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Editorial

This edition of the journal contains four themed articles on attitudes and opinions about hypnosis. The articles featured on this theme cover populations in Spain, Hong Kong and Australia. Over the decades, the research in this area has continued to demonstrate that people throughout the world, who have not had the opportunity to learn about hypnosis through education and training programs, or who have not been exposed to it through various treatment modalities by qualified and skilled professionals, continue to hold views about hypnosis which are erroneous in some critical ways, one of them being the idea of mind control and the other that memory retrieval is always accurate and true and that one can engage in exotic regressions with confidence.

Professional hypnosis societies may need to promote more about the positive contributions of hypnosis in practice areas, and mend bridges that have been severely damaged by the bad press on "false memory therapies," and by movies and television shows that emphasise that hypnosis leads to mind control and others that promote beliefs about exotic experiences, such as past life regression and recall of events under hypnosis that one could not possibly have encoded at the time of the occurrence of the event/s.

The film review in this edition deals with media portrayals of the forensic uses of hypnosis. For film enthusiasts, there is a website for attitudes to hypnosis in films called "Hypnosis in Our Culture: Movies, Myths, Misperceptions and…" conducted by the Banyan Hypnosis Center. The web address is (accessed 17 March 2006.): http://www.hypnosiscenter.com/hypnosis-media-popular-beliefs-misconceptions.htm.

There are two major articles from England and Hong Kong; one is a literature review covering applications of hypnosis in anxiety and sleep disorders and the other is an in-depth case study of the use of hypnosis in a trauma client. The hypnosis scripts are home grown and are written for treatment of trichotillomania, self-mastery, adjusting to a new life and increasing creativity. The book review is about specialist skills in therapy.

By the time this edition is published, the ASH conference will have taken place and we hope to publish some of the papers in the following editions of AJCEH, as conferences encourage creative research and practice dissemination.

Kathryn M. Gow
November 2006

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Change of Attitudes Toward Hypnosis: Effects of Cognitive-Behavioural and Trance Explanations in a Setting of Hetero-Hypnosis

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This paper deals with the effects on attitudes toward hypnosis when it is introduced in three different ways to people who explicitly indicated that they did not want to be hypnotised. One hundred and ten participants (university students) were assigned to three experimental conditions, namely: minimum information control group, trance group, and cognitive-behavioural group. After hypnosis was introduced, those participants who agreed to continue were hypnotised and their suggestibility levels were assessed. The results revealed that trance explanation produces an attitudinal change, since a very high

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percentage of participants dropped out of the study. Cognitive-behavioural explanation decreased the misconceptions that hypnosis makes people lose control over themselves and remains in the hands of the hypnotist. Thus, this explanation reduces the gullibility, the participant's fear of being hypnotised, and changes the initial opposition to allow someone to hypnotise him/her. The trance explanation only proves to be superior by increasing the participants' interest in hypnosis. No differences between the three groups were found with respect to hypnotic suggestibility.

Despite the fact that studies about attitudes and beliefs about hypnosis are recent (Green, 2003), some of them have shown that attitudes have an influence on hypnotic suggestibility (Barber & Calverley, 1964; Sheehan & Perry, 1977; Spanos & Barber, 1974), and that they affect the results of those interventions that use hypnotic techniques as an adjunct to treatment (Barber, Spanos, & Chaves, 1974). Some authors even argue that having positive attitudes and expectancies toward hypnosis at the start of the sessions predicts the therapeutic change better than suggestibility does (Schoenberger, Kirsch, Gearan, Montgomery, & Pastyrnak, 1997).

However, currently there is no agreement about the extent of the influence that attitudes have on hypnotic suggestibility. Views differ depending on the theoretical approach of the research (De Groh, 1989). According to the cognitive-behavioural approaches, the role of attitudes and expectancies is very important, since they account for a greater proportion of the variance than other variables (Kirsch & Council, 1992; Kirsch, Silva, Comey, & Reed, 1995; Wickless & Kirsch, 1989). On the other hand, state approaches consider socio-psychological variables to be of secondary importance (Bowers, 1976; Kilhstrom, 1985; Perry, 1977). The authors advocating the latter approach think that attitudes are not stable enough to explain the stability of hypnotic suggestibility (Hilgard, 1965; Perry, 1977; Shor, Orne, & O'Connell, 1966). Nevertheless, there is a consensus between both perspectives that having positive attitudes and beliefs toward hypnosis is a necessary condition, but not sufficient to achieve high levels of hypnotic suggestibility (Perry, Nadon, & Button, 1992; Spanos, 1982; Spanos, Robertson, Menary & Brett, 1986). Finally, cognitive-behavioural perspectives advocate that there is a non-linear relationship among attitudes and beliefs and hypnotic suggestibility, giving attitudes a moderating role, since they only increase the levels of suggestibility along with other conditions (Spanos et al., 1986).

From our point of view, the first step in creating positive attitudes and appropriate expectancies is the establishment of rapport. This implies generating a relationship of trust between the therapist (researcher) and the client (participant). The way hypnosis is introduced has an influence on the rapport (Capafons, 2001, 2004), and it is intended to make the participant experience relaxation and well-being (Sheehan, 2001), as well as acceptance of hypnosis and greater adherence to the treatment. In fact, the way hypnosis is explained and introduced may have decisive importance in changing misconceptions and negative attitudes (Capafons, Cabañas, Espejo, & Cardeña, 2004) and in fostering good rapport.

From a cognitive-behavioural approach, several authors (Capafons, 2001, 2002; Kirsch, 1994, 1999) have emphasised the problems with introducing hypnosis to the client as a trance. It may make therapists reluctant to use it and may also produce resistance in some clients due to fear. It even might inhibit those people who are not afraid of being hypnotised and would like to cooperate. At the same time, it can reduce the experience of feeling hypnotised, since it facilitates the creation of inaccurate criteria to assess whether they are hypnotised or not. Given that there is no empirical support confirming the hypothesis that an altered state of consciousness defines hypnosis (Kirsch, Mobayed, Council, & Kenny, 1992), the existence of the trance should be considered as another myth to be clarified.

In a previous study, similar to this one but carried out with self-hypnosis (Capafons et al., 2005), it was found that all groups changed positively and that the trance concept did not jeopardise the change of attitudes. The fact that there were no differences could be explained by the use of self-hypnosis, which gives the person a greater perception of control.

On the other hand, Lynn, Vanderhoff, Shindler, and Stafford (2002) found that introducing hypnosis as an altered state of consciousness produces lower scores in an objective scale of hypnotic suggestibility than introducing it in terms of cooperation. The authors concluded that emphasising cooperation, instead of trance, in the introduction increases the sensitivity to test suggestions.

The main goal of this study is to explore the effect of introducing hypnosis, in three different ways in a setting of hetero-hypnosis, on attitudes toward hypnosis. This effect has been studied with those subjects who made it explicit that they did not to want to be hypnotised and would not let somebody hypnotise them.

Even though Capafons et al. (2005) did not find these differences by using self-hypnosis, we assume that defining hypnosis as a trance state and dissociation may generate rejection and problems as stated by Kirsch (1994) and Capafons (2002). Therefore, our predictions are as follows: (a) The cognitive-behavioural explanation will produce a greater positive change in attitudes toward hypnosis compared to trance explanation (which will make that change difficult) and minimum information control explanation; (b) There will be more responses to test suggestions (especially the subjective responses) when the cognitive-behavioural explanation is given than when the participants receive a trance explanation; even though this difference might not be large, since there seems to be no linear relationship between the attitudes and the responses to the test hypnotic suggestions (Spanos, Brett, Menary, & Cross, 1987).

To sum up, we assume that in a setting of hetero-hypnosis, the trance explanation produces greater rejection and resistance to the hypnotic suggestions, as well as less change in negative attitudes toward hypnosis and less acceptance of the hetero-hypnosis technique. Furthermore, the participants may give fewer responses to the hypnotic suggestions when the criteria they create to assess, whether they have been hypnotised or not, are not realistic (Kirsch, 1994). In a recent study, Lynn, Green, Jaquith, and Gasior (2003) confirmed this idea. These authors concluded that the criteria adopted by the participants to assess their performance under hypnosis have an influence on the responses they give to the hypnotic suggestions, in such a way that the more strict those criteria are, the greater the difficulties the participants will have in responding to hypnosis, both in objective and subjective terms.

METHOD

Participants

The sample consisted of 110 undergraduate students of Psychology and Psychopedagogy (25 men [22.7%] and 85 women [77.3 %]). They did not receive any economic or academic reward for their participation. Participants were assigned to the three groups: control group or minimum information (CG) (N = 30; 7 [23.3 %] men; 23 [76.7 %] women), trance group (TG) (N = 30; 10 [33.3 %] men; 20 [66.7 %] women), and cognitive-behavioural group (CBG) (N = 30; 7 [23.3%] men; 23 [76.3 %] women). Age ranges were 18–47 years for the CG (M = 20.77; DT = 6.5), 18–40 years for the TG (M = 21.03; DT = 4.77), and 18–22 years for the CBG (X = 19.3; DT = 1.26). One individual dropped out in the CG (3.2%), four in the CBG (11.76%),

and 15 in the TG (33.3%). We decided to consider another group comprised of those people who had dropped out the study since there was a high level of attrition ($N = 20$; 1 man [5%] and 19 women [95 %]). This group consisted of 5% of the CG (1 participant), 20% of the CBG (4 participants) and 75% of the GT (15 participants). Age range for this group was 17-24 years ($M = 19.45$, DT = 2.09).

Measures

The Valencia Beliefs and Attitudes Toward Hypnosis Scale-Client (VBAHS-C; Capafons et al., 2004). This scale consists of 34 items assessing beliefs and attitudes toward hypnosis. The items are rated on a 5-point scale from 1 (do not agree) to 5 (totally agree). This scale is the result of a confirmatory factor analysis of an old version of the "Beliefs and Attitudes Toward Hypnosis-Client" (BAH-C; Capafons, Alarcón, Cabañas, & Espejo, 2003). The items are distributed in eight factors: Control (14, 15, 21, 24, 25), Help (1, 10, 12, 23), Automaton (7, 11, 18, 19, 22), Magical Solution (3, 5, 6, 9), Collaboration (2, 8, 13), Interest (26, 27, 28), Memory (30, 31, 32), and Marginal (33, 34, 35). The test-retest correlations were close to .60, except for the factor "Collaboration" ($r_{xy} = .39$) (Capafons et al., 2003). Items 4 ("Hypnosis scares me") and 17 ("Hypnosis encourages self-control") were retained, despite their high loading on more than one factor because they fulfilled theoretical criteria.

Barber Suggestibility Scale (BSS) (Barber, 1965; Barber & Wilson, 1979). The BSS can be applied with, and without, a hypnotic induction. It consists of two scales, one objective and another subjective, each containing eight items which are the responses to different kinds of suggestions. The experimenter completes the objective scale that has a score ranging from 0 to 8. The participant completes the subjective scale, rating the score from 0 to 24. The test-retest correlation is over .80 for both scales. Split-half reliability is between .70 and .84 for objective scores and .84 to .88 for subjective ones. We used the BSS for the following reasons: It does not take long to be completed; it includes both objective and subjective scales; it can be used with or without a hypnotic induction; and it correlates with the SHCS: A, showing good validity and reliability (Council, 1999).

Procedure

The VBAHS-C was administered to the students of an Introductory Psychology and Psychopedagogy course in Spain. Subjects responding 1 or 2

(disagree or slightly disagree) to item 26 ("I would like to be hypnotised") and 3, 4 or 5 (moderately agree; quite agree; completely agree, respectively) to the item 27 ("I would not let myself be hypnotised if somebody tried to do it") were selected to participate in the study.

Assignation to groups could not be done randomly, due to the lack of availability of experimenters and research rooms. That lack of availability was due to the difficulty of getting participants, as they were absolutely reluctant to be hypnotised. In fact the completion of the sample took two years. The timing of the completion of the groups was: first, CG; second, CBG; and finally, TG.

Three experimenters, two women and a man, blind to the starting hypothesis, contacted the candidates by phone to set up an appointment to participate. A total of 53.4% of the selected people agreed to participate in the research. Each experimenter set up a meeting with the participants and gave them scientific information about the techniques they were about to receive. Then, if the participant agreed, hetero-hypnosis, along with test suggestions, were administered.

In each condition, one of the researchers gave a different presentation of hypnosis. Thus, CG participants received information as follows: Hypnosis is not dangerous, it is similar to other everyday life experiences, it may be useful for different problems, and the person's willingness and cooperation are necessary in order to be hypnotised. The CBG received the same information, but the cognitive-behavioural presentation of hypnosis was added (Capafons, 2001, 2004), as in the Capafons et al. (2005) study, where the complete script verbatim can be found. In Capafons' (2004) own words:

> In implementing this introduction, it is important to transmit several ideas to the clients: a) the responses to the suggestions are actions committed by the clients and therefore they are not dependent on any power that the therapist might have — therapists only help the clients to experience the suggested responses; b) such actions are automatic but voluntary, given that clients are the ones who do or do not initiate them; c) what happens during hypnosis depends mainly on the clients' utilization of certain resources (the resources which are activated are similar to the many other actions in everyday life); d) hypnosis implies reactions in everyday life which can be activated or deactivated at will at any given moment; e) from this point of view, hypnosis is seen as a form of self-control, even if less conscious effort is required on behalf of clients to regulate certain behaviors; and f) to be hypnotized does not imply entering into a trance or altered state of consciousness, but rather involves preparing the mind for setting off the resources which, in everyday life, also lead us to activate responses that we perceive as automatic. (p. 188)

Finally, everything was the same for the TG, but hypnosis was defined as an altered state of consciousness or trance produced by the cognitive dissociation that hypnotic induction causes. The exercise using the pendulum and the metaphor of movies included in the cognitive-behavioural presentation was adapted to trance explanations.

The following procedure was the same for the three groups. Once the participants came to the appointment and signed the informed consent form they received information about hypnosis in accordance with the experimental condition everyone had been assigned. Some participants decided to drop out of the experiment at this point. Both type of participants, those who continued the research, and those who left, were given a sealed envelope containing the VBAHS-C. However, the experimenters did not know the content of the envelopes. They did not answer any questions about the scale, and they left the room while the subjects completed it. When they had finished, they put the scale into the envelope and the experimenter came back into the room to seal the envelopes and write down the reasons the subjects decided to drop out of the study. Thus, there were two scores of the objective scale of the VBAHS-C for every participant, including those who decided not to continue. The first score had been taken in the classroom and the second one was taken after receiving one of the presentations (control or minimum information, trance or cognitive-behavioural). After this, the method of induction was applied to the participants who agreed to continue.

The hetero-hypnosis procedure was carried out using relaxation. Thus, before starting the procedure the participants were warned about the possible reactions they could experience due to the relaxations experience (i.e., tingling in the arms, strong heaviness, etc.). Doing so reduced the probability of subjects misinterpreting their reactions, or some participants dropping out. When the participants indicated that they felt hypnotised, the BSS was applied to assess their hypnotic suggestibility. This was the only part of the study recorded in video. The tape was assessed both by the experimenter and by an independent observer.

When a suggestion had discrepant ratings, the experimenter and the independent observer watched the tape together to decide if the discrepancies in the score were maintained. However, there was no case in which discrepancies had to be maintained.

Analyses

Dropouts

In order to find out if dropouts depended on the experimental condition to which the participant was assigned, proportion contrasts were carried out among the proportions of people leaving the study in each of the three experimental groups. Bonferroni adjustment ($\alpha = 0.05/3 = 0.017$) was applied in order to avoid Type I error accumulation. Moreover, a qualitative analysis of the participants' reasons to give up the study was undertaken.

Attitudes Toward Hypnosis

The dependent variables considered were the items 4, 17, 26, and 27, and the score in every factor of EVCAH-C. Therefore, there was a total of 12 variables and Bonferroni adjustment was applied ($\alpha = 0.05/12 = 0.0042$).

Differences Between Dropouts and Participants who Continued The following analyses were carried out:

1. *T*-test to determine whether there were differences in the pre-test between the participants who left the study and those who continued.
2. Analysis of covariance (ANCOVA) for each of 12 dependent variables in order to demonstrate whether there were differences in the post-test between the participants dropping out of the study and those continuing, excluding the possible influence of the previous levels of the dependent variables in the pre-test.
3. Twelve analyses of variance (ANOVA), one for every dependent variable, considering two independent variables in each analysis: *abandonment* and *moment* were carried out. The *abandonment* variable is an inter-subjects variable. This variable has two levels: participants who left the research, and the participants who remained. The *moment* variable is between subjects, and also has two levels: before and after the different explanations belonging to each experimental condition. The goal of these ANOVAs was to study the interaction between both independent variables.

Differences Among Experimental Groups The following analyses were carried out:

1. Analysis of covariance (ANCOVA) for each of the 12 dependent variables, in order to verify whether there were significant differences among the

three experimental groups (CG, CBG, and TG) in the post-test, removing the influence that previous levels of the dependent variables may have had in the pre-test.

2. Twelve ANOVAs, one for each dependent variable, were conducted, considering two independent variables in each analysis: *group* and *moment*. The *group* variable refers to each experimental condition (CG, CBG, and TG), and the *moment* variable indicated again when the measures of the dependent variables were taken (before and after each experimental intervention).

Response to Hypnotic Suggestions

To verify whether there were differences between the experimental groups (CG, CBG, and TG) in the subjective and objective subscales of scores (Barber, 1965; Barber & Wilson, 1979), two ANOVAs were carried out, one for each dependent variable. Bonferroni adjustment ($\alpha = 0.05/2 = 0.025$) was applied, since two analyses were addressed.

RESULTS*

Dropouts

As reported previously, the dropout rate in the three experimental groups was: 3.2% in the CG group, 11.76% in the CBG group, and 33.3% in the TG group.

The rate contrasts, conducted to test whether the dropouts of the study depend on the group they were assigned to, showed that differences between CBG and TG ($Z = -2.22$, $p < 0.016$), and between CG and TG ($Z = -3.15$, $p < 0.016$) were statistically significant. For both cases, there were more participants dropping out in the TG group. However, differences between CG and CBG were not statistically significant ($Z = -0.41$, $p > 0.016$). In terms of participants' reasons for dropping out of the study, the participants who left the CG said they were very afraid of being hypnotised because of the way in which this technique was represented in books and movies. In the CBG, three participants stated that they were scared, also one of them reported having respect for and reservations about hypnosis, these being the main reasons for their not continuing. In this group, there was a participant

*Tests of differences and graphics for significant interactions are not included. Interested readers can obtain them from the first author.

with very negative attitudes and indifference about being hypnotised. Finally, in the TG, the reasons were the following: "I do not find the experimenter's presentation convincing" (three participants); "I think that hypnosis is something mysterious" (two participants); "my mother would not like my being hypnotised", "I do not know anybody who has been hypnotised and it is something new for me", "I am afraid of losing control", "I am afraid of the effects it may have", "I consider hypnosis to be a non natural and unnecessary manipulation", "hypnosis gives me the creeps," and "I am not very fond of hypnosis" (each given by one participant). Three participants did not give any reason for dropping out of the study.

