to treatment outcomes with a wide range of disorders. However, I felt that this latter part of the chapter was too broad and would have preferred to see these issues explored in greater depth with a narrower range of disorders. Further guidelines for the research-oriented clinician or the clinical researcher would be welcome here.

Gorassini provides a thought-provoking evaluation and comparison of the efficacy of a range of procedures held to enhance responsiveness to hypnotic suggestions. These include standard (relaxation) and non-standard (arousing) induction procedures, Barber's task-motivation instructions, and the Carleton Skills Training Program (CSTP) developed by Gorassini and Spanos. The CSTP is empirically evaluated against a range of key objections. It is proposed as the most effective current method of enhancing hypnotic responsiveness. Core elements of the package's effectiveness are specifically identified. This chapter is particularly relevant to clinicians wishing to maximise hypnotic responsiveness to extend the applicability of hypnosis-like interventions to a broader range of clients than might otherwise be available.

Finally Graham Turpin, an independent clinician and psychophysicologist working outside the area of hypnosis, provides a critical overview of the contributions of each of the previous chapters.

Any edited collection of hypnosis research will have important gaps in its coverage of topics, and this book is no exception. There are too many findings, researchers, and ideas for it to be fully comprehensive and we will each have our particular disappointments about what was left out, or not sufficiently developed. One (negative) feature that stands out is the narrowly Anglophone club from which the contributors are drawn (English, American, and Australian). Undoubtedly, this was unintended, but perhaps it offers some insight into the restricted circle of conversation on which hypnosis research has been based.

Despite these criticisms, this book is a splendid contribution to the continued development of research, teaching, and practice within the field of hypnosis. If we are to move beyond the current malaise of hypnosis within the academy, it is imperative that the hypnosis community unites to support efforts such as the current book. If you are reading this review, then you should buy, read, and make use of this book.

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***Sybil*. 1976. Directed by Daniel Petrie**  
***Voices Within*. 1990. Directed by Lamont Johnson**  
***Identity*. 2003. Directed by James Mangold**

In this review I compare the director's portrayal of dissociative identity disorder (DID) in the movie *Identity* with the portrayals found in *Sybil* and in *Voices Within* and with the existing theory base on dissociation, specifically the development of DID, triggering of alters, and treatment issues. The movies selected represent a time span of 27 years, during which time our understanding of DID is portrayed in movies as stagnant. The phenomenon of dissociation has attracted criticism from researchers and false memory proponents alike and remains poorly understood, with a majority of the general population relating dissociation only to the formation of generally "evil" multiple identities, as reported in, and sensationalised by, the media.

The movies portray the basic theory correctly (i.e., extreme trauma experienced by a child leads to the creation of alternative personalities, with integration being the optimum treatment goal). However, Malcolm Rivers (played by Pruitt Taylor Vince), a key character in *Identity*, is portrayed as a figure not unlike Frankenstein's monster — a freak, a curiosity, pure evil. His character is drawn to enhance the psychological twist ending, and not to create a genuine understanding of the phenomenon in the hearts and minds of the audience. DID was used as a vehicle to enable the director to realise his genre. This is a retrograde step when compared to the compassion, empathy, and understanding created by *Sybil* and *Voices Within*.

### **The Establishment of DID**

In all three movies, a direct link is established between extreme childhood trauma and the establishment of DID, with a primary focus on the creation of alters to bear the unbearable on behalf of the child (Cardena, 1994). Dissociative theorists have long proposed that dissociation served to distance the child from overwhelming events that the child had no schema for understanding, particularly when faced with issues of betrayal and trust, as is indicated by a history of severe child abuse (Cameron, 2000; Figley, 1986; Loewenstein, 1996; Owens & Chard, 2001; Terr, 1994). Severe child abuse has been defined as abuse that is frequent, lengthy, associated with violence and/or death threats, and perpetrated by a person close to the child. The abuse portrayed in *Sybil* and *Voices Within* is graphically characterised as severe abuse which included physical, sexual, and psychological aspects. Indeed, the abuse *Sybil* (*Sybil*) and

Truddi (*Voices Within*) experienced is characterised as an orchestrated campaign of terror, with DID saving these children from losing their minds. In *Identity*, Malcolm's childhood is characterised by neglect and abandonment by his mother. In this movie, the link between extreme abuse and dissociation was not as well established. The director employed two different storylines to fulfill his genre. While this is effective in establishing the appropriate psychological thriller atmosphere, the device also serves to weaken the link between abuse and DID in order to preserve the integrity of the twist ending. In essence, the story of Malcolm seems to have nothing to do with the story of the strangers stranded at a motel.

The purpose of the movies differs, with *Sybil* and *Voices Within* depicting the experiences of two abuse survivors and their DID in a biographical manner, whereas *Identity* uses DID in a fictitious manner, to form the core of a psychological thriller, possibly sacrificing some theoretical accuracy for the sake of adrenaline impact.