Attitudes

Differences Between Dropouts and Participants who Continued Results obtained from *t*-tests showed differences for the "Magical Solution" factor only ($t = 2.15$, $p < 0.0042$); that is, participants who finished the study had a higher score in this factor in the pre-test ($M = 1.41$) than the participants who dropped out ($M = 1.18$). However, the effect size was not significant ($\eta^2 = .041$).

Results of the ANCOVAs revealed significant differences between the group of participants who dropped out of the study and the group of those who continued. The differences were in the factor "Interest" ($F_{(1,107)} = 42.827$, MSE = .550, $p < 0.0042$; $\eta^2 = .864$), and in the item 26 "I would like to be hypnotised" ($F_{(1,107)} = 1.675$, MSE = .666, $p < 0.0042$; $\eta^2 = .666$), and the score was lower in both cases for the group of dropouts. Also, there were differences in the items 4 "Hypnosis scares me" ($F_{(1,107)} = .216$, MSE = 1.578, $p < 0.0042$; $\eta^2 = .726$), and 27 "I would not let myself be hypnotised if someone tried to do it" ($F_{(1,107)} = 1.473$, MSE = .550, $p < 0.0042$; $\eta^2 = .864$), being higher for the group who left. The corrected averages of these two groups (dropouts and people who continued) for each of the 12 dependent variables under study are shown in Table 1.

Results of ANOVAs indicated that the interaction between the *abandonment* variable and the *moment* variable was statistically significant for the item 26 "I would like to be hypnotised" ($F_{(1,108)} = 21.970$, MSE = 0.789, $p < 0.001$; $\eta^2 = 0.280$); and for the factor "Interest" ($F_{(1,108)} = 15.649$, MSE = 0.424, $p = 0.000$; $\eta^2 = 0.127$).

Table 1: Table of Corrected Means From ANCOVAs

	Dropouts	Participants who continued	CBG	CG	TG
Item 4	3.329	2.194	2.377	2.044	2.145
Item 17	2.784	2.959	2.658	3.252	3.024
Item 26	1.283	2.959	2.509	3.022	3.369
Item 27	3.023	4.050	3.889	4.263	4.014
Control	3.197	3.325	2.758	3.702	3.520
Automaton	1.826	1.730	1.940	1.382	1.885
Help	3.118	3.421	3.425	3.451	3.499
Magic	1.310	1.462	1.288	1.466	1.679
Collaboration	4.478	4.272	4.152	4.471	4.243
Interest	1.829	2.994	2.711	3.095	3.194
Memory	2.685	2.437	2.525	2.369	2.495
Marginal	2.537	2.162	1.945	1.903	2.630

Differences Among the Experimental Groups ANCOVAs, carried out for the group variable, show significant differences for the following factors: "Control" ($F_{(2,87)} = 10.359$, MSE = .718, $p < 0.0042$; $\eta^2 = .194$), "Automaton" ($F_{(2,87)} = 6.92$, MSE = .392, $p < 0.0042$; $\eta^2 = .139$), and "Marginal" ($F_{(2,87)} = 12.78$, MSE = .386, $p < 0.0042$; $\eta^2 = .229$). In order to determine in which groups there were differences, the Bryan and Paulson test (1976) was applied. The results are shown in the Table 2.

Table 2: Results Obtained After the Application of Bryan-Paulson test on Corrected Means of ANCOVAs

Differences between means for every factor				
Groups		Personal control	Marginal	Automaton
CG	CBG	- 0.994**	0.042	0.558**
	TG	- 0.762**	-0.685**	0.055
CBG	TG	0.182	-0.727**	- 0.503*

* $p < 0.05$, ** $p < 0.01$.

The results of ANOVAs indicated that the interaction was statistically significant for item 26 ($F_{(2,87)} = 5.467$, MSE = .830, $p < 0.0042$; $\eta^2 = .112$), and for the following factors: "Automaton" ($F_{(2,87)} = 10.486$, MSE = .277, $p < 0.0042$; $\eta^2 = .194$), "Control" ($F_{(2,87)} = 7.903$, MSE = .404, $p < 0.0042$; $\eta^2 = .154$), and "Marginal" ($F(2,87) = 10.844$, MSE = .309, $p < 0.0042$; $\eta 2 = .200$).

Hypnotic Suggestibility

ANOVAs carried out for each of two subscales of the BSS did not show statistically significant differences among the groups.

DISCUSSION AND CONCLUSION

Firstly, as participants were not assigned randomly, our conclusions should be treated with caution. Nevertheless this assignment does not invalidate our result, as all participants were pre-selected, taking into account their very negative attitudes towards hypnosis. Moreover, the various groups did not show differences in the dependent variables in the pre-test. However, further research should be conducted to overcome this weakness in our research. The prediction that cognitive-behavioural presentation would be more effective than trance presentation and produce fewer dropouts was confirmed. However, it did not improve the results of the minimum presentation or control, in which there were no explanations about how the hypnotic responses work.

Therefore, it has been demonstrated that introducing hypnosis as an altered state of consciousness in a hetero-hypnosis setting produces more rejection and less reduction of the fear of being hypnotised than any other explanation which does not use terms like trance, alteration of consciousness, or similar ones. Moreover, participants who dropped out of the study showed more fear (item 4), less desire to be hypnotised (item 26), less willingness to be hypnotised (item 27), and less interest in hypnosis, in comparison to those participants who continued participating in the study.

On the other hand, as we predicted, the gullibility ("Marginal" factor) increased for the TG, while it decreased for the CG and CBG. That is, participants belonging to the TG had the following beliefs: Hypnosis is a trance state in which dissociation is produced; hypnosis is a technique developed without considering scientific research; and overall hypnotisable people's characteristics are: gullibility, ignorance, dependence, and presence of psychological alterations. In saying this, the prediction may be made that the trance explanation may increase some misconceptions about hypnosis (for instance, that it is not a scientific technique).

Furthermore, the hypothesis that the trance explanation jeopardises the change in misconceptions about hypnosis is partially demonstrated, insofar as the minimum explanation produces more positive changes than the trance ones. These changes can be observed by the fact that the person is not considered an automaton in the hypnotist's hands ("Automaton factor") and gullibility ("Marginal" factor) decreases.

With regard to hypnotic suggestibility, our prediction was that trance explanations would produce a lower score on the Barber scale. This result was achieved to the extent that participants who dropped out, after the trance explanation, decided not to continue with the BSS either. Nevertheless, the prediction of a higher score of the CBG in comparison with the other two groups was not demonstrated to be true. A possible explanation for this may be that, as Capafons et al. (2005) state, the BSS seems to give a better performance using a trance wording (Barber, Wilson, & Scott, 1980); and also that there was a great change in the attitudes of the participants who continued the study produced by the three explanations.

This could explain why we have not found differences in suggestibility in this study similar to those found by Lynn et al. (2002) in the study mentioned previously (taking into account what we have said about the dropouts produced by the trance explanation). Also, the fact that the presentation used by Lynn et al. emphasises that the experimenter has the control, whereas we stressed that it is the participant who has the control, may have had an influence as well. Another possible explanation could be related to the hypnotic induction. In the Lynn and colleagues study, the induction is given by a tape recorder and the participant assesses his/her own suggestibility, completing both subjective and objective scales. However, in our research the objective scale was completed by the experimenter and also it was recorded on video to be assessed again by an independent observer.

To sum up, the cognitive-behavioural presentation surpasses the trance and non-explicit explanations, since it produces more positive change in attitudes toward hypnosis. Furthermore, results confirm that trance explanation (in the same way it has been given to the participants in this study) makes the change of attitudes in a positive direction difficult. It also decreases the responses to the test suggestions, since it produces a high number of dropouts. It would be convenient to study what happens when trance is defined as a state making the participant dependent on the hypnotist, since this is a usual impression that lay hypnotists and showmen give to the people they hypnotise.

Finally, it has been shown that the most important variable in fostering a positive rapport is that the participant believes that s/he maintains control while being hypnotised, that hypnosis is not iatrogenic, and that the person applying hypnosis is using this technique properly (Capafons et al., 2005). Those issues are relevant for clinical practice: If hypnosis is introduced as an altered state of consciousness or dissociation, the client will most probably drop out of the therapy using hetero-hypnosis. On the other hand, introducing

hypnosis in cognitive-behavioural terms can create a higher acceptance of the therapy including hypnosis and a greater adherence to the treatment.

Future research should investigate if the same results can be reached using clinical samples, as well as what the results would be if the participants have initial attitudes that are excessively positive and have very high expectations about hypnosis, and how the different presentations would affect the change of attitudes.

Further investigation also needs to assess the effects of the three explanations on participants not belonging to the student population, since we do not know if the students of psychology are more trusting than other groups of participants in the explanations given in the university by expert researchers (Green, Rasekhy, Johnson, & Bernhardt, 2000). Also, the possible influence of the experimenter's gender on the participants should be considered in other studies. In this case, the experimenter in the trance condition was a male (while in the other conditions, they were females) and 100% of dropouts were women. Nevertheless, the studies about conformity and the susceptibility to being influenced predict the opposite effect, that is, that women are more susceptible to influence when the researcher is a male (Martínez & Bonilla, 2000).

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Sources of Information About Hypnosis and Attitudes Towards Being Hypnotised in Hong Kong

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Extending earlier Chinese studies that examined beliefs and attitudes towards hypnosis and its applications, the present article explores the sources from which Chinese people encounter information about hypnosis. Two samples, with a total of 541 Chinese respondents, were included in the present study: (a) college students, and (b) medical and mental health-related professionals. Significant preferences for information sources were noted between the professional and student participants. However, the current results indicate that any discrepancies between the Chinese students and Chinese professionals regarding their beliefs and attitudes towards hypnosis are not likely to be moderated by the sources from which they receive their information. Rather than demonstrating public media and information sources to be ineffective in modifying beliefs and attitudes towards hypnosis, the current results reveal a lack of direct or indirect experience of hypnosis among the Chinese, and a severe inadequacy of public education about hypnosis and its applications.

Surveys in Britain, America, and Australia have confirmed a widespread misunderstanding about hypnosis in the general public (Daglish & Wright, 1991; McConkey, 1986; McConkey & Jupp, 1986; McIntosh & Hawney, 1983; Vingoe, 1992; Wagstaff, 1981, 1988; Wilson, Greene, & Loftus, 1986). According to Kroger (1963), public misperception and fear of hypnosis revolve around potential loss of control. Most people seem to hold the stereotypical view of hypnosis as a powerful form of mind control, with the most common misconceptions based on this notion (Levitan & Jeven, 1986; Mann, 1986; Udolf, 1981; Wester, 1984; Yapko, 1995).

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Widespread misunderstanding about hypnosis is thought to be at least partly attributable to stage hypnosis demonstrations, sensationalist movies and media stories, and superstitions passed from one person to another (Johnson & Hauck, 1999; Marcuse, 1964; Pratt, Wood, & Alman, 1988; Wallace, 1979), which frequently portray hypnosis as a powerful tactic for mind manipulation. Some rigorous research has shown that people's perception of hypnosis is not static and can be affected by stage hypnosis demonstrations (Echterling & Whalen, 1995; Large & James, 1991). Furthermore, attitudes and beliefs regarding hypnosis can be modulated in diverse and specific ways by various educational and entertainment portrayals of hypnosis (Echterling & Whalen, 1995).

A surprisingly small number of studies have examined the sources from which people obtain their information about hypnosis. However, a relatively comprehensive study comprised of four sample groups (i.e., college students, members of a social club, attendees at a women's spirituality conference, and members of a retirees' association) indicated differences between different populations in the sources of their opinions of hypnosis (Johnson & Hauck, 1999). For instance, college students tended to base their beliefs and opinions on stage presentations and television to a greater extent than the other groups. The analysis also indicated that, although the four sample groups obtained their information about hypnosis from different sources, their beliefs about hypnosis were similar.

Chinese studies of hypnosis are extremely rare. There are two studies that have investigated how Chinese college students and health professionals perceived hypnosis (Yu, 2004a, 2004b). The Chinese college students demonstrated precisely the same set of beliefs and misconceptions that were reported in Western samples (Yu, 2004a). In contrast to the Western studies, which involved primarily psychology students as subjects, however, the Chinese study underscored that students from different disciplines embraced distinct attitudes towards the uses of hypnosis and the idea of being hypnotised. To be precise, the psychology students in the Chinese sample showed more positive attitudes towards hypnosis and were more open to the idea of being hypnotised. Furthermore, the professionals or clinicians in the Chinese study appeared to share, albeit to a lesser degree, the same beliefs and misconceptions as the college students regarding the general nature of hypnosis and its applications, such as memory recovery and forced truthfulness (Yu, 2004b). Nevertheless, the professionals adopted a comparatively more sceptical attitude.

No research has hitherto been conducted to ascertain where people in Asian countries, and in particular in China, source information about hypnosis.

Extending the preceding Chinese studies that examined beliefs and attitudes towards hypnosis and its applications, the present study explored the sources from which Chinese people encounter information about hypnosis. These include direct experience such as receiving hypnotherapy, as well as indirect experience, such as watching television programs that contain information about hypnosis. In addition, their general attitudes towards being hypnotised were also examined.

METHOD

Design

In considering the primary subject matter under enquiry, two samples with a total of 541 respondents were included in the present study: (a) college students, and (b) medical and mental health-related professionals. Participation was completely voluntary. The entire procedure used for both students and professionals was identical, except that the survey was administered in groups for the student sample, whereas professionals completed it individually.

Participants

Sample 1: College Students Four hundred and sixty-six Hong Kong college students, initially reported in Yu (2004a), formed the first sample and comprised 157 males (33.7%) and 309 females (66.3%). The average age was 21.33 years (SD = 2.16, min. = 18, max. = 46); 43.6% were psychology major students and 56.4% were non-psychology major students (i.e., social work, sociology, language, etc.). (See Yu, 2004a, for more details and findings of this student sample.)

Sample 2: Professionals in Medical Settings Seventy-five medical and helping professionals, initially reported in Yu (2004b), comprised the second sample of the current study. Most of them (72%) were drawn from a psychiatric hospital in Hong Kong, and approximately half of them were psychiatric nurses. There were also social workers, occupational therapists and a counsellor from other medical settings. This sample consisted of 32 (42.7%) males and 43 (57.3%) females. The mean age was 33.47 years (SD = 7.20, min. = 21, max. = 49). (See Yu, 2004b, for more details and findings of this sample.)

Measures

The 41-item questionnaire used in this research consists primarily of two sections, which are intended to measure the general beliefs about hypnosis and the perceived value of hypnosis. The first part of the protocol (25 statements) is equivalent to McConkey's inventory (1986), concerning the nature, experience, and effects of hypnosis and hypnotic suggestions. The second part (16 statements), sourced from Northcott's questionnaire (1996), contains two dimensions: "transcend" (describing hypnosis as enabling the enhancement of abilities or achievement of feats not normally achievable) and "worth" (which concerns the usefulness of hypnosis).

A form was designed for collecting demographic information. In this form, the participants were also required to identify the sources and media from which they obtained information about hypnosis, and to specify the titles of the materials about hypnosis that they had encountered from the information sources. In addition, the participants were requested to indicate their experience with both receiving and employing hypnosis, specify whether they had attended any course in hypnosis, and estimate their susceptibility to hypnosis (see Yu, 2004a, 2004b, for details).

RESULTS

Sources of Information About Hypnosis

A low proportion of the participants had encountered information about hypnosis through a variety of media (Table 1). Even for the highest percentage category, "Television," fewer than half of the student and professional participants (i.e., 40%) learned about hypnosis via this source. Similar proportions of student and professional participants obtained information from the various sources. Television was the most likely medium for both students and professionals to receive information about hypnosis, followed by movies. Stage performance was the least likely medium. Compared to students, a larger percentage of professionals gave affirmative answers across all categories of media sources other than "Television." This was particularly true for the categories "Newspapers" and "Stage hypnosis." On the other hand, the students and professionals relied on different groups of people to obtain their information. Regarding the category of people, a greater percentage of professionals received information from "Clinicians," whereas students received their information mostly from "Teachers." In addition to the information

sources listed in Table 1, the participants also encountered information about hypnosis from textbooks, popular books, comics, magazines, and the internet. The television programs that participants specified as being information sources were invariably drama programs or comedy series.

Table 1: Media and People Sources of Information about Hypnosis

Sources	Students (n = 458)	Professionals (n = 75)	Total (N = 533)
Media			
Television	40.2%	40%	40.2%
Radio	6.8%	12%	7.5%
Movies	27.1%	29.3%	27.4%
Newspapers*	7.4%	24%	9.8%
Fiction	13.1%	13.3%	13.1%
Stage hypnosis*	2.6%	10.7%	3.8%
People			
Clinicians*	3.1%	17.3%	5.1%
Teachers*	20.1%	14.2%	18.9%
Friends	7.9%	9.3%	8.1%
Others	4.8%	13.3%	6%

* Significant differences.

Statistical tests were completed by stratifying the student sample into subgroups that had either a psychology or non-psychology major. These two subgroups were examined with respect to their sources for obtaining information regarding hypnosis. There were no significant differences between the observed and expected frequencies in the majority of the categories, and most of the information sources were equally used by the psychology and non-psychology students. Specifically, they did not differ in their frequency of receiving information from television, radio, newspaper, fiction, stage hypnosis, clinicians, and friends. Significant preferences for information sources were only found in the categories of "Movies" and "Teachers." A larger percentage of the psychology students (33.7%) received information about hypnosis from movies than the non-psychology students (22.4%) (Pearson's $\chi^2 = 7.21$, $df = 1$, $p < 0.01$; $\phi = 0.13$, $p < 0.01$). The psychology students (32.2%) were also more likely than the non-psychology students (10.6%) to learn about hypnosis from teachers (Pearson's $\chi^2 = 32.46$, $df = 1$, $p < 0.001$; $\phi = 0.27$, $p < 0.001$).

In contrast, four significant preferences for information sources were documented between the professional and student participants. The professionals (24%) were more likely to read about hypnosis from newspapers than the psychology students (9%) (Pearson's $\chi^2 = 10.67$, $df = 1$, $p < 0.01$; $\phi = 0.20$, $p < 0.01$) and the non-psychology students (5.9%) (Pearson's $\chi^2 = 21.14$, $df = 1$, $p < 0.001$; $\phi = 0.25$, $p < 0.001$). A higher proportion of the professionals (10.7%) rather than psychology students (1.5%) (Pearson's $\chi^2 = 11.86$, $df = 1$, $p < 0.01$; $\phi = 0.21$, $p < 0.01$) and the non-psychology students (3.5%) (Pearson's $\chi^2 = 6.04$, df = 1, $p < 0.05$; $\phi = 0.14$, $p < 0.05$) had ever watched stage hypnosis performances. The professionals (17.3%) tended more than the psychology students (3.5%) (Pearson's $\chi^2 = 15.37$, df = 1, $p < 0.001$; $\phi = 0.24$, $p < 0.001$) and the non-psychology students (2.4%) (Pearson's $\chi^2 = 23.97$, $df = 1$, $p < 0.001$; $\phi = 0.27$, $p < 0.001$) to obtain information about hypnosis from clinicians. On the other hand, the professionals (12%) were less likely to hear about hypnosis from teachers than the psychology students (32.2%) (Pearson's $\chi^2 = 11.33$, $df = 1$, $p < 0.01$; $\phi = 0.20$, $p < 0.01$). There was no significant difference between the non-psychology students (10.6%) and professionals (12%) with regard to acquiring information about hypnosis from teachers (Pearson's $\chi^2 = 0.12$, $df = 1$, $p = 0.73$; $\phi = 0.02$, $p = 0.73$).

Experience of Hypnosis

Very few students and professionals had direct or indirect experience of hypnosis (Table 2). Only 1% of the students and no professionals had ever received hypnotherapy. Less than 5% of all participants had ever been hypnotised. Twenty-seven (36%) of the respondents in the professional sample had undergone counselling or psychotherapy, and nine (12%) had used hypnosis as a part of counselling or psychotherapy. Among the 75 respondents, two (2.7%) had studied hypnosis, albeit without using it in their practice. The sample groups (i.e., psychology students, non-psychology students, and professionals) did not significantly differ in their experience of receiving hypnotherapy, being hypnotised, knowing acquaintances with hypnotic experience, and studying courses in hypnosis.

Table 2: Experience of Hypnosis

Sources	Students (n = 461)	Professionals (n = 75)	Total (N = 536)
Have you received hypnotherapy before?	1.1%	0%	0.9%
Have you been hypnotised before?	3%	6.7%	3.5%
Do you know anyone who has been hypnotised before?	5.4%	9.3%	6%
Have you studied any course about hypnosis?	4%	2.7%	3.8%

A larger proportion of the professionals (26.7%) than the students (5.5%) knew where they could find a hypnotherapy service if they required it (Pearson's $\chi^2 = 37.27$, $df = 1$, $p < 0.001$; $\phi = 0.27$, $p < 0.001$). There was also a tendency that, compared to the students (2.2%), the professionals (8%) were more likely to know where they could watch a stage hypnosis performance (Pearson's $\chi^2 = 7.43$, $df = 1$, $p < 0.01$; $\phi = 0.12$, $p < 0.01$).

Effect of Participant Groups Versus Sources on Beliefs About Hypnosis

A 369 (41 statements measuring the general beliefs about hypnosis versus 9 information sources) sample group versus source interaction (three versus two) factorial analysis of variance was completed to test the effects on the beliefs about hypnosis. Only one out of the 369 interaction effects was significant, although a number of significant main effects, due to the sample group factor and differences between the college students and professionals in the beliefs and attitudes towards hypnosis and its applications, were documented (see Yu, 2004b, for details). The analysis of the degree of agreement regarding the statement: "Hypnosis can be experienced by everyone to a similar degree, under the right circumstances" revealed a significant main effect due to the sample group ($F(2,521) = 4.9$, $p < 0.01$), and the interaction between the sample group and the source factor "Television" was significant ($F(2,521) = 5.81$, $p < 0.01$, partial $\eta^2 = 0.022$). The main effect of the source factor "Television" was not significant ($F(1,521) = 2.92$, $p = 0.088$). Specifically, those professionals who had encountered information about hypnosis through television gave more credence to this statement ($X = 2.77$) than the professionals who had not ($X = 2.29$). A slightly opposite effect of television was noted in the psychology and non-psychology student samples. For instance, the psychology

major students who had watched television programs about hypnosis scored lower ($X = 2.18$) than those who had not ($X = 2.32$).

Attitudes Towards Being Hypnotised

There was a significant difference between the three sample groups in regard to self-perceived hypnotisability (Pearson's $\chi^2 = 14.34$, $df = 4$, $p < 0.01$; $\phi = 0.12$, $p < 0.01$). While the observed frequencies were very close to the expected frequencies in the categories of "medium hypnotisability" and "high hypnotisability," notably fewer psychology students (9.2%) claimed themselves as "low hypnotisables" than both non-psychology students (16.9%) and professionals (25.7%) (see Table 3). All 14 student participants who had been hypnotised before indicated that they would like to be hypnotised again. Three out of the five professional participants who had been hypnotised before gave the same answer, while two responded negatively. Among the 447 student participants who had never been hypnotised, 170 (38%) would not like to be hypnotised. More than half (57.1%) of the 70 professional participants would not like to be hypnotised. The discrepancy was significant, and the professional participants were less likely to accept being hypnotised (Pearson's $\chi^2 = 9.17$, $df = 1$, $p < 0.01$; $\phi = 0.13$, $p < 0.01$). Among those participants who had not been hypnotised before, the psychology students (66%) tended to accept being hypnotised more than the non-psychology students (58.6%), while the professionals (42.9%) were least likely to accept being hypnotised (Pearson's $\chi^2 = 11.47$, df = 2, $p < 0.01$; $\phi = 0.15$, $p < 0.01$).

Table 3: Self-Perceived Hypnotisability

Self-perceived hypnotisability	Psychology students ($n = 196$)	Non-psychology students ($n = 254$)	Health professionals ($n = 74$)
High	12.2%	9.1%	13.5%
Medium	78.6%	74%	60.8%
Low	9.2%	16.9%	25.7%
Total	100%	100%	100%

DISCUSSION

Several findings of the present study are of cultural interest. It is far less common for Chinese college students to come across materials and information about hypnosis from various media than it is for Western college students. In Johnson and Hauck's (1999) study, 53% of the Western college students based their

opinions of hypnosis on watching a stage hypnosis performance. They pointed out that the use of hypnotists at high school class parties is popular. In stark contrast, the stage performance of hypnosis is hardly accessible to Hong Kong Chinese, and only 2.6% of the Chinese student participants had actually watched stage hypnosis. Similarly, whereas 75% of the Western student sample claimed that their opinion of hypnosis was influenced by television, less than half of the current Chinese sample had ever watched television programs involving materials about hypnosis.

Cultural differences in the accessibility of information and experience about hypnosis became even more apparent when considering that 63% of the women's spirituality group and 33% of the college group in Johnson and Hauck's study (1999) thought that they had been influenced by clinicians with regard to their opinions on hypnosis, whereas only 17% of the Chinese professionals had obtained this type of information from clinicians. Furthermore, 21% of the Western participants in Johnson and Hauck's study indicated that they had been hypnotised, while less than 5% of the Chinese participants had such an experience. In the Western study, the women's spirituality group (84%) and the college group (70%) clearly showed their interest in being hypnotised. On the other hand, 40% of the Chinese participants responded that they would not like to be hypnotised, reflecting the overall reluctance of Chinese to approach the hypnotic experience.

For Johnson and Hauck (1999), the participants were asked to rate six different sources by indicating the level of influence (most, some, and none) that each had on their ideas about hypnosis. As neither educational nor entertainment presentation of hypnosis is prevalent in local media, it is hardly possible, and probably unreliable, for Chinese participants to decide the extent to which a certain information source has an impact on their knowledge about hypnosis. Therefore, the present study requested the participants to indicate whether or not they had encountered materials about hypnosis through a certain source.

Compared to the Chinese students, the Chinese professionals were more alert to media information about hypnosis. Yet the Chinese students and professionals, by and large, appear to have obtained their information about hypnosis from similar sources, albeit to a different degree in some categories, just as they share generic beliefs and opinions with respect to hypnosis. Johnson and Hauck (1999) argued that resemblance of beliefs may reflect a general consistency in the way hypnosis is portrayed across different sources. Corresponding to this argument, the current results underscore

the position that any discrepancies between the Chinese students and the Chinese professionals, regarding their beliefs and attitudes towards hypnosis, are not likely to be modulated by the sources from which they receive their information about hypnosis.

In Hong Kong, there is a very limited number of sources that provide the general public with accurate information about hypnosis. There is similarly insufficient formal teaching with regard to hypnosis provided by the specialist and clinical training programs at universities and professional bodies in Hong Kong (Yu, 2004b). Nevertheless, psychology training has significant positive effects on the beliefs of the usefulness of hypnosis and openness to hypnotic practices. Echoing previous findings, the professionals consistently embrace more stringent attitudes towards hypnosis, self-perceived hypnotisability, and being hypnotised than the psychology students. This is reasonably attributable to their professional cynicism, rather than the sources of information (Yu, 2004b).

CONCLUSION

Rather than demonstrating public media and information sources to be ineffective in modifying beliefs and attitudes towards hypnosis, the current results reveal a lack of direct, or indirect, experience of hypnosis among the Chinese, and a severe inadequacy of public education about hypnosis and its applications. This seems particularly alarming when taking into account the finding that the vast majority of the materials the participants did come across were entertainment focused, irrespective of the type of the information source. Still, the reluctance of the Chinese participants towards being hypnotised is obvious. In view of this, public media and education may constitute potentially important and useful means for providing accurate information to the public, and thereby, perhaps, alleviating the prevalent negative attitudes regarding the use of hypnosis.

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Change of Attitudes Towards Hypnosis After a Training Course

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The aim of this study was to examine the changes of attitudes towards hypnosis after attending a training program about hypnotic techniques and their clinical applications. An adjective check list was developed specifically for this research and was administered to a sample of undergraduate and graduate Psychology students (N = 80) to assess their attitudes before, and after, attending the training program. The results showed that after the training program, the negative attitudes towards hypnosis had vanished, the positive attitudes that had already existed were reinforced, and several new positive attitudes related to the contents explained during the training program emerged. Therefore, to facilitate a clinical use of hypnosis that benefits the patients, it is crucial to develop theoretical-practical training programs about hypnosis that foster proper attitudes towards this technique among health professionals.

Recently, there has been a growing interest in the study of the attitudes towards hypnosis since it had been found that positive attitudes are related to positive outcomes of the therapy (Chaves, 1999; Schoenberger, Kirsch, Gearan, Montgomery, & Pastyrnak, 1997) and they are very important in the establishment of rapport and the increase of sensations of relaxation and well-being (Sheehan, 2001).

There are three major approaches to the study of attitudes. The first one is focused on the relationships of attitudes with other constructs or characteristics of hypnosis, such as hypnotic suggestibility and absorption. A second approach has focused on the development and validation of scales to

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measure the attitudes towards hypnosis of different population groups, namely, health professionals, patients, and the general public. Finally, the third approach has studied the changes in attitudes after giving different kinds of information to the subjects, or after they had been hypnotised. Some of these relevant studies are detailed in the next paragraphs.

Research About the Relationship of Attitudes and Other Constructs

Spanos and McPeake (1975) assessed absorption (i.e., involvement in imaginary activities of everyday life), attitudes towards hypnosis, and hypnotic suggestibility in a sample of 183 subjects. They found relationships among absorption, positive attitudes towards hypnosis, and hypnotic suggestibility. This indicated that subjects high on absorption tended to have positive attitudes towards hypnosis, whereas low absorption subjects tended to keep less positive attitudes. A possible explanation of this tendency may be that people who like to be involved in different everyday situations also like, and do not feel threatened by, the opportunity of getting involved in unusual psychological activities (e.g., the hypnotic situation). This result was replicated in the study by Spanos, Brett, Menary, and Cross (1987), with the peculiarity that in the latter study, taking into account the correlation between positive attitudes and absorption, the lineal combination of attitudes and absorption predicted better the hypnotic responsiveness than just attitudes and absorption alone.

Research About the Attitudes Held by the General Public

Large and James (1991) interviewed a sample group of people randomly selected from the population of Auckland (New Zealand), and another group of outpatients visiting Auckland Hospital Pain Clinic. These authors concluded that all those subjects who had seen hypnotic shows on television, or on stage, felt reluctant to use hypnosis and had built up in their minds a negative impression of this technique. Hence, Large and James warn us about the consequences of using hypnosis as entertainment, since they consider that the way that hypnosis is shown in the media promotes wrong assumptions or beliefs that may deter people from believing in the benefits of clinical hypnosis.

On the other hand, Johnson and Hauck (1999) studied four different samples comprised of people of different ages, interests, geographic locations, and socioeconomic level inside the United States. The attitudes towards hypnosis,

as well as the sources from where the subjects had derived their opinions, were analysed, with the result that although the subjects had obtained information from different sources, their ideas and beliefs about it were quite consistent. The main misconceptions found were the following: 98% of the subjects thought that hypnosis is a special state of consciousness; 86% of the surveyed people thought that the success accomplished by hypnosis depended on the hypnotist's skills; 78% of the respondents agreed that the hypnotised person does not realise what is going on around him/her; and most people considered hypnosis as a powerful tool to remember accurate memories that took place both as far back as birth (74%) and past lives (58%).

Studies About the Students' Attitudes

McConkey and Jupp (1985–1986) carried out research on an Australian population that replicated the results obtained by McConkey (1986) with a population in the USA. The results emphasised the fact that the subjects consider hypnosis is like an altered state of consciousness and that they think that hypnotic suggestions can improve memory, make the person tell the truth about facts they usually would lie about, and forget everything that took place during the hypnotic session. The same results were found in a subsequent study carried out in Scotland by Daglish and Wright (1991), although with some differences that show that Australian students are better informed than those from Scotland. For example, Australian students knew that the hypnotised person could ignore any suggestion s/he wanted to, while the Scottish students did not know how to answer that question.

In 2004, Yu published his research on attitudes towards hypnosis on Asiatic students. It was the first important approach to the international cross-cultural replication of Chinese versus English speakers (Yu, 2004a). This author found that the Chinese held the same misconceptions about hypnosis that had been found in studies carried out with American, Australian and British population. A significant number of Chinese students considered that hypnosis improves memories, even those referring to the time of birth and previous lives. Also, those subjects more likely to be hypnotised tended to have more positive attitudes towards hypnosis and to show less sceptical attitudes towards hypnosis. This differs from the findings of Daglish and Wright (1991) and McConkey and Jupp (1986). In the latter study, subjects considered as medium hypnotisables had a less accurate knowledge of hypnosis than those who considered themselves as being either low or high hypnotisables. However, the

Chinese subjects, who were considered as medium and low in hypnotisability seemed to adopt relatively more sceptical viewpoints. These subjects tended to believe less, for example, that the hypnotic experience depends on the ability of the hypnotist, rather than on the hypnotised person's ability. On the other hand, those subjects considered high on hypnotisability seemed to have more positive attitudes towards the use of hypnosis (Yu, 2004a).

Finally, Capafons, Espejo, and Cabañas (2005) compared the attitudes towards hypnosis of a sample of Cuban medical students with a sample of Spanish, Honduran, Argentinian, and Chilean students. Cubans believe that hypnosis is a useful technique, and are less reluctant to use it than the other Latinos in the sample. Cubans also believe that hypnosis fosters memory and that hypnotised people cannot lie. In this way, they believe that memories recovered under hypnosis actually confirm the recalled facts as true. This may be because they believe that hypnosis makes people lose control. These misconceptions may lead to a misuse of hypnosis. And the fact that Cubans consider hypnosis a non-scientific discipline worsens the problem since they disregard the correction of the misconceptions and this technique becomes iatrogenic (Capafons, Espejo, & Canañas, 2005).

Studies About Health Professionals' Attitudes

Yapko (1994) developed and administered a questionnaire of attitudes towards hypnosis to a sample of 869 psychotherapists in the USA, finding that they had a favourable attitude towards hypnosis. However, this attitude was based on misconceptions about this technique. As a consequence, wrong beliefs — such as that memories recovered through hypnosis are accurate — can lead to an iatrogenic use of hypnosis, especially when it is applied to recall repressed episodes of abuse in childhood, that can be more the result of suggested rather than actual memories.

In 1982, Vingoe published his research on British health professionals' attitudes towards hypnosis. In this study, a questionnaire about attitudes was applied to a group of clinical and educational psychologists and their responses were compared. This questionnaire was focused on attitudes towards the use of hypnosis and its perceived effectiveness, rather than on the misconceptions of the professionals. Overall, the results showed that educational and clinical psychologists had a positive attitude towards the use of hypnosis and considered it an effective technique for the treatment of some emotional problems, since it helps to reduce the time of the treatment and its benefits last much longer.

However, educational psychologists showed a greater interest in hypnosis, and tended to consider it more effective as a treatment of choice, whereas clinical psychologists were more reluctant to use hypnosis. The author suggests that this difference could be due to the fact that these groups of psychologists deal with a different kind of patients. Finally, both groups think that they do not have enough training for adding hypnosis to their treatments, and believe that more training courses in hypnotherapy should be made available (Vingoe, 1982).

Yu (2004b) carried out a subsequent research program with health professionals in Hong Kong, using the same questionnaire. It was observed that the surveyed professionals had the same misconceptions about hypnosis and its applications as did students. However, the professionals had a more sceptical attitude. This could be considered a positive approach, taken in order to avoid a misuse of this technique, although it would also prevent the patients from receiving the benefit that hypnosis could offer to them. Finally, this study shows that there is little access to training about hypnosis in Hong Kong universities, people who are currently teaching this discipline lack any basic psychological background or are not health professionals, and this lack of training may perpetuate both misconceptions about, and misapplications of, hypnosis (Yu, 2004b).

Finally, a research project, combining three different groups of population from Indiana (USA), was carried out by Chaves (2004). A questionnaire about attitudes towards hypnosis was administered to undergraduate students, faculty members, and patients of a dental clinic. The results indicated that all surveyed groups had positive attitudes towards hypnosis, although faculty members were more positive than students or patients. It was also observed that those subjects who had already had some experience with hypnosis were more positive about it, as were staff members who had attended a course in hypnosis. Although caution must be exercised in generalising these results, it may be surmised that if positive attitudes have been found in a large Midwestern dental school, located in a relatively conservative state, the same attitude might also be found in other less conservative areas of the same country (Chaves, 2004).

Studies Assessing Changes in Attitudes

McConkey (1986) developed and administered a questionnaire of opinions about hypnosis to a sample of Australian students, before and after they had experienced hypnosis, in order to assess pre- and post-test differences. The

author concluded that having a personal experience with hypnosis could reduce misconceptions about this technique. Subsequently, Green (2003) pointed out that this research did not take into account the possible attitudinal changes due to the repeated testing or the passage of time. For that reason, he carried out another research project administering the same questionnaire to a sample of American students, both before and after giving them a suggestibility scale. Another group of subjects filled in the questionnaire, but did not have any experience with hypnosis. The results showed that the experience of being hypnotised modified the misconceptions that the subjects showed in the pre-test. The inclusion of the control group established the test-retest reliability of the questionnaire and also proved that the changes of opinion in the experimental group were a result of their personal experience with hypnosis (Green, 2003).

In a similar study conducted by Thomson (2003), 300 health professionals attended a lecture about the nature of hypnosis and its therapeutic uses. The lecture included slides, videos, and written material followed by a question and answer period. Those subjects who wanted to experience hypnosis were hypnotised for the purpose of relaxation. Their attitudes towards hypnosis were assessed before the lecture, after it, and three months later. The researcher concluded that the subjects' attitudes changed after having received correct information about hypnosis, and that being hypnotised promoted a positive attitude towards this technique.

With regard to the impact of stage shows on attitudes to hypnosis, it is worth mentioning the studies by Echterling and Whalen (1995), and MacKillop, Lynn, and Meyer (2004). According to their results, it was concluded that stage hypnosis fostered a positive attitude towards hypnosis.

A common characteristic of all these studies (except for Green, 2003) is that participants already had a positive predisposition towards hypnosis since they had attended both the lectures and the stage hypnosis event voluntarily. As a contrast, a research study, conducted in Spain, used a sample of subjects who showed a negative attitude towards hypnosis (Capafons et al., 2005). The researchers developed a scale to measure attitudes towards hypnosis (Capafons, Cabañas, Espejo, & Cardeña, 2004) and administered it to first year Psychology students. Those subjects who had shown a negative attitude to be hypnotised were chosen for participating in the second part of the study. They were given different explanations about hypnosis: The control group received the minimum information; one of the experimental groups received a cognitive-behavioural explanation of hypnosis; and the second experimental group was given a

presentation where hypnosis was defined as an altered state of consciousness or trance. All participants were taught a self-hypnosis procedure and then completed the Barber Suggestibility Scale (BBS: Barber 1965; Barber & Wilson, 1979). It was concluded that both the cognitive-behavioural and the trance presentations, followed by the experience of hypnosis, had a significant impact on the attitudes towards hypnosis and tended to correct the misconceptions about it (Capafons et al., 2005).

In a subsequent study (Capafons et al., 2006), the same scale and design were used, but in this case the subjects did not learn self-hypnosis, but the Barber Suggestibility Scale was administered to them with hetero-hypnosis. The results of the previous study were replicated with the difference that the cognitive-behavioural explanation led to more positive changes in the attitudes towards hypnosis and fostered the ideas that people keep the control of their behaviour while hypnotised and that, when applied properly, it was a useful technique. When a trance explanation was given to the subjects, their attitudes towards hypnosis did not change to positive attitudes, as occurred when the subjects received the cognitive-behavioural explanation. Also, subjects receiving the trance explanation made fewer responses to test suggestions than subjects receiving the cognitive-behavioural explanations. Finally, subjects receiving the trance explanation dropped out of the research more than those who had been given the other explanations. This difference could be due to the fact that, in the first study, the subject hypnotised him/herself and this helped him/her maintain a greater perception of control, whereas in the second study, the subjects were hypnotised by the experimenter, which could have reinforced his/her idea that the hypnotist maintains control over the subject's behaviour (Capafons et al., 2006).

All these studies have assessed attitudes towards hypnosis through questionnaires. As a contrast, this research used a different methodology, namely, the adjective check list (Katz & Braly, 1933). The aim of this study is to examine the changes of attitudes about hypnosis detected by the adjective check list developed specifically for this research, with a group of psychologists after they had attended a theory and practice training course of hypnosis.

METHOD

Subjects

The sample consisted of 80 (60 women and 20 men) undergraduate and graduate Psychology students from different Spanish universities who registered for four training courses in hypnosis techniques offered at different times. The age of the subjects varied from 19 to 43, with an average age of 24.5 (SD = 5.1).

Procedure

Instrument Construction

The adjective check list created by Katz and Braly (1933) is an assessment method of stereotypes and has been utilised for a long time (Gonzalez et al., 1990; Molina, 2000; Molina & Caballero, 1999).

In this study, we used the modification of the original check list by Sangrador (1981) that consisted of making a classification of the adjectives according to their favourability and unfavourability. First, it was necessary to develop a specific adjective check list for each attitude to be assessed, using a sample independent from the ones that would be used in the experimental study. Consequently, the sample of the pilot study comprised undergraduate Psychology students from the University Complutense of Madrid ($N = 34$). They attended an introductory course about hypnotic techniques, and then were asked to write a minimum of three positive adjectives and three negatives adjectives describing hypnosis.

The descriptors gathered were selected eliminating all those words that were not adjectives, making groups of synonyms, and choosing those that were mentioned more often. The "surviving adjectives" were classified according to their theoretical favourability and unfavourability and their frequency in being mentioned. In this way, the 40 adjectives that formed the final checklist (20 positive and 20 negatives) were obtained. This number of adjectives was considered adequate since a wide range of possible responses was covered, and the resultant test does not take a long time to be administered.

Five different lists were prepared to avoid the possible recency and primacy effect. The order of the adjectives in the lists was changed at random, and positive and negative adjectives were inserted alternatively. Table 1 lists the 40 adjectives used in this study.

The instructions to fill in the adjective check list given to the subjects of the experimental group ($N = 80$) were as follows:

1. Read carefully the adjectives of the list. (All of them were printed on the same page to make their visualisation easier.)
2. Choose those adjectives that better describe hypnosis. (It was considered as a criterion to choose a maximum of five adjectives.)
3. Assess the favourability and unfavourability ratings of the chosen adjectives using a 5-point Likert scale, where "1" represents the highest unfavourability rating and "5" the highest favourability rating.

Table 1: Adjective Check List About Hypnosis

Positive adjectives	Negative adjectives
Different	Discredited
Applicable	Unknown
Beneficial	Wasted
Enriching	Fraudulent
Effective	Spectacular
Special	Esoteric
Exploratory	Fake
Mysterious	Deceiving
Interesting	Marginal
Liberating	Incredible
Painless	Mystifying
Striking	Useless
Therapeutic	Unpopular
Useful	Manipulative
Quick	Limited
Relaxing	Occult
Revealing	Dangerous
Practical	Unexplored
Innovative	Scary
Easy	Embarrassing

The assessment of attitudes towards hypnosis through the adjective check list was applied at two different times, before starting the training program (pre-test) and after concluding the training program (post-test).

Training Program

The average duration of the program was eight hours and had the following stages.

Informative Stage In this stage, subjects received information about what hypnosis is and how it works from a cognitive-behavioural perspective. Some of the myths dispelled were the following: Hypnosis is like sleeping and involves the lost of consciousness; hypnotised people lose control of their behaviour; the hypnotist has a "special power" to induce hypnosis; hypnotised people cannot lie and they can even recover memories of their past that they

would not recall otherwise; hypnotised people obey everything the hypnotist asks them to do; hypnotised subjects are passive and hypnosis does not require any effort from them; hypnosis produces dependence on the hypnotist; and hypnosis is dangerous. Also, participants learned about theoretical approaches to hypnosis, some induction methods, and some of the applications that hypnosis can have in therapy.

Stage of Modelling The instructor modelled the application of different hypnotic test suggestions and some induction techniques, and explained the reinforcement and generalisation of hypnotic effects. The modelling was performed in two different ways: (a) an individual application to a specific subject, which was observed by the rest of the audience; and (b) a collective application to the whole audience in a way that allowed each individual to report what was his/her subjective experience of what "to feel hypnotised" means.

Stage of Reinforced Practice In small groups, participants administered to each other the hypnotic techniques they learned in the former stage, while supervised by an instructor.

RESULTS

Once the adjective check list had been completed by all subjects (before and after the training program), the theoretical probability that each adjective had to be chosen at random was calculated. All the adjectives that surpassed that limit were considered as possible content of the stereotype about hypnosis. In order to get the most representative adjectives, the threshold was increased, adding a confidence limit of 5% (González, 1988).

Thus, the previous and subsequent stereotypes of hypnosis were configured. Tables 2 and 3 show the adjectives that surpassed the minimum significant percentage, the frequency and percentage of each one of them, and the unfavourability-favourability ratings of all the adjectives. Following this, the previous stereotype was compared to the subsequent one. To achieve this aim, the average proportions of each of the adjectives that conformed both stereotypes were contrasted using McNemar's test. Table 4 shows the proportion, before and after the training program, for each of the adjectives, the difference between both stereotypes, and the *p*-value for statistical significance.

Table 2: Stereotypes About Hypnosis Before the Training Program

Adjectives	Frequency	Percentage	Unfavourability-favourability ratings (Rate 1–5)
Interesting	43	53.7	4.30
Therapeutic	27	33.7	4.18
Unknown	26	32.6	2.23
Striking	22	27.5	3.54
Relaxing	21	26.2	4.30
Mystifying	21	26.2	1.95
Discredited	20	25.1	2.05
Useful	18	22.5	4.30
Unexplored	15	18.7	1.93
Practical	15	18.7	4.07

$N = 80$
Number of choices: 397
Mean of choices: 4.96
Percentage of choices at random: 12.40
Minimum significant percentage: 17.40
Minimum frequency to be included in the stereotype: 14
Total mean of unfavourability (1)–favourability (5) ratings: 3.39

Table 3: Stereotypes About Hypnosis After the Training Program

Adjectives	Frequency	Percentage	Unfavourability–favourability ratings (rate 1-5)
Relaxing	46	57.5	4.35
Interesting	43	53.7	4.26
Therapeutic	41	51.2	4.32
Practical	35	43.7	4.23
Useful	34	42.5	4.18
Applicable	28	35.1	4.11
Beneficial	28	35.1	4.29
Quick	20	25.0	4.40
Effective	19	23.7	3.90

$N = 80$
Number of choices: 399
Mean of choices: 4.99
Percentage of choices at random: 12.47
Minimum significant percentage: 17.47
Minimum frequency to be included in the stereotype: 14
Total mean of unfavourability (1)–favourability (5) ratings: 4.24

Table 4: Differences Between Stereotypes Before and After the Training Program

Adjectives	Proportion pre-training	Proportion post-training	McNemar's test	*p*-value
Interesting	.537	.537	1.0000	n.s.
Therapeutic	.337	.512	0.0450	⋆
Unknown	.326	.100	0.0013	⋆⋆
Striking	.262	.012	0.0000	⋆⋆⋆
Relaxing	.262	.435	0.0005	⋆⋆⋆
Mystifying	.262	.000	0.0000	⋆⋆⋆
Discredited	.251	.112	0.0266	⋆
Useful	.225	.425	0.0120	⋆
Unexplored	.187	.087	0.0770	n.s.
Practical	.187	.437	0.0011	⋆⋆
Applicable	.162	.351	0.0108	⋆
Beneficial	.125	.351	0.0013	⋆⋆
Effective	.075	.237	0.0010	⋆⋆
Quick	.000	.250	0.0000	⋆⋆⋆

Note: n.s. = not significant, ⋆ $p < 0.05$, ⋆⋆ $p < 0.01$, ⋆⋆⋆ $p < 0.001$

DISCUSSION

An examination of the stereotypes that the subjects had before the training course revealed that the evaluation of hypnosis was neither especially positive nor negative, with the mean score of the unfavourability–favourability ratings being near the neutral point (3.39). This may have been due to the fact that participants were previously interested in the potential application of hypnosis in the clinical field, and therefore their attitude did not seem to be especially critical, but rather expectant before so many potentialities. It is worth pointing out that, from the very beginning, there were positively valued adjectives: *interesting*, *therapeutic*, *relaxing*, *useful*, and *practical*, which reflect a favourable attitude towards hypnosis. That could be the reason why they may have decided to attend this program. However, there are also negatively valued adjectives, namely: *unknown*, *mystified*, *discredited*, and *unexplored*. Finally, the adjective *striking* is close to the neutral point.

The stereotype the subjects exhibited after attending the training program revealed that they had a more positive attitude towards hypnosis, since the mean score of the unfavourability–favourability ratings was 4.24, and there were no more negatively valued adjectives. The stereotype of hypnosis, according to the frequency in which the adjectives were chosen and to their favourability

ratings included the following: *relaxing*, *interesting*, *therapeutic*, *practical*, and *useful*. Furthermore, some new positively valued adjectives came up: *applicable*, *beneficial*, *quick*, and *effective*.

Relative to the results of contrasting both stereotypes, it can be observed that:

1. The change in the unfavourability–favourability ratings of all the adjectives were statistically significant, except for the terms *interesting*, that had not changed from one application to the other, and *unexplored*, that showed a considerable decrease on the choice proportion although it was not statistically significant.
2. There was a significant increase in the choice proportion of the following adjectives: *therapeutic*, *relaxing*, *useful*, *practical*, *applicable*, *beneficial*, *effective*, and *quick*.
3. There was a significant decrease in the choice proportion of the following adjectives: *unknown*, *striking*, *mystifying*, *discredited*, and *unexplored*.
4. The adjective *interesting* kept exactly the same choice proportion, before and after the application of the hypnosis training program.

CONCLUSION

Overall the data demonstrated that, after the training program, the negative attitudes about hypnosis had already disappeared and the positive ones, that had already existed had been reinforced, and several new ones closely related to the contents studied during the training program, had emerged.

To sum up, the empirical evidence indicates that subjects' misconceptions about hypnosis may be modified as follows:

1. Giving proper information about the underlying features that form the hypnotic process;
2. Clarifying myths and incorrect beliefs associated with it;
3. Offering specific performing models for the application of hypnotic techniques; and
4. Giving subjects the opportunity to practise the aforesaid techniques by themselves.

Therefore, to facilitate a clinical use of hypnosis that benefits the patients, it is crucial to develop informative training programs about hypnosis that foster correct attitudes towards this technique among health professionals.

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Attitudes and Opinions About Hypnosis in an Australian City

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To investigate the sources of influence on attitudes and misconceptions of hypnosis, 279 adult members of the general public in Brisbane (Australia) were recruited via door knocking. Their demographic details, ratings on 12 sources of influence about hypnosis, and responses to 58 question items on attitudes to hypnosis were collected in survey format. As predicted, results revealed moderate to strong endorsement of some misconceptions about hypnosis. Television, stage hypnotists, and movies were the most common sources of influence. There was a general trend of moderate attitude responses and it appeared that the majority of the target population had very few sources of influence on which to base their knowledge of hypnosis.

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There is, and has been, controversy over how to best describe hypnosis. Capafons (2000) considers that the public should have at least some idea about what hypnosis means, and that they essentially see it as either a show, a weapon used by skilled people, or a therapeutic device. Clinicians, however, cannot reach consensus on what hypnosis is, or what it is capable of doing (Wagstaff, 1995). Some clinicians practise hypnosis as a part of a broader therapeutic approach (Kirsch, Lynn, & Rhue, 1997). Other clinicians believe that hypnosis is a special, or altered, state of consciousness, where the client is aware only of the hypnotist and that the client experiences time distortions and timelessness (Brown & Fromm, 1986; Yu, 2004b). Yapko (1995) and Kirsch et al. (1997) also suggest that hypnosis is simply role-playing, that is, it is due to the willingness of the client to carry out suggested behaviours.

A different but simplified version of this view sees hypnosis as a "process," where the client chooses to suspend their reality testing; that is, they stop listening to the feedback provided by the senses about the body's relationship to the outside world (Tellegen, 1978/1979). Another alternative view of hypnosis is that it is a suggestive process that relies on the conditioning properties of words, experiences and gestures, which have internal meaning for each individual and result in unique responses (Erickson, in Matthews, Lankton, & Lankton, 1997). Nevertheless, across all theoretical positions, there remains an emphasis on hypnosis being a result of an interactional outcome, where the quality of the relationship between client and clinician enhances the process of change within hypnosis (Smith, 1984). Indeed both the client and the clinician are seen to be investing in the relationship and following one another's lead (Yapko, 1995).

It would be beneficial to gain a more complete picture of the opinions and attitudes that future clients may have about hypnosis, as it seems reasonable to conjecture that it may relate to the hypnotic behaviour they will exhibit.

An attitude influences, and is influenced by, the amount of affect a person has about an object (Fishbein & Ajzen, 1975). An attitude will be adopted internally if the source of influence is perceived as having credibility, if it is based on a value system that is congruent with the individual, and if it elicits a reorganisation of a person's means and end goals within their value system (Kelman, 1971).

To date, international researchers have gathered data to try to interpret the internalised attitudes of the general public, with reference to hypnosis (Yu, 2004a, 2004b, 2006). Various participant groups have been studied using, not only measures that highlight common views about the nature of hypnosis, but

also those that identify the potential basis of these attitudes. While there may be some dispute about what is an opinion and what is an attitude in the research presented herein and the previous research undertaken across the world, the *Macquarie Dictionary* (1981) defines an opinion as "a judgement or belief resting on grounds, insufficient to produce certainty"; a second interpretation of it, however, is "a personal view, attitude or estimation" (p. 1197), while an attitude is defined as "position, disposition, or manner with regard to a person or thing" (p. 147). On a semantic level, it is attitudes that we are talking about, but, in effect, we may be really measuring opinions.

Numerous studies have used samples of undergraduate students (e.g., Capafons, 2000; Channon, 1984; McConkey & Jupp, 1985–1986), but it is acknowledged that their attitudes are not necessarily representative of the general population. Bryant (1993), Northcott (1996), and Yapko (1994) have sampled the attitudes of therapists and clinical practitioners towards hypnosis. Additionally, potential client populations' attitudes to hypnosis have been measured, including cancer patients (Hendler & Redd, 1986), pain clinic patients (Large & James, 1991), and children (Fellows & Paintin, 1989). Large studies of the public's attitudes to hypnosis have been randomly sampled from general health and medical centre populations (e.g., McIntosh & Hawney, 1983; Van Der Walde, 1974). Such a sampling method appears to be a very effective way to gain access to the views of a cross-section of the population.

Nash (2001) and Wagstaff (1995) point out that there are several commonly held attitudes about hypnosis. These include: Hypnosis is an altered state of consciousness; those in hypnosis are unaware of their surroundings; in hypnosis, a client gives over control to the hypnotist; in hypnosis, you cannot lie; hypnotic phenomena cannot be faked; in hypnosis, you can be made to do unusual things; and hypnosis enhances memory, capacity, and accuracy. Many of these items are used by researchers to measure attitudes pertaining to hypnosis.

It appears that Scottish students (Daglish & Wright, 1991) agree with the conception of hypnosis being an altered state of consciousness more than Australian students (McConkey & Jupp, 1985–1986), who in turn agree with this idea more than American students (McConkey, 1986). Three-quarters of the therapists studied by Bryant (1993) also endorsed this concept.

The opinion that "hypnotic clients are unaware of their surroundings" has been found to be higher in adults (Wilson, Green, & Loftus, 1986) compared to children (Fellows & Paintin, 1989), but lower in clinicians (Northcott, 1996) compared to the general public (Elkins & Wall, 1996).

Australian pre-medical students (Channon, 1984) did not believe that a client hands over control to the hypnotist, but the majority of British law and medical students (Vingoe, 1995), as well as Spanish undergraduates (Capafons, 2000), endorsed this idea. A between-groups difference for a student sample was found on this item about control, in that those who had witnessed hypnosis conducted by a stage hypnotist agreed more strongly with this idea than those who had obtained their information about hypnosis from lecture attendance (Echterling & Whalen, 1995).

Most students from the Daglish and Wright (1991), McConkey (1986), and McConkey and Jupp (1985, 1985–1986) studies thought that a person could not lie in hypnosis. However, a majority of clinicians sampled by Northcott (1996), Vingoe (1995), and Yapko (1994) did not hold the same opinion. Not all surveys are so clear cut, as the undergraduate participants in the Vingoe, (1995) and Wilson et al. (1986) studies did not reach a majority consensus about being unable to lie in hypnosis.

Opinions that hypnosis cannot be faked were expressed by students (Vingoe, 1995; Wilson et al., 1986), as well as rehabilitation and burn therapists (Bryant, 1993), but clinicians with knowledge of hypnosis (Northcott, 1996; Vingoe, 1995), as well as children (Fellows & Paintin, 1989), believed faking was entirely possible.

Students sampled by Daglish and Wright (1991) and Vingoe (1995), as well as cancer patients (Hendler & Redd, 1986), all endorsed the idea that "hypnosis can make you do things you would not normally do."

Finally, a commonly held attitude, up till the time when some major publicity about "false memories" was aired in the media, has been that hypnosis can increase memory capacity and accuracy. At least 90% of students (e.g., Daglish & Wright, 1991; McConkey & Jupp, 1985–1986) and hospital therapists supported this conception (Bryant, 1993). The sample of children in Fellows and Paintin's (1989) study were split in their opinions on this item. Psychotherapists in Yapko's (1994) study were divided in their opinions about the increased capacity of memory resulting from hypnosis, but tended to disagree with the suggestion that hypnotically obtained memories were inherently more accurate.

Attitudinal Factors

The diversity and volume of questions in the surveys relating to attitudes about hypnosis make comparisons a lengthy process. Some studies found

smaller dimensions, within their total questionnaire, that could help to identify and highlight factors that may predict hypnotic behaviour from attitudes. McConkey and Jupp's (1985–1986) analysis yielded factors that they labelled "time stands still" and "incorrect views." Spanos, Brett, Menary, and Cross (1987) identified three factors which they labelled "positive beliefs about hypnosis," "mental stability," and "low fear of hypnosis." Six dimensions have been suggested by Northcott (1996): "will," "weird," "transcend," "altered state of consciousness," "worth," and "cynical." Capafons' (2000) preliminary factors were labelled as "positive," "negative," and "magical beliefs towards hypnosis." Identifying common response patterns within such factors could assist in behaviour prediction.

Experience

Previous experience with hypnosis has been shown to have a strong effect on a person's attitude to hypnosis. Student samples show that actual personal experience with hypnosis ranged from 4% (Channon, 1984) to 10% (Daglish & Wright, 1991). Jan and Wagstaff (1994) found that students who had experienced a hypnotic induction before completing a rating of the likelihood of seeking hypnotherapy as a treatment were more likely to seek hypnosis as a therapy than students who experienced a hypnotic induction after rating treatment. Contrary to this, Hendler and Redd (1986) found that previous experience with hypnosis, for undergraduates and cancer patients, did not affect their belief in treatment outcome. When evaluating patient experience, Elkins and Wall (1996) found that 11% to 13% of their sampled patient population had previous experience with hypnosis, and that 29% to 33% of the population would accept hypnosis as a treatment if it was suggested.

Sources of Information

Also of interest in understanding attitudes to hypnosis are the sources from which a person has obtained their information about hypnosis. McConkey (1986) found that changes in attitude, from pre- to post-testing, could be attributed to participants' attendance at an information talk on hypnosis. Echterling and Whalen (1995) surveyed people who were classified as belonging to three groups: (a) those who had seen a stage hypnotist, (b) those who had viewed an information lecture on hypnosis, or (c) those who were in the control group (no exposure to, or information on, hypnosis). They found that any of the information sources increased positive evaluations of hypnosis, compared to controls who had no information about hypnosis.

It would appear that the majority of children gather their information about hypnosis via observations from films and television shows (Fellows & Paintin, 1989). Participants whose views were also sourced from television were anxious and worried about the prospect of being hypnotised (Large & James, 1991). McIntosh and Hawney (1983) observed that three-quarters of their participants had only one source of information for their views on hypnosis, but for those with more than one, at least 50% had more positive attitudes to hypnosis.

Rationale

A wide range of opinions about hypnosis have been shown to exist in patient and potential client populations. Previous research has assessed a broad range of attitudes to hypnosis and some of these have been argued to be misconceptions (see Discussion). It has been found that experience of, and information about, hypnosis alters attitudes to hypnosis.

The rationale for conducting this study then was to determine what attitudes and opinions, and particularly "misconceptions" about hypnosis (taken as those established as such by Nash, 2001, and Wagstaff, 1995, as utilised by other researchers across the world in their studies), exist in an Australian sample of the general public (not undergraduate university students); to use a diverse array of attitude items from previous research in order to find common, meaningful dimensions among attitudes to hypnosis; and to assess how the population differs in these attitudes and how sources of influence might better explain their attitudes to hypnosis.

Three hypotheses were tested. First, it was expected that the general public would endorse the previously mentioned opinions, including misconceptions, about hypnosis. Second, it was predicted that the large number of attitude items would be reducible to several smaller common dimensions that would describe attitudes to, and opinions about, hypnosis in a more parsimonious and useful way. Finally, it was expected that participant characteristics would be less important in explaining attitudes to hypnosis than experience of, and information about, hypnosis.

METHOD

Design

A survey was constructed to gather information pertaining to participants' background details, their experience with hypnosis and ratings of other

sources of influence, and their ratings on statements reflecting opinions about hypnosis.

The independent variables included five measures of participants' biographical details, as well as 12 independent variables that represented sources of information about hypnosis. The dependent variables are the 58 statements that convey attitudes to, and opinions about, hypnosis. To reduce the number of dependent variables, a principal components analysis and an exploratory factor analysis were used to extract a reduced number of interpretable factor components, which represented original variables.

Participants

A sample of 279 Australian adults (156 females and 123 males), who resided in the Brisbane metropolitan area, were recruited from four suburban locations that represented three different socioeconomic brackets (average individual incomes were in the ranges of $200–299, $300–399, and $400–499 per week) according to the Australian Bureau of Statistics (1998). The four suburbs were also selected on the basis that they were known to represent different social strata, as well as economic differences. Potential participants over the age of 18 years were identified at their place of residence and included in this study when verbal consent was received.

Materials

Biographical Details Participants' biographical information was requested in reference to their sex, age range, educational level, nationality, country of origin, and affiliations with religious groups or spirituality beliefs.

Sources of Influence Participants were requested to answer the question "Have you ever been hypnotised by a hypnotist?" with a "yes" or "no" response. They were also asked to rate the sources which had influenced their views of hypnosis, with a "most," "some," or "none" scale, for each of the following: television, movies, friends/family, stage hypnotists, lay hypnotists, state registered health professionals, non-registered health professionals, formal studies, novels/fiction, non-fiction books and magazines (see Johnson & Hauck, 1999).

Survey Items This study used an instrument containing 58 items taken from the published work of previous researchers who had studied various populations' beliefs, opinions, and attitudes towards hypnosis. The survey was

composed of items selected from the studies of McConkey and Jupp (1985–1986), Wilson et al. (1986), McConkey (1986), Spanos et al. (1987), Bryant (1993), Northcott (1996), and Johnson and Hauck (1999). The items selected were those that the researchers felt could be answered without previous experience of hypnosis, and in some cases were chosen from a number of questions that were similarly worded. The Appendix outlines the specific items taken from each of the published works and its corresponding item number in the current survey. The responses to the items were rated, using a 1 to 4 scale, with 1 representing "strongly agree," 2 representing "agree," 3 representing "disagree," and 4 representing "strongly disagree."

Misconceptions Because there has been some dispute in the literature (see Rainville et al., 1999, about proof of an altered state of hypnosis while in the hypnotic state) and on internet discussions about what constitutes a misconception of hypnosis, the items listed by the authors as misconceptions had been canvassed previously with members of the Hypnosis Maelstrom St Johns Edu list serve (2001) and only those that had received a majority of endorsement were categorised herein as misconceptions.

Procedure Researchers door-knocked in designated suburbs to recruit participants over several days, between the hours of 9 am and 7 pm. Upon giving consent, participants received a survey and were informed that the researchers would return to collect it in one week.

RESULTS

Descriptive Statistics

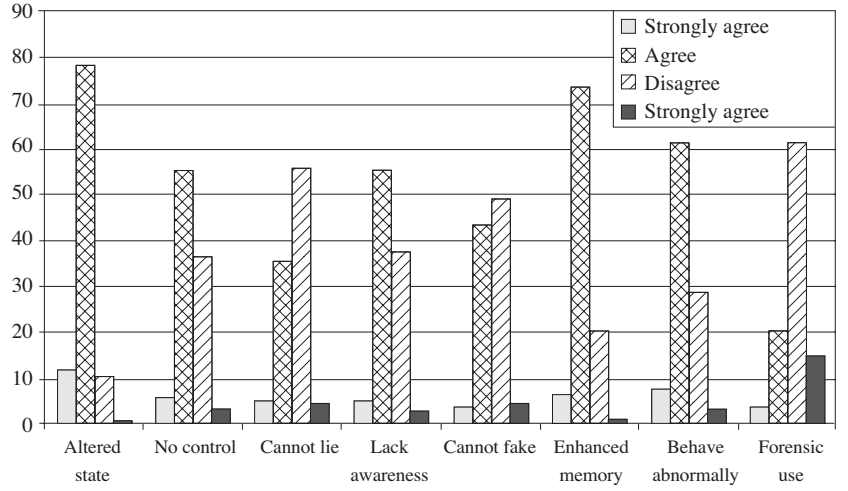
Biographical Details Fifty-six per cent of the sample were female; 55% of the sample were above 36 years of age; 58% of the sample had attempted some form of post-secondary education; 76% of participants stated that Australia was their country of origin; and 55% of the sample stated they had no religious affiliations or spiritual beliefs.

Sources of Influence Participants' ratings revealed that 30% to 74% of the sample claimed to have had at least some influence from the following sources on their opinions about hypnosis: television (74.2%), stage hypnotist (54.5%), movies (52.7%), friends/family (38.7%), magazines (38%), novels/fiction (31.2%), non-fiction (30.1%), while 11.5% of the sample had previously experienced hypnosis with a hypnotist.

Misconceptions The general public did endorse some common misconceptions about hypnosis. Figure 1 displays participants' ratings for eight items that are considered to be misconceptions about hypnosis as jointly indicated by Nash (2001) and Wagstaff (1995).

The majority of participants endorsed views of hypnosis as: an altered state of consciousness (89.5%), which makes subjects behave unusually (68.7%), where they have no control (60.8%), and experience enhanced memory capacity (79.5%). However they lack awareness within the hypnotic experience (60.1%). Participants were unsure about whether the hypnotic experience could be faked (46.8% agreement), but more disagreed (59.8%) than agreed that it was possible to lie in hypnosis and did not endorse (75.7% disagreement) putting more faith in hypnotically obtained witness testimony.

Figure 1: Percentages of Participants' Ratings on Items of Misconceptions About Hypnosis



Data Reduction for Further Analyses

The 58 survey items reflecting attitudes to, and opinions about, hypnosis were reduced and new variables were computed using factor analysis. As a first step, the data were subjected to a principal components analysis, which extracted 16 factors with Eigen values greater than one, and which accounted for 65.9% of the variance in the data. Bartlett's test of sphericity (5492.57, $p < .001$) and Kaiser's measure of sampling adequacy (.825) indicated that the data were

factorable. The factors were then rotated using Promax rotation, as there were several moderate correlations between factors (highest r = .54). Extraction of 11 factors with loadings greater than .34 yielded the most interpretable solution and were consistent with the previous literature. The 11 factors extracted accounted for 46.2% of the variance in the data. Item loadings and internal consistency coefficient alphas for each factor are shown in Table 1.

There were five complex variables in the solution: item 20, loading on Factor 2 and 5, conceptually belonged with Factor 2 – "Openness"; item 42, loading on Factors 9 and 11, conceptually belonged with Factor 11 – "Pain reduction"; item 43, loading on Factors 3 and 6, conceptually belonged with Factor 6 – "Client creates experience"; as well as item 44, loading on Factors 3 and 8; and item 58, loading on Factors 3 and 5, both conceptually belonged with other items on Factor 3 – "Hypnotist controls experience."

Items that did not load above .34 on any of the factors were: I am wary about becoming hypnotised because it means giving up my free will to the hypnotist; a deeply hypnotised person is robot-like and goes along automatically with whatever the hypnotist suggests; the extent to which hypnosis is successful depends on the skill of the hypnotist; hypnosis involves some sort of magic; hypnosis can heighten spirituality; a hypnotised person can lie if it is suggested that the truth has to be told; apparently genuine hypnotic behaviour is largely faked; all hypnosis is self-hypnosis; when hypnotised, a person's innermost thoughts/secrets can be found out by the hypnotist.

The final eleven factors were labelled respectively as: (1) Memory enhancement, (2) Openness, (3) Hypnotist controls experience, (4) Negative stereotypes, (5) Fear, (6) Client creates experience, (7) Cannot lie or fake, (8) Experienced by anyone, (9) Altered state, (10) Abnormal behaviour, and (11) Pain reduction.

MANOVAs

One-way MANOVAs were conducted for each of the independent variables to assess if there was a consistent effect across the 11 dependent factor variables and also to protect against increasing the Type I error rate. A Bonferroni adjustment was made for evaluating tests of significance on univariate ANOVAs.

Table 1: Factor Solution for Attitudes to Hypnosis

Factors	Factor loading	Coeff. alpha
Factor 1: Memory enhancement		.8
A witness should have more confidence in the accuracy of memories elicited by hypnosis than in those remembered while in the normal waking state	.84	
Jurors listening to a trial should have more faith in the testimony of someone who had been hypnotised as compared to that same testimony from someone who had not been hypnotised	.81	
Hypnosis is a good technique for police to use to refresh witnesses' memories	.64	
Hypnotically obtained memories are more accurate than just simply remembering	.59	
Material remembered during hypnosis is likely to be more accurate than material remembered outside hypnosis	.59	
Hypnosis increases one's level of certainty about the accuracy of one's memories.	.50	
People cannot lie under hypnosis	.50	
During hypnosis, subjects can be made to "remember" things that did not actually happen*	.36	
Factor 2: Openness		.87
I would like to become deeply hypnotised	.90	
I find the whole idea of becoming hypnotised an attractive prospect	.87	
I am totally open to being hypnotised	.77	
I would not mind being known as someone who can be deeply hypnotised	.74	
One's ability to be hypnotised is a sign of their creativity and inner strength	.46	
I feel that I could experience a deep hypnotic trance	.45	
I'm not afraid of becoming hypnotised	.35	
Factor 3: Hypnotist controls experience		.81
When a person is hypnotised the hypnotist has control of that person*	.61	
Hypnotised people can be made to do things against their will*	.43	
A person can come out of a hypnotic experience whenever they want to	.43	

When hypnotised, a person's innermost thoughts/secrets can be found out by the hypnotist*	.42	
Suggestions given during hypnosis cannot be resisted by subjects*	.34	
A hypnotised person is unaware of what is going on around him or her	-.85	
During hypnosis, responsive subjects are not conscious of their surroundings.	.72	
After being awakened, people tend to forget those things experienced while hypnotised	-.64	
When hypnotised, a person can be told to forget what they experience under hypnosis and they will forget	-.53	
Very deeply hypnotised people tend to forget things while they are hypnotised	-.40	
Factor 4: Negative stereotypes		.79
I wonder about the mental stability of those who become deeply hypnotised*	.80	
Those who are easily hypnotised are weak people*	.80	
Intelligent people are the least likely to get hypnotised*	.77	
Those who can become deeply hypnotised are as normal and well adjusted as anyone	.40	
Factor 5: Fear		.63
I have some apprehensions about hypnosis and being hypnotised*	.66	
I am wary about becoming hypnotised because it means giving up my free will to the hypnotist*	.61	
If someone attempted to hypnotise me, I would tend to hold myself back rather than let myself get carried away by the process*	.59	
I'm not afraid of becoming hypnotised	.38	
During hypnosis, responsive subjects are not conscious of their surroundings	.37	
Factor 6: Client creates experience		.63
Hypnotic experiences are created by the person's own imagination	.64	
All hypnosis is self-hypnosis	.60	
A person can come out of a hypnotic experience whenever they want to	.45	
Hypnosis is a normal state of consciousness that simply involves the focusing of attention	.40	

Factor 7: Cannot lie or fake		.62
Suggestions given during hypnosis can make subjects tell the truth about things that they would normally lie about	.63	
Apparently genuine hypnotic behaviour is largely faked*	.42	
Hypnosis can be faked such that even an experienced hypnotist could not detect the fake*	.40	
Hypnosis can be used to recover memories of actual events as far back as birth	.38	
Suggestions given during hypnosis can make subjects remember things that they could not normally remember	.35	
Factor 8: Experienced by anyone	.62	
Hypnosis can be experienced by everyone to similar degree, under the right circumstances	.72	
With a proper hypnotic induction, anyone can experience a deep hypnotic state	.52	
The extent to which hypnosis is successful depends on the skill of the hypnotist	.52	
When hypnotised, a person's innermost thoughts/secrets can be found out by the hypnotist*	-.39	
Factor 9: Altered state		.39
Hypnosis is an altered state of consciousness, quite different from normal waking consciousness	.54	
Hypnotised persons can undergo medical procedures without pain	.41	
Suggestions given during hypnosis can only make subjects insensitive to pain if the pain is "in their head"	-.44	
Factor 10: Abnormal behaviour		.35
A hypnotised person can lie if it is suggested that the truth has to be told*	.48	
Suggestions given during hypnosis can make subjects do things that they would not normally do*	.36	
Hypnosis increases an individual's suggestibility	-.45	
Factor 11: Pain reduction		.52
Suggestions given during hypnosis can make subjects insensitive to pain.	.70	
Hypnotised persons can undergo medical procedures without pain.	.47	

* refers to items that were reverse scored prior to factor analysis.

As a source of influence, television had a significant multivariate effect (Pillai's $F(22,534) = 3.06$, $p < .001$, $\eta^2 = .11$), but no univariate effects were significant. Other sources of influence, which included non-registered health professionals, non-fiction books and magazines, had significant multivariate effects, but due to the small sample sizes in the "most" category, the "most" and "some" categories had to be collapsed together ("At least some") to establish where the between groups differences were.

It is important to note that low scores, rather than high scores, on initial attitude statements reflected a positive view of hypnosis outcome. Also some factor items were reverse scored (see Table 1).

Table 2 outlines only the factor score means which were significantly different from one another between levels of the biographical details and sources of influence variables. For example, 26–35-year-olds scored significantly lower than the over-66-year-olds on the factor "Openness," reflecting a more open attitude to hypnosis for the 26–35-year-old group. However, for the negatively labeled factor "hypnotist controls experience," 36-45-year-olds scored significantly lower than the over-66-year-olds, but as the item was reverse scored, this reflects less agreement with this factor for the 36–45 year olds.

Regression Analyses

Eleven hierarchical regression analyses (Table 3 refers) were employed to determine if the addition of participant information regarding their sources of influence about hypnosis improved prediction of factorial attitude scores beyond that afforded by differences in biographical details. For five of the factor variables, biographical details, although small, were significant linear regression predictors, explaining between 3.9% to 7.2% of the variance, while sources of influence were significant on eight, explaining between 4.4% to 14.4% variance in addition to that contributed by biographical details. Table 4 displays the regression statistics for portions of variance in factorial variables accounted for by these independent variable groups.

DISCUSSION

The first hypothesis that the general public would endorse "misconceptions" about hypnosis was supported on most of the relevant items. The Brisbane sample had a high level of agreement with the designated misconceptions of hypnosis as an altered state and in its memory enhancement capacity.

Table 2: Factor Means, Standard Deviations and Effect Size for Levels of Biographical Details and Sources of Influence with significant (Post Hoc) Differences

	Mean	*SD*	η^2
Factor 2: Openness			
Age — 26–35 years	11.72[a]	3.28	
Age — 66+ years	14.08[b]	2.47	.08
Experience — "Yes"	10.51[a]	3.37	
Experience — "No"	13.04[b]	2.91	.07
State registered health professional — "Most"	10.43[a]	3.14	
State registered health professional — "Some"	11.40[a]	3.21	
State registered health professional — "None"	13.16[b]	2.90	.08
Non-registered health professional — "At least some"	9.94[a]	3.55	
Non-registered health professional — "None"	12.95[b]	2.94	.06
Non-fiction books — "At least some"	11.81[a]	3.13	
Non-fiction books —"None"	13.16[b]	2.96	.04
Magazines —"At least some"	11.83[a]	3.18	
Magazines —"None"	13.32[b]	2.87	.06
Factor 3: Hypnotist controls experience			
Age — 36–45 years	-2.50[a]	2.03	
Age — 66+ years	-.44b	1.66	.08
Experience — "Yes"	-2.85[a]	2.37	
Experience — "No"	-1.60[b]	1.92	.04
State registered health professional — "Most"	-3.30[a]	2.13	
State registered health professional — "None"	-1.58[b]	1.92	.04
Factor 4: Negative stereotypes			
Experience — "Yes"	4.55[a]	1.28	
Experience — "No"	5.44[b]	1.55	.03
Friends/family — "Most"	4.51[a]	1.42	
Friends/family — "None"	5.60[b]	1.56	.05
Factor 5: Fear			
Experience — "Yes"	6.15[a]	1.46	
Experience — "No"	7.13[b]	1.27	.06
Factor 7: Cannot lie or fake			
Magazines — "At least some"	4.79[a]	.88	
Magazines — "None"	5.76[b]	.75	.07

Factor 9: Altered state			
State registered health professional — "Most"	.47[a]	.65	
State registered health professional — "None"	.98[b]	.50	.06
Factor 10: Abnormal behaviour			
Stage Hypnotist — "Most"	1.30[a]	.51	
Stage Hypnotist — "None"	1.02[b]	.47	.04
Factor 11: Pain reduction			
Non-fiction books — "At least some"	2.72[a]	.60	
Non-fiction books — "None"	3.03[b]	.58	.06

Note: Means sharing same superscripts (a, b) are not significantly different.
Bonferroni adjustment $p < .05/11$; i.e., $p < .0045$.

Eighty-nine percent of the sample agreed that hypnosis is an altered state of consciousness, similar to samples of Scottish (Daglish & Wright, 1991) and Australian students (McConkey & Jupp, 1985–1986). Furthermore, 79% of respondents endorsed the memory enhancement capacity of hypnosis, a similar response rate to that of rehabilitation and burn therapists (Bryant, 1993). In contrast to this, 76% of respondents disagreed with using hypnosis in a forensic setting, even though they believed it could enhance memory.

Respondents agreed moderately with misconceptions of being unaware of one's surroundings in hypnosis (89.5%), as have previous clients (Elkins & Wall, 1996) and students (Wilson et al., 1986); having no control in hypnosis (60.8%), which was not as strongly expressed as the opinion of prior undergraduate samples (Capafons, 2000;Vingoe, 1995); and that the hypnotist could make you behave abnormally (68.7%), a lower response rate than previous British (Vingoe, 1995) and Scottish students (Daglish & Wright, 1991). There was a moderate level of disagreement with the opinion that you cannot lie in hypnosis (59.8%), which is also the position taken by clinicians in earlier studies (Northcott, 1996; Yapko, 1994). It would seem that while respondents believed in the memory enhancement capacity of hypnosis, they did not see it as a truth formula and so did not think hypnotic testimony should receive more weight in a forensic setting. Respondents did not particularly agree or disagree with the statement that you cannot fake the hypnotic experience (46.8 %).

Table 3: Statistics for Significant Regression Analyses of Factor Variables With Biographical Details Entered in Model 1 and Sources of Influence Added in Model 2

	Sig.	*R*	R^2	Adj. R^2
Memory enhancement				
Model 1 $F(5,273) = 2.23$	.052	.198	.039	.022
Model 2 $F(17,261) = 2.17$	.006	.351	.123	.066
Openness to experience				
Model 1 $F(5,273) = 5.34$	.000	.299	.089	.072
Model 2 $F(17,261) = 5.49$	.000	.513	.263	.216
Hypnotist controls experience				
Model 1 $F(5,273) = 3.57$	.004	.248	.061	.044
Model 2 $F(17,261) = 2.79$	.000	.382	.154	.099
Negative stereotypes				
Model 1 $F(5,273) = 3.28$	.007	.238	.057	.039
Model 2 $F(17,261) = 2.68$	.000	.386	.149	.093
Fear				
Model 1 $F(5,273) = 3.69$	.003	.252	.063	.046
Model 2 $F(17,261) = 3.76$	.000	.444	.197	.144
Cannot lie or fake				
Model 1 $F(5,273) = 1.25$	.285	.150	.022	.005
Model 2 $F(17,261) = 2.78$	.000	.392	.154	.098
Altered state				
Model 1 $F(5,273) = 4.42$	.001	.274	.075	.058
Model 2 $F(17,261) = 3.25$	.000	.418	.175	.121
Pain reduction				
Model 1 $F(5,273) = 1.28$	.272	.151	.023	.005
Model 2 $F(17,261) = 2.97$	.000	.402	.162	.107

The factors "Client creates experience," "Experienced by anyone," and "Abnormal behaviour" did not result in regressions that were significantly different from zero. Of the eight significant linear regression equations, the largest significant beta weights were for the variables of age, sex of participants, experience, magazines and television. Table 4 highlights the beta weights for all of the unique predictors within the eight significant factor variables.

Table 4: Beta Weights and Squared Semi-Partial Correlations for Significant Bivariate Predictors in Each of the Factor Variable Regression Equations

	β	Sig.	sr^2
Memory enhancement			
Education level	.170	.009	.153
Friends/family	-.137	.030	-.127
Magazines	.281	.001	.198
Openness to experience			
Age range	.164	.010	.137
Education level	.093	.040	.110
Religious affiliation or spiritual beliefs	.369	.003	-.158
Experience	.571	.000	.192
Friends/family	.119	.039	.110
State registered health professional	.359	.012	.134
Novels/fiction	.399	.008	.018
Hypnotist controls experience			
Age range	.183	.008	.153
Experience	.150	.019	.134
Television	.214	.035	-.121
Negative stereotypes			
Sex	.156	.010	.148
Friends/family	.147	.017	.137
Fear			
Education level	.146	.019	.131
Religious affiliation or spiritual beliefs	.172	.003	-.164
Experience	.223	.000	.199
Novels/fiction	.198	.004	.160
Cannot lie or fake			
Magazines	.205	.003	.169
Altered state			
Age range	-.301	.000	-.253
Education level	-.147	.019	-.133
Friends/family	.172	.005	.159
State registered health professional	.225	.001	.181
Pain reduction			
Age range	-.265	.000	-.223
Non-fiction books	.183	.009	.149

The vast majority of responses were in either the "Agree" or "Disagree" categories, and very few participants endorsed the "Strongly agree" or "Strongly disagree" opinions. Furthermore, there was an average of 7.1% missing values for the attitude statements, most likely due to the survey not having a "Neither" or "I don't know" option for participants. However, as debated by Northcott (1996) and researchers and participants on the Hypnosis Maelstrom St Johns Edu list serve (2001), and because attitude statements can be both correct and incorrect depending on the context, having included an "I don't know" option would not have usefully separated these two categories.

As shown in Table 2, there were only three sources of information about hypnosis that the majority of respondents endorsed as having had at least "some" influence on their opinions of hypnosis: television, stage hypnotist, and movies. While television is a medium for news, current affairs and documentaries, to a large extent, it is a source of entertainment, as are stage hypnosis shows and movies. Therefore, many participants have probably witnessed aspects of hypnosis that are likely to be entertaining, such as people being made to behave out of character. Fewer participants have had contact with clinicians, read non-fiction publications, or experienced hypnosis, all of which would provide information about the use of hypnosis in therapy (see Capafons, 2006, for an overview).

Factor Analytic Solution

In answering the second hypothesis, attitude statements were reduced to 11 underlying factors to represent the opinions of hypnosis. These factors allowed a streamlined interpretation of the general public's attitudes and comparison with participants' biographical details and their sources of influence. Eight of the 11 factors had moderate to high reliability and the lower reliability of the last three factors (altered state, abnormal behaviour, and pain reduction) coincided with having only a few statements loading onto them.

The factor solution did find that several misconceptions (see Nash, 2001; Wagstaff, 1995) formed reliable factors: memory enhancement, hypnotist controls experience, and cannot lie or fake. Some of the factors found in this solution support previous research by Spanos et al (1987). Nearly all of the items from these researchers loaded onto factors similar to their initial study. The Spanos et al. factor label of "positive beliefs about hypnosis" corresponds with "Openness"; "mental stability" is similar to the current "Negative stereotypes," and "low fear of hypnosis" has been labelled "Fear" in this factor solution.

Future analyses of the robustness of this factor solution would hopefully involve using a larger sample size, increasing the number of relevant factor items, particularly on the last three factors, and possibly removing complex variables to reduce correlations between factors.

Interpreting Attitudes Using Biographical Details and Sources of Influence

As hypothesised, sources of influence were more useful than biographical details in explaining differences in attitudes to hypnosis. Age had a significant effect on attitudes to hypnosis, with the over-66-year-olds holding the opinion that the hypnotist controls the experience, and being less open to experiencing hypnosis than some of the younger age groups. This older age group may not have been exposed to the information about the therapeutic uses of hypnosis.

Compared to those who had no experience of hypnosis, personal experience of it created a more open attitude to it. It reduced the extent to which the public held (a) the opinion that the hypnotist controls the experience, (b) negative stereotypes about those who could experience hypnosis, and (c) the opinion that it should be feared. Having been in contact with a state registered (licensed) or non-licensed health professional also created a more open attitude to hypnosis, while those who were most influenced by a state licensed health professional thought hypnosis to be an altered state, but were less of the opinion that the hypnotist controls the experience, compared to those who had no contact from such professionals. While hypnosis does not have to be an altered state of consciousness, this sample's opinion that it can be experienced as such contributed to their also having a positive attitude to hypnosis on other factors.

Participants who had been mostly influenced by a stage hypnotist were more of the opinion that hypnosis could create abnormal behaviour than those who had no such influence. It would seem that contact with a therapeutic practitioner is useful for enhancing understanding of the processes involved in hypnosis and reducing misconceptions.

The influence of friends and family helped to reduce negative stereotypes about those who can experience hypnosis, which is understandable, as generally we would think about the people close to us and their behaviours or interests in a positive way. Reading materials, such as non-fiction books and magazines, increased openness to experiencing hypnosis. The act of having

read non-fiction books increased conviction in the therapeutic use of hypnosis to reduce pain, whereas having read magazines increased the likelihood of holding misconceptions that one cannot lie, or fake, in hypnosis. Having more information about hypnosis appeared to increase openness, but the quality of the source fuelled misconceptions.

While many of these differences were meaningful and enhanced our understanding about attitudes to hypnosis, the effect sizes of these differences were smaller than anticipated. However, the results of the regression analyses did assist in interpreting the overall influences of participants' biographical details and their sources of influence on the attitude factors. Media and entertainment variables were the largest unique predictors for the misconceptions about memory enhancement: that the hypnotist controls the experience and that subjects cannot lie or fake in hypnosis. Age was the largest, but negative, unique predictor for the opinion that hypnosis is an altered state of consciousness.

Variables that did not produce significant differences on mean factor scores across their levels, but did contribute something unique to the explanation of factorial attitudes to hypnosis, were: memory enhancement — education and family/friends; openness — education, religious affiliation, family/friends and novels/fiction; negative stereotypes — sex; fear — education, religion and novels/fiction; altered state — education and family/friends and pain reduction — age.

Studies that have directly tested the influence of providing a source of information about hypnosis have found that attitudes become more positive from pre- to post-testing (McConkey, 1986) or compared to the attitudes of controls (Echterling & Whalen, 1995). Johnson and Hauck (1999) measured the influence of a variety of sources of information, for several groups within the general public, but did not test whether source variables contributed to attitude differences between groups. This study has shown that demographic variables contribute only a small amount of variance in attitude factors for the general public, half the amount contributed by sources of influence. Entertainment variables such as television, magazines and stage hypnotists helped to explain attitudes that were misconceptions about hypnosis, while credible sources such as health professional and non-fiction books helped to promote hypnosis as a therapy.

CONCLUSION

Broadly speaking then, it does seem that this one section of the Australian general public continues to view hypnosis as either a tool used by a controlling hypnotist, a form of entertainment where people are made to behave out of character, or as a form of therapy, perhaps for pain reduction. Because the participants' biographical details and their sources of influence on hypnosis accounted for only 21.6% of the variance in attitude scores, there is a need for further research to find what other values or experiences people may have that account for their attitudes to hypnosis.

While this study has enhanced our understanding in the area of opinions about hypnosis within the general public, by assessing how attitudes relate to potential sources of influence, the authors conclude that the researchers on attitudes and opinions about hypnosis across the world need to agree on what constitutes misconceptions or at least negative or positive attitudes towards hypnosis and conduct cross national studies in this area.

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APPENDIX

Original Sources of Items Used in the Current Survey

Researchers	Original item numbers	Current item numbers
Spanos, Brett, Menary, & Cross (1987)	1–14	9–22
Wilson, Greene, & Loftus (1986)	1–13	23–25
Northcott (1996)	28, 45, 46	36–38
Johnson & Hauck (1999)	2, 6, 8–11, 14–17, 19–22	39–53
Bryant (1993)	20	54
McConkey (1986)	1, 2, 15–19, 21	55, 56, 58–63
McConkey & Jupp (1985–1986)	3, 5	66, 57
McConkey & Jupp (1985)	3, 4	64, 65

Note: Items 1–8 relates to biographical questions and sources of influences.

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The Place of Hypnosis in Psychiatry: Its Applications in Treating Anxiety Disorders and Sleep Disturbances

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"I do not generally view hypnosis as the therapeutic agent, but rather as the catalyst for communicating therapeutic ideas or facilitating therapeutic experiences."

This is the view of Yapko (1993), which endorses our view of the role of hypnosis in the treatment of emotional disorders. Hypnotherapy can be used extensively for a wide range of conditions in the field of psychiatry: It is valuable for the treatment of anxiety disorders, sleep disturbances, eating disorders, depression, psychosexual disorders, addictions, and particularly, in the treatment of phobic disorders (Waxman, 1980). Hypnotherapy is advantageous, as it allows patients to face their fears in a relaxed and safe environment; in hypnotherapy, patients are able to explore problem areas together with the therapist (Kraft, 2000). The purpose of this article is to focus on the treatment of anxiety disorders, including obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD), and a range of sleep disturbances.

ANXIETY DISORDERS

Anxiety disorders, according to DSM-IV (American Psychiatric Association, 1994), may be considered under the following six major categories:

1. Panic disorder (with and without agoraphobia),
2. Specific phobia (replacing simple phobia),

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3. Social phobia,
4. Obsessive-compulsive disorder,
5. Generalised anxiety disorder, and
6. Post-traumatic stress disorder.

These disorders will be elaborated now and the role of hypnosis in their treatment considered.

Panic Disorder (With or Without Agoraphobia)

Patients suffering from panic disorder, with or without agoraphobia, experience high levels of anxiety associated with a "fear of fear," loss of control, a fear of dying, and a dread that they might go mad (Evans & Coman, 2003). These patients describe a wide variety of symptoms which include chest pain, hyperventilation and parasthesia, faintness, dizziness, and in some cases, depersonalisation.

Hypnotherapy is valuable when treating this disorder, as patients can be encouraged firstly to experience a safe place where they are free from anxiety, and where they feel secure (Callow, 2003). The safe place can either be an imaginary situation or a real one; and it can be a scene from the past, present, or future. Although beach settings are frequently chosen by patients, there is a wide range of possible scenes and, invariably, patients visualise being on their own.

Once the patient is comfortable and relaxed in the safe place, one can explore situations which give rise to panic. When the anxiety level starts to cause distress, the patient is returned to the safe place.

Patients who suffer from agoraphobia have complex disturbances in which control is a central feature (Salzman, 1982). It is not possible to treat agoraphobic patients using a simple behavioural approach with hypnotherapy. The therapist must focus on, and gradually introduce the patients to, the concept that the family dynamics must be changed in order for them to recover from the agoraphobia. This involves the use of psychoanalytically oriented psychotherapy, which should be used in conjunction with the hypnotherapy (Kraft, 1976). It is frequently found that the agoraphobia is a function of the whole family dynamics and that high levels of hostility exist in the family.

The hypnotherapy concentrates on the behavioural therapy which, in turn, focuses on increasing the patients' mobility — that is to say, the distance that they are able to move from their home. It is extremely important that patients

actually go into the outside world; this, in turn, gives rise to insights into the nature of the disorder. In hypnosis, systematic desensitisation is employed; at first, patients visualise walking a few steps to the pillar box and then to the local shops and, later on, they are encouraged to drive their car. The whole process of mobilising agoraphobic patients is an extremely difficult one and requires a great deal of patience. The desensitisation can be carried out in the hypnotherapy or, alternatively, patients may prefer to be accompanied by the therapist — on walks, going into department stores using the lifts and escalators, using trains and buses — and this process is referred to as in vivo desensitisation (Kraft, 1975).

Specific Phobias

A specific phobia is applied to any circumscribed fear reaction which is capable of causing severe distress and avoidance behaviour. Most commonly, people are afraid of animals — dogs, cats, snakes (Horowitz, 1970), spiders, dead birds (Van der Hart, 1981), and mice. Other specific phobias include fear of heights, enclosed spaces, injections (Kraft, 1984), heat (Kraft & Al-Issa,1965), flying and driving phobia (Kraft & Kraft, 2004). In all of these specific phobias, the patient is asked to imagine the feared situation in the form of a graded stimulus hierarchy, starting from relatively simple situations to the most complicated; in addition, the patient must experience the feared situation outside the consulting room.

Patients suffering from arachnophobia should be encouraged initially to look at diagrams of spiders in a children's book; once this has been achieved, the next stage is to look at photographs of real spiders, and then to handle toy spiders of varying sizes, followed by the handling of real dead spiders. The final stage is to handle (non-venomous) live spiders. Ideally, patients should be able to cope with a spider running over their hands; but, frequently, patients will terminate the therapy before this stage has been reached.

Social Phobias

Patients who suffer from social phobia develop a variety of symptoms in social situations. They experience a feeling of distress when being faced with certain social situations and this can often lead to complete avoidance. Often, the patients suffer from blushing, trembling, tachycardia, and excessive sweating. Symptoms frequently arise in adolescence, but they can often be traced back to childhood events where the patients have experienced feelings

of embarrassment either in the classroom situation or at home. Some patients develop such a severe amount of sweating that they can literally wring out their clothing after being in a social situation — this is referred to as hyperhidrosis (Kraft, 1985). Young people often find that alcohol is an effective way of counteracting social anxiety and it may become increasingly tempting for them to use this as a form of self-medication; in fact, it has been the first author's experience that social anxiety is invariably the underlying cause of excessive alcohol intake (Kraft, 1971).

Systematic desensitisation is an excellent method of treating patients with social phobias. At first, patients are encouraged to imagine relatively simple social situations; they then move on to more difficult scenarios which become increasingly more challenging. Again, if the patients show any distress during the hypnosis, they are immediately returned to the safe place. Interestingly, they are frequently surprised that symptoms, which have proved crippling over many years, can be resolved in this way.

Whether the predominant symptom of the social phobia is apprehension, trembling, blushing, or excessive sweating, the treatment approach is very similar. The emphasis, in all cases, is to reduce the anxiety in social situations: This allows the patients to have greater freedom of movement, generally more self-esteem, and the confidence to interact with other people. During the treatment, patients frequently become aware of the underlying psychodynamic factors which gave rise to the symptoms (Wachtel, 1987).

Performance anxiety is a sub-group of social phobia in which patients have a marked and persistent fear of one or more social or "performance" situations; this often occurs when patients are exposed to unfamiliar people, or when they are subjected to scrutiny by others (DSM-IV, 1994). While the most common form of performance anxiety is public speaking, there are many other areas; these include actors who are frightened that they might forget their lines, musicians who are afraid of making mistakes, and athletes who worry about being beaten in contests (Lazarus & Abramovitz, 2004).

Lazarus and Abramovitz (2004) give a detailed account of a 30-year-old violinist (first violinist) who led a prestigious orchestra and, having enjoyed a promising career, developed a crippling performance anxiety which could well have put an end to his career. In the early stages of therapy, systematic desensitisation was used as the sole treatment strategy. Little progress was made in the therapy, until he was encouraged to bring his violin into the consulting room. The therapist asked him to play a series of pieces, starting with the easiest and working to the most difficult, while the patient chose appropriate

pieces forming a graded hierarchy. A turning point in the therapy occurred when he played the first violin part to a record of Mozart's *Linz Symphony*. After 20 sessions, he made a complete recovery and this was maintained. This case underlines the importance of incorporating live performance into the treatment session. Patients who are afraid of public speaking are encouraged to rehearse the speech in the treatment session, first in hypnosis and then without the use of hypnosis. Singers who are frightened of performing in public are encouraged to bring in *Minus One* tapes so that they can sing along with the recording — again this is done first with the assistance of hypnosis, and then, subsequently, without the use of hypnosis.

Obsessive-Compulsive Disorder

An extensive search carried out by the Royal Society of Medicine has shown that there are very few papers written on the use of hypnotherapy for the treatment of obsessive-compulsive disorder (OCD), although there are a few case reports.

OCD is characterised by uncontrollable, intrusive thoughts and actions that, as far as the patients are concerned, can only be alleviated by patterns of rigid and ceremonial behaviour (DSM-IV). One of the important features of this disorder is that patients are well aware that these thoughts and actions are irrational, but feel that they are unable to resist them. It can take the form of excessive ruminations or compulsive behaviour which may include continuous hand washing, checking of locks, gas taps, water taps and plugs; all of these may be associated with highly complex rituals. Patients are often obsessively anxious about dirt, contamination, flooding, germs, or a fear of real or imagined traumas (DSM-IV). If the patients are interrupted while carrying out a ritual, or if they make a mistake, then the whole sequence has to be repeated once more from the beginning.

If the main symptom of OCD consists of obsessive rumination, a technique which is extremely helpful is one of "thought-stopping." Here, the patient is encouraged in the hypnotherapy session to focus on the obsessional thought; next, the therapist forcibly says the word, "stop." At this point, the patient is encouraged deliberately to think of something else, thus interrupting the obsessive pathway. This technique was used in the case of a 12-year-old boy who had repetitive matricidal thoughts (Kellerman, 1981). Over a period of 10 weeks, the patient made a complete recovery after receiving six treatment sessions.

A 32-year-old married woman was plagued by obsessive sexual thoughts about Jesus and the Virgin Mary: At church, she was unable to concentrate properly on the service because these intrusions. The treatment strategy here was to rehearse the whole church service without any sexual overtones, and this was achieved in hypnosis (Kraft & Kraft, 2005). After 21 hypnosis sessions, she told me that she was able to attend church services without any intrusion of a sexual nature.

An interesting approach to the treatment of OCD is a technique referred to as "split-screen imagery." This was illustrated by a single case study of a disturbed 18-year-old girl who feared that she might use a knife in order to kill her parents. In hypnosis, the patient was asked to divide a screen into two halves: On the one side, she was encouraged to visualise a knife, and on the other half of the screen she was asked to imagine flowers. The rationale of the treatment was that the flowers should neutralise the harmful thoughts that she had in relation to the knife. It has been established that nature scenes are particularly helpful in this respect, because they are capable of evoking nourishing associations and are able to reduce feelings of isolation and loneliness (Ahsen, 1977). In this way, she felt that she had control over the sharp instrument and could choose what to do with it. This form of treatment is particularly helpful for younger patients who watch a great deal of television (Taylor, 1985).

Another technique which has been used successfully in the treatment of OCD involves flooding the patient with situations which are regarded by the patient as being contaminated. An example of this technique is that of a 47-year-old housewife who was plagued by contamination fears to the extent that she had to wash her hands 250 times a day, and had to clean her house almost constantly (Scrignar, 1981). The only time when she felt relatively calm was when she was lying in bed wearing a freshly laundered night-dress. In hypnosis, the therapist instructed her to touch all the objects which she felt were contaminated, and she was told that no harm would come to her. Although the patient was very distressed during the course of the sessions, she made a successful recovery and maintained her improvement for two years.

General Anxiety Disorder

Patients who have been diagnosed as having generalised anxiety disorder complain about a variety of symptoms which include an excessive worry about a whole range of events in their lives, often coupled with feelings of fatigue, lack of concentration, and a general sense of weariness. Frequently,

these patients show anticipatory anxiety in relation to a wide variety of life events and often they go to their general practitioners to obtain tranquilisers such as Diazepam or antidepressant drugs such as Fluoxetine. The problem arises when the general practitioner either refuses to continue prescribing these drugs or when the patients decide to stop taking the medication.

Patients with generalised anxiety disorder may benefit considerably from hypnotherapy: The treatment can involve focusing on specific anxiety-provoking situations, free association, or a combination of these two approaches. The great advantage of self-hypnosis is that it gives the patients a feeling that they are in control of the problem, rather than being at the mercy of their symptoms.

Post-Traumatic Stress Disorder (PTSD)

This term was introduced into the psychiatric literature in 1980. Previously, there had been several other terms used, such as traumatic syndrome (Seguin, 1890), shellshock, gross stress reaction, and combat neurosis (Kennedy & Duff, 2001). *The Diagnostic and Statistical Manual of Mental Disorders* (APA, 1994) defines PTSD as a collection of symptoms which develop after exposure to a traumatic event that "involves actual or threatened death or serious injury, or other threat to one's physical integrity." PTSD may occur following combat (Brende, 1985), rape (Spiegel, 1989), child abuse, domestic violence, accidents (Mutter, 1987), terrorism, disaster (De Silva, 1999), and torture. The symptom complex of PTSD may include a number of these features: intrusive imagery associated with flashbacks, nightmares, a heightened arousal and startle response, phobic avoidance of situations reminiscent of the original trauma, and in some cases, emotional numbness and fugue states (Degun-Mather, 2001).

It is widely recognised that patients who suffer from PTSD show high hypnotisability and there are many studies which support this finding (Evans & Coman, 2003; Hollander & Bender, 2001).

The aim of hypnotherapy is to ensure that patients re-experience all the components of the original traumatic incident. This may be achieved by ensuring that the patients feel totally secure in the treatment situation in their safe place. Although some patients find it difficult to understand why the therapy should involve returning to the original trauma, it is central to the recovery process. At the end of each session, the therapist must ensure that the patient's anxiety level is relatively low, so that the patient's fear, connected with the original trauma, is reduced (Evans & Coman, 2003).

SLEEP DISORDERS

According to the *International Classification of Sleep Disorders* (ICSD, revised; American Sleep Disorders Association, 1997), sleeping disorders can be divided into four categories: (a) dyssomnias; (b) parasomnias; (c) sleep disorders associated with mental, neurological, or other medical disorders; and (d) proposed sleep disorders.

The term dyssomnia refers to any condition which involves either difficulty in initiating or maintaining sleep, or excessive sleeping (ICSD, 1997). According to the ICSD, there are 88 sleep disorders in all, and in this article a number of these will be reviewed. The term "insomnia" has now been replaced with the term "dyssomnia" as insomnia literally means "no sleep," which is a rare phenomenon (Becker, 1993). Dyssomnias are divided into three main categories: (a) intrinsic sleep disorders, which originate within the body, such as idiopathic insomnia, narcolepsy, obstructive sleep apnoea syndrome, and restless legs syndrome; (b) extrinsic sleep disorders, which originate outside the body, such as altitude sleep disorder or alcohol-dependent sleep disorder; and (c) circadian-rhythm sleep disorders which include shift work sleep disorder and time zone change (jet lag) syndrome.

Parasomnias are conditions which are primarily associated with arousal, partial arousal and sleep-stage transition which interfere with sleep (ICSD, 1997). These are divided into four main groups: (a) arousal disorders, which include sleepwalking (somnambulism) and night terrors; (b) sleep-wake transition disorders, for example, sleep talking and nocturnal cramps, (c) parasomnias usually associated with REM sleep, such as nightmares, sleep paralysis; and, finally, (d) "other parasomnias" which include sleep bruxism and enuresis.

Where the sleep disorder is associated with major psychiatric illness or neurological disorders, the primary focus of attention must be directed first and foremost to the underlying condition. If the sleep disturbance persists after the underlying condition has been satisfactorily treated, then hypnotherapy may be considered to correct the sleep disturbance.

Proposed sleep disorders are disorders which had not been classified until the 2005 edition of the *International Classification of Sleep Disorders*. These include sleep-related laryngospasm, terrifying hypnagogic hallucinations, sleep hyperhidrosis, and menstrual associated sleep disorder.

The Use of Hypnotherapy in the Treatment of Initiating or Maintaining Sleep/Dyssomnias

In the younger age group, the problem is usually one of difficulty getting off to sleep (onset insomnia), whereas, in the over 50 age group, the most frequent problems are interrupted sleep and early morning awakenings (Kales & Kales, 1984). In order to qualify as a sleep disorder, the patient must experience difficulties for a minimum of three nights per week, continuing for more than one month.

Nielson (1990) describes two male patients with whom he uses an integrative approach combining psychodynamic principles with the use of hypnotherapy. The first patient, aged 30, had onset insomnia, while the second, aged 40, suffered from early morning awakenings. The treatment approach was similar in both cases, in that it combined brief psycho-dynamically oriented psychotherapy with hypnotherapy. The aim of the psychotherapy was to focus attention on the emotional factors which were responsible for the sleep problem, whereas the hypnotherapy was directed towards helping them get to sleep. In the hypnotherapy, these patients were encouraged to visualise scenes which were pleasant and comfortable; and, during the hypnosis, they were told that they would be able to conjure up these scenes whenever they chose to do so. The therapist encouraged them to practise self-hypnosis twice a day, especially at bed-time. Both patients found that not only had their target symptoms (the sleep disorders) improved, but also there was a marked change in their general well-being; they were less irritable, more relaxed, and were able to enjoy their leisure activities.

Scholz and Ott (2000) examined the efficacy of hypnotherapeutic audiotapes with 21 subjects who had suffered from chronic insomnia for several years. They prepared lengthy audiotapes in which they made indirect suggestions of relaxation and sleep. The researchers introduced two main characters: One was referred to as the "protagonist" and the other the "antagonist." The message was that the person who was able to achieve relaxation and sleep adequately (the protagonist) was also able to perform more competently in his daily life; the second person (the antagonist), who had difficulty sleeping, found that he was lethargic during the day and performed his daily tasks less adequately. The patients were required to listen to these lengthy and repetitive tapes in order to induce sleep.

Another technique used in hypnotherapy involves the patient drawing an imaginary circle on the blackboard and inserting the number 100. Next,

the patient is instructed to imagine the words DEEP SLEEP, erasing the number 100 and replacing it with the number 99. This process is repeated by subtracting one number, one at a time, until the patient is asleep (Bauer and McCanne, 1980; Becker, 1993). In the two cases described, both patients found that this was an extremely effective method of achieving sleep; and, at one year follow-up, their improvement was maintained.

Narcoleptic Tetrad

Narcolepsy is a disorder which is characterised by repeated episodes of sleep and overwhelming urges to lapse into sleep during the day. Sleep periods often last less than one hour; the patient feels refreshed on waking, only to lapse into further sleep two or three hours later. Interestingly, it has been established that narcoleptic patients move directly into REM sleep without entering the previous stages of sleep (Maron, Rechtschaffen, & Wolpert, 1964). Often, these periods of sleep occur in circumstances where there is no active participation, such as attending a lecture, listening to music, watching a play, or travelling on a train; but they may also occur while driving, eating, or when holding an active conversation. It is frequently found that patients who suffer from narcolepsy may have one or other of the following conditions: cataplexy, sleep paralysis, and/or hypnagogic hallucinations. This is often referred to as the narcoleptic tetrad.

Cataplexy, a characteristic and unique feature of narcolepsy, involves the rapid loss of bilateral muscle tone in response to high states of emotion — particularly laughter and elation — but may also be precipitated by anger. The frequency of cataplectic attacks increases with sleep deprivation. In cataplexy, the episodes are often brief — ranging from 1 to 10 seconds — although episodes can last up to one minute (Price, 1987): During a cataplectic attack, the patient remains conscious and the loss of muscle tone varies from a slight weakness or head droop to complete postural collapse.

Sleep paralysis, which is a frequent concomitant of narcolepsy, is a frightening experience in which the patient is unable to move all muscle groups and is unable to speak; in some cases, patients fear that they are unable to breathe (ICSD, 1997). In addition, the intensity of this experience may be increased by vivid hypnagogic hallucinations.

Schneck (1980) reports the successful treatment of a 40-year-old lady who had frequent episodes of uncontrolled sleep. In the first phase of the hypnotherapy, the patient was given suggestions of wakefulness and alertness at times when the she felt irresistible urges to go to sleep during the day. As this

was only partially successful, the therapist gave her post-hypnotic suggestions that when she was feeling drowsy, she should deliberately touch one hand with the other, and this would anchor her ability to remain awake.

Price (1987) described a 45-year-old male patient who had had a 32-year history of narcolepsy and cataplexy. He was particularly sensitive to praise, and sought treatment after he had been promoted at work. He would experience a number of cataplectic episodes during treatment sessions when discussing emotional themes relating to his wife. During the hypnosis sessions, the patient was given metaphors which were centred on past experiences of overcoming problems, acquiring new skills, and his inherent ability to perform tasks automatically. As this patient was particularly sensitive to being complimented at work, and this was responsible for the cataplectic attacks, these themes were introduced into the treatment program: in hypnosis, the patient rehearsed being given a compliment for a project in which he had had a considerable involvement. He was also encouraged to use self-hypnosis to rehearse situations which would have normally triggered cataplectic attacks. At the end treatment, this patient was able to control his cataplectic attacks and, at a 10-month follow-up, he was given a promotion to general manager at work. He was also able to communicate much more freely with his wife, to express anger and other feelings towards her without this precipitating cataplexy.

Nardi (1981) described two patients, the first being a 25-year-old woman whose attacks of sleep paralysis began shortly after her marriage. At these times, she feared that she was dead or that others might assume that she had died. These episodes of sleep paralysis occurred about once a month. In the hypnotherapy, it was suggested to her that, even though she was very relaxed, she could still control her arm to raise it. It was then suggested to her that she could exercise a similar control during sleep paralysis, and that she should relax and enjoy the experience. The therapist explained that there was a link between hypnosis and her sleep paralysis; the patient was also taught self-hypnosis and was asked to "count herself out" and to use this technique when she had an attack. A follow-up 14 months later showed that she was no longer distressed by the sleep paralysis and that she could either wake herself up or be relaxed enough to go back to sleep.

The second patient, a 30-year-old woman, had suffered from sleep paralysis and hypnagogic hallucinations since the age of six. A similar treatment approach was used as in the first case; and, after the combined use of hypnotherapy and self-hypnosis, she felt able to handle these experiences, dismissing them as "interesting" and "non-threatening."

Somnambulism

Sleepwalking occurs more frequently in children, but may also be seen in adults (Hurwitz, Mahawald, Schenck, Schluter, & Bundlie, 1991). It has been found that adults suffering from sleepwalking are often unable to deal with their own aggression (Klackenberg, 1982). Although most sleepwalkers merely sit up in bed, walk briefly, or carry out some repetitive activity only to return to bed, there are some patients who carry out more complex movements such as cooking a meal or even driving a car. These episodes are more frightening for the sufferer, who would then tend to seek treatment (Gutnik & Reid, 1982). It tends to occur in the first third of the night and it is associated with an abrupt arousal in either stages 3 or 4 of non-rapid eye movement sleep (nREM) or slow wave sleep (SWS). At these times, the patient will show purposeful movements, walking out of the room or even out of the house. Reid, Ahmed, and Levie (1981) describe a treatment approach which was found useful for somnambulistic subjects. They were given two direct suggestions, the first that, like hypnosis, sleepwalking occurs in a trance-like state and, secondly, that they could utilise this state at night, so that whenever their feet touch the ground they would immediately wake up.

Hurwitz et al. (1991) described a technique for treating sleepwalking in which the patients imagined a screen where they were lying comfortably in bed, sleeping peacefully. In the consulting room, an audiotape was prepared so that the patients could practise self-hypnosis at home. The therapists also gave post-hypnotic suggestions that the patients should be safe during the night and that movement would be minimal. They used this technique for adult sufferers of sleepwalking and night terror disorder. The patients received between one and six sessions. The authors reported that, out of the 17 patients who had only one treatment session, 11 patients had immediate success, whereas the remaining six did not improve and stopped the hypnosis treatment.

Night Terrors

Night terrors — also known as sleep terrors — tend to occur in children aged 4 to 12, but can also be seen in adults, particularly between the ages of 20 and 30, with a male preponderance. Night terrors, like somnambulism, begin with an abrupt arousal in stage 3 or stage 4 sleep (nREM/SWS). They are characterised by a scream at the outset, associated with a number of autonomic disturbances, including tachycardia, rapid breathing (tachypnoea), mydriasis, flushing of the skin, combined with heightened fear responses. Patients will

often sit up in bed or leave the bedroom; and, if awakened, they are frequently confused and disorientated. In most patients, there is amnesia for the whole event, and it is for this reason that patients tend to be referred for treatment by other family members or partners.

In children suffering from night terrors, the favoured method of induction is to ask the patient to describe their favourite story, which may then be embellished in their fantasy. Kohen, Mahowald, and Rosen (1992) reported four children, aged between 8 and 13, all of whom suffered from sleep arousal disorders. These authors also found it helpful when treating children to compare the brain to the computer and likened the night terror to a "bad habit" which could be "reprogrammed." It was found that the children were fascinated with this concept and were interested to learn how to undo this "habit." At follow-ups 6 to 18 months later, it was found that all these children made a complete recovery.

Kraft (1986) reported a single case study of a 22-year-old single male who had been suffering from night terrors for four years. His father reported that at night his son would suddenly scream out, "Go away," and he would be found huddled in a corner of the hall in a state of sheer terror. The patient had no memory of these attacks and thus it was important to re-activate the contents of these episodes during the hypnotherapy. It was established that the terror was associated with a gang of boys attacking him, and the aim of therapy was to use a re-framing technique to change the outcome of this sequence of events. As soon as he had changed the outcome of the chase, so that he was in the winning position, his fear was eliminated, and a 6-month follow-up showed that there was no recurrence of these night terrors. An alternative treatment approach was used by Kennedy (2002), who suggested that his patient, a 37-year-old female whose night terror consisted of her being chased by a man in a theme park, should imagine a television screen where she would be able to have complete control and where she would be able to change the ending.

Obstructive Sleep Apnoea Syndrome

Patients who suffer from obstructive sleep apnoea syndrome (OSAS) have repeated episodes of upper airway obstruction: During sleep, patients typically gasp or snore loudly and this alternates with periods of silence lasting between 20 to 30 seconds (ICSD, 1997). These periods of apnoea cause arterial desaturation which, in turn, lead to psychological impairment during the daytime. In addition, OSAS can lead to an increase in accidents during the

day, underperformance, heart rhythm abnormalities, coronary heart disease, and cerebrovascular accidents. Whenever heavy breathing at night is associated with daytime somnolence, the diagnosis of OSAS should be considered (Kraft, 2003). Factors which contribute towards OSAS are obesity, alcohol intake, smoking, and the use of hypnotics at night (Krieger, 1996). While snoring is a constant feature of OSAS, many patients snore without having the condition (Stores, 2003).

Finking (2000) describes the use of a tennis ball which is placed in the pyjamas of the patient suffering from OSAS, and this is designed to prevent the patient lying on his back. It was shown that this was an effective form of treatment. Several authors have referred to the use of a nasal continuous positive airway pressure device (nCPAP), but this is a cumbersome device which does not in any way correct the snoring or the OSAS and many patients object to wearing this apparatus at night.

Hypnotherapy has the great advantage in that no mechanical devices are required, and a useful approach is to concentrate on weight reduction. In the case report of Kraft (2003), a 53-year-old married man requested that he be given the direct suggestion that, when snoring at night, he would automatically turn onto his side. This suggestion, in fact, was taken up, and his wife commented that the snoring had decreased, even though she was unaware that he was receiving treatment for this condition. Later in the therapy, he was advised to lose some weight and, after losing 6.3 kilograms and having had 10 treatment sessions, the snoring symptom was completely eliminated.

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The Application of Hypnosis in The Treatment of a Woman With Complex Trauma

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This case study describes the application of hypnosis in the treatment of a Chinese-born Indonesian woman, Mrs B, who had post-traumatic stress disorder (PTSD) resulting from her long history of being maltreated by her father and witnessing his acts of violence when she was in Indonesia. Although she seemed to be able to suppress her negative feelings about these events after she came to Hong Kong, her psychological condition deteriorated in 2004. She was referred by the Family Service Centre to the Clinical Psychology Unit of the Social Welfare Department for psychological treatment. Through the use of hypnosis, her symptoms of PTSD were eliminated, her self-efficacy was enhanced, and her relationship with her husband and children improved as well. Six months after the last treatment session, she was contacted for follow-up, and no relapse had occurred.

PRESENTING CONDITION

Mrs B, a 35-year-old married woman, was referred by the Family Service Centre to the Clinical Psychology Unit of Social Welfare Department, in May 2005, for psychological assessment and treatment.

Mrs B complained of having sleep problems, and feeling anxious and distressed from time to time over the years. She cried and became irritable easily with no specific reasons. Sometimes she would unleash her negative feelings on her children. Whenever she saw violent or traumatic incidents on television programs, she felt anxious and was compelled to switch channels.

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She had intrusive flashbacks about the violent acts of her father, but she managed to suppress these feelings by shifting her attention to something else. The severity of the symptoms of PTSD seemed to be successfully controlled by her all along, but her psychological condition took a turn for the worse in 2004, following family stresses.

In 2004, her eldest son, who suffered from autism and mild grade mental deficiency, was placed into a hostel for mentally handicapped children. She felt guilty about leaving him alone and causing him suffering. At about the same time, her husband's close relative, who suffered from a psychotic disorder, committed suicide. After that, her husband became very bad-tempered. Mrs B was overwhelmed by these changes in her family. She said her husband always yelled at the children and employed corporal punishment when they were not obedient to him. No matter what she suggested, he turned it down and discouraged her from doing it. Sometimes, he yelled at her too. His attitude aroused all her negative feelings about herself and the image of her father, which she had suppressed for years, came back to her mind. She was deeply distressed and anxious whenever she recalled all her traumatic experiences in the past and she felt that she, like her mother, could not protect her children from being hurt. Moreover, intrusive thoughts and nightmares about her father's acts of violence, pitiless look, and his vindictiveness continually appeared in her mind.

BACKGROUND

Mrs B is a Chinese-born Indonesian, the third of nine siblings. Her father was a farmer and her mother a housewife. She described her life in Indonesia as depressing and traumatic. Her father, a heavy drinker with a violent temper, always yelled, humiliated, and battered her, her sisters, and her mother fiercely on trivial matters (e.g., he punched her mother with his fist and hit her and her sisters with rope and coconut shells). He held a conservative view that women were inferior to men, and that his daughters were not allowed to go to school and must take care of the sons and the whole family financially. If they did not do so, they would be battered and terrorised by him. The sisters and Mrs B were angry with their father, but dared not utter a word.

Mrs B's relationship with her father was filled with hatred, fear, and frustration. She remembered that, apart from the battering, he always debased her and exploited her needs by damaging the things she valued. For example, he threw away her schoolbag and tore up all her books, even though he knew

she enjoyed going to school; he threw the only dress she had — bought with pocket money that she had saved for a long time — into the manure pit; he kicked her out of the house if she finished her meal too slowly; and he would splash cold water onto her after he became intoxicated. Once he did not allow her and her sisters to have dinner after work and dirtied the remains of the food in front of them. Mrs B was very anxious and heartbroken, but she could not stop him and could only cry. Growing up in this environment, Mrs B suffered from anxiety and fearfulness and low self-esteem.

Although she moved out of home and worked as a maid when she was 16, the negative feelings persisted. She recalled that, whenever she received a letter or phone call from her father asking for money, she was very disturbed as she lived on a very low wage and knew that her father would take out his anger on her mother by battering her if she did not comply with his demands. At the age of 21, she emigrated to Hong Kong, where she married and had three children. Although Mrs B was able to control most of the symptoms for 15 years after leaving Indonesia, she suffered emotional disturbance from time to time. In 2004, her psychological condition worsened after her eldest son moved into a hostel for mentally handicapped children and her husband's temper worsened.

ASSESSMENT FINDINGS AND THERAPEUTIC FRAMEWORK

Diagnosis

According to the DSM-IVR (American Psychiatric Association, 2000), Mrs B suffered from the symptoms of post-traumatic stress disorder. She responded to the past experiences that involved actual and anticipated threat to the physical integrity of herself, her mother, and her sisters with intense fear and a feeling of helplessness. She complained of frequent flashbacks and nightmares about her father's acts of violence, pitiless looks, and vindictiveness. She had a tendency to avoid thoughts, feelings, and people which she associated with the experiences. She was unable to have loving feelings and suffered from persistent symptoms of increased autonomic arousal, such as irritability, insomnia, and difficulty in concentration.

The Impact of Event Scale (IES: Horowitz, Wilner, & Alvarez, 1979) was administered and the results indicated the traumatic experiences had moderate impact on Mrs B (IES = 49). The Beck Depression Inventory (BDI: Beck &

Steer, 1993) and Beck Anxiety Inventory (BAI) (Beck & Steer, 1993) were administered and the results indicated she had mild depression (BDI = 18) and moderate anxiety (BAI = 19).

Treatment Goals and Treatment Approach

The goals of the treatment were to enhance Mrs B's self-acceptance and eliminate her symptoms of PTSD, such as distressing flashbacks, nightmares, feelings of not being safe, as well as sleep disturbance, by restructuring her negative thinking and feelings towards her past traumatic experiences. Restructuring the events of a traumatic incident can be accomplished through the use of hypnosis, as hypnosis is effective for symptom alteration. Another treatment goal was to improve the relationship with her husband.

Several factors indicated that Mrs B's psychological problems could be alleviated by the use of hypnosis. Apart from the efficacy of using hypnosis in treating PTSD (Carter, 2005; Degun, 1997, 2001; Desland, 1997; Gafner & Benson, 2001; Moore, 2001; Perkins, 2005; Salerno, 2005; Willshire, 1996), Mrs B was found to be a good hypnotic subject according to her scores on the Creative Imagination Scale (Barber and Wilson, 1978), scoring 25, a medium high score. The results of the Beck inventories (she had mild depression and no suicidal ideation) also indicated there should be no contradiction to apply hypnosis on her.

Treatment Framework

Considering Mrs B's problem, the therapeutic framework was designed to comprise four phases. The first phase would concentrate on building resources. The second phase would focus on increasing her self-confidence, as it was important to help her clear her mind of self-doubt and negativity. It was the crucial groundwork for proceeding to treatment of the third phase, which was to restructure her negative feelings and perception about her past traumatic experiences in order to facilitate her emotional processing. The fourth phase would target her personal growth and was future-orientated. The purpose of this phase was to help her get rid of the past traumatic experiences and start a new life.

The treatment details are set out below.

THE FIRST PHASE

Session 1

Details about Mrs B's personal history were obtained in the first two sessions. Gathering her personal history was important in order to understand the

formation of the problem and to use this information during hypnotherapy. Psychological inventories were also administered to assess her psychological state.

Session 2 (one week later)

Mrs B was informed of the PTSD diagnosis and the formation of her problems (i.e., how her emotions and the relationship with her husband were affected by her past traumatic experiences). Hypnosis was introduced to Mrs B, after consent was obtained to use it as a major treatment strategy to achieve symptom reduction. Her level of suggestibility was assessed by the Creative Imagination Scale. Mrs B's husband was also invited, through Mrs B, to come to see me, but he declined, as he believed he did not need treatment.

THE SECOND PHASE

The purpose of this phase was to increase Mrs B's self-efficacy. According to information gathered from the assessment sessions, it was found that Mrs B had some internal resources which she was not aware of. For example, she put a great deal of effort in taking care of her children, especially her eldest son, who suffered from autism. The approach taken in restructuring her negative perception about herself was to use the experiences, particularly of mastery, from her personal life history.

Session 3 (one week later)

Mrs B was led into trance by progressive relaxation and the stair script (Dowd & Healy, 1986). It is a deepening technique to suggest to the client the image of walking down a long stairway. Following induction and deepening techniques, direct suggestion positively focused on imagining her successful and happy life experiences. (The concept of the cinema, to follow, was based on an idea in one of the Milton H. Erickson's age regression techniques: Regression with the Visual Hallucination Screen Technique [Hammond, 1990]. It has been used in treating an anorexia nervosa case by Hornyak, 1996.)

The suggestion was given as follows: *You are in a cinema. On the screen, you see your eldest son receiving a Certificate of Merit from his teacher [this piece of information was gathered from the assessment sessions]. You hear the praise from his teachers and his classmates' parents. You see the happy face of your son. You feel the happiness and contentment, as you know that your effort is being recognised* … The process

attempted to bring Mrs B back to the scene and re-experience the positive feelings that could enhance her self-worth. A post-hypnotic suggestion was made: *You feel the power inside. Whenever you feel down, you will be able to visualise this screen and experience all the positive feelings* … When Mrs B came out of the trance, she told me that the scene was very impressive. She felt relieved and could feel the positive strength inside her mind.

In the second part of the treatment, her relationship with her husband was discussed and communication skills were suggested to her in order to improve their relationship.

Session 4 (one week later)

The induction phase involved progressive relaxation, followed by deepening through a counting technique, and then taking Mrs B to a place where she felt safe and relaxed (she had mentioned that she felt relaxed and comfortable when she lay on her bed after sending her children to school). *You are lying on your bed and watching television* … While she was deeply relaxed, suggestions were made to her that she was watching her successful experiences on television and becoming aware of her happiness and satisfaction. The positive feelings formed a power inside her and made her feel confident. She felt physically and psychologically healthy as well. A post-hypnotic suggestion was given as follows: *Whenever you feel down or frustrated, you can immediately feel the inner strength, and the strength helps you face your difficulty.* (This suggestion was repeated three times). These techniques were used in the sessions so that the stronger part of herself was reinforced from her past positive experiences. When she was out of the trance, Mrs B reported feeling relaxed and that she could feel the power inside her.

Ego-strengthening was important to enable Mrs B to believe she had greater mastery of her own mind and inner potential. It was used to facilitate her dealing with her traumatic experiences.

THE THIRD PHASE

The purpose of the third phase was to restructure Mrs B's negative feelings about her past traumatic experiences, so as to facilitate her emotional processing.

Session 5 (one week later)

Before starting the hypnotherapy, Mrs B was told that in these sessions she would be imagining parts of her negative experiences of being maltreated by her father. The notification before treatment was important, so she would not be astonished when it was suggested she do so in trance. She was also notified that, if she felt uncomfortable, she could let me know by telling me or by raising her finger at any time, and I would help her to handle the discomfort in the trance.

We then started the hypnotherapy. Following the induction phase, Mrs B was regressed to the negative experiences in Indonesia. In the trance, she told me she saw her father pouring dirty water onto the family's remaining dishes of food after he had finished eating. He did not allow the children to eat, as he felt they had been disobedient. Mrs B and her siblings were standing aside and crying. Mrs B was anxious, angry, and heartbroken. I then suggested that she imagine that she had a remote control in her hand and that she could stop the scene. She reported that she felt better after stopping him. I suggested her that a "present self," who was full of confidence and strength (making use of the ego-strength that she had formed in the first phase), was standing next to her "past self" (her vulnerable self) to protect her from being hurt. *She is holding you and soothing you. She is also telling you not to be anxious, as you have now become stronger and bigger. [I used "big" because I wanted to let her visualise the strength that she had.] You can protect and love yourself* … This technique came from Joan Murray-Jobsis' Suggestions for Creative Self-Mothering (Hammond, 1990). It is a useful technique to help clients re-parent themselves, provide some restitution for the lack of nurturing and mothering that some clients experience, and helps to foster self-love and self-acceptance.

Mrs B reported that she felt secure and calm. I then asked her to turn the scene off by using her remote control and return to her bed to relax. When she was relaxed, she was led out of the trance. Ego-strengthening suggestions were used with age regression, so that the stronger part of herself could comfort and counsel her past vulnerable self; her negative feelings about the past traumatic experiences could then be restructured.

Following the hypnotherapy sessions, Mrs B reported an improvement in her relationship with her husband. He was not so irritable and they were able to talk to each other.

Session 6 (one week later)

Mrs B reported that she was emotionally stable, but her husband was still bad tempered. She felt that her husband, like her father, was domineering. She

felt unhappy when she communicated with him. She understood that his emotions were affected by the death of his brother and the stress from his job, but he tended to hide his feelings. The skills of communicating with her husband in order to let him feel her concern and support were discussed. She was taught how to assert herself when he asked her to do the things that she did not want to do.

Considering Mrs B's condition, the focus of this session was to enhance her confidence to assert herself. John Hartland's Suggestions for Ego-Strengthening (Wicks, 2002) were used in this session after some modifications. A post-hypnotic suggestion was given: *You have become confident in yourself* … When Mrs B was out of the trance, she reported feeling more confident and willing to apply what she had learned to her daily life. She reported that her condition improved after receiving treatment. Although the negative experiences sometimes surfaced, she found that the negative feelings towards her father were desensitised. Apart from that, she was not so bothered by the behavior of her husband. It was reiterated that she had done a very good job and made important progress.

Session 7 (one week later)

Mr B finally was willing to come to see me under the persuasion of Mrs B. He appeared rigid, but sincere. He did not talk much about himself and said he did not have any problem, but came to see me because he wanted to have a better understanding of his wife's condition. His concern over her was recognised.

The formation of Mrs B's problem was explained to him with the consent of Mrs B. The purpose of explaining this to him was to let him have a better understanding of his wife's feelings and how his temper escalated the anxiety in her. The importance of maintaining a good family relationship was also discussed with him, and he agreed that Mrs B was doing