### **Triggering of Alters**

The triggering of the alter states is well handled in *Sybil* and *Voices Within*, with the actors Sally Field and Shelley Long using body language, make-up, clothing, smoking, and vocal intonation to mark the transition from one alter state to another. Both movies portray the fugue state that precedes the transition process. In *Sybil*, this is accomplished with a visual device that places the viewer in a first-person perspective, where vision and sound are initially hazy, becoming clearer with time. In *Voices Within*, the fugue state is portrayed by the actor, who stares blankly into space for a period of time. The trigger events for both movies include sounds, smells, and experiences that resembled the original trauma. These are portrayed both in flashback form, such as Truddi hearing a dog bark and re-living a time when her stepfather chained her like a dog, and through experiencing heightened emotions, such as when Sybil spends her first night with her boyfriend.

The alters are given specific names and roles, such as Black Katherine (*Voices Within*) who holds the rage for the other alters, and Marsha (*Sybil*) who embodies the suicidal impulses for the other alters. This portrayal aligns with Van der Kolk's (1996) findings that dissociated memories were stored as sensory fragments.

In *Identity*, the audience is not made aware that the strangers stranded at the motel are actually alters until the final fifteen minutes of the movie, in keeping

with the thriller genre. The two storylines are reconciled to show that Malcolm, the abandoned and neglected child, murdered six people on 10 May 1958. This date represents the link between the strangers, being their common birthdate, and also the date on which Malcolm developed DID. The stranger storyline represents the cognitive processes of Malcolm, who was being transported to a court hearing in another state the night before his execution was scheduled to take place.

*Identity* cleverly establishes the alters as independent and seemingly real people caught in a random situation where they are being murdered by an unknown party, one by one. All have their individual history and story and, except for the two married couples, no knowledge of each other; whereas some but not all of the alters in the other two movies have knowledge of each other. However, the fugue state is not depicted in *Identity*, and the alters interact in the same time and place.

All three movies use mirrors to indicate that the key characters actually saw themselves as the alter, although their appearance remained relatively stable to the audience, with the exception of the mirror reflections. Coons (1996) noted that DID includes perceptual disturbances for the individual in the form of not recognising one's true self in the mirror and feeling as if body parts are detached, absent, unreal, foreign, or changed in size. *Identity* uses the mirror as a means of confronting Malcolm with his DID, by showing an alter (Edward, played by John Cusack) that how he saw himself physically was not how he appeared to other people. This confrontation led to Edward returning to the "motel" and attempting to locate and kill the darkest alter — the one who murdered the six people years ago and who has recently murdered the other alters. This would achieve a stay of execution for Malcolm and commitment to a psychiatric facility for further treatment.

### **Treatment Issues**

Putnam (1989) suggested that although dissociation lessened the pain and anxiety associated with trauma, the individual thereby sacrificed fully integrated functioning. The goal of treatment was to facilitate integration of the alters into one coherent personality. This goal is explicitly described in all three movies, with *Sybil* achieving re-integration and intrapsychic unity through the use of guided imagery, hypnosis, and regression therapy. Integration was achieved after she confronted her most traumatic memory. While integration was the therapeutic goal for Truddi, another goal was formulated



and adopted by her — that of cooperation of the alters, rather than their destruction, which represented death to Truddi. Therapy included hypnosis and regression therapy. In both cases, physical evidence of the abuse was presented as corroboration that it occurred. In both movies, the abuse survivor was able to enjoy a productive and happy life after many years of pain.

The therapeutic goal of treatment for Malcolm Rivers is also integration. However, the methods used to achieve that are quite brutal. Malcolm is confronted with the mirror while in an altered state. The psychiatrist explains that treatment involves forcing the alter personalities to confront each other, with the aim of destroying the darkest one. The personalities that are destroyed in the process are portrayed as collateral damage. The therapy fails, with the process leaving the darkest personality — the only child — intact and in control. He kills the other personalities without mercy, including his mother and father figures. As he kills the final alter, Malcolm kills again (this time his therapist and a transport guard), leaving him free to escape with an integrated personality — that of a murderous child. The therapy is portrayed as cold, clinical, and calculating, whereas the therapy outlined in *Sybil* and *Voices Within* is portrayed as warm, caring and sensitive.

Dissociative identity disorder is clearly and carefully depicted in *Sybil* and *Voices Within*. Members of the general population would have been left with an enhanced understanding of the disorder, the effect it has on the survivors and their families, and the therapeutic goals and treatment methods available. In contrast, *Identity* portrays the more sensational aspects of DID in a fictitious setting, designed to add to the atmosphere required for an effective psychological thriller, rather than to enhance the public's understanding. The subtle nuances of the disorder, such as entry into a fugue state and the types of events which trigger the change from one alter to another, were discarded, leaving the audience with a half-truth — a dissociated view of dissociation.

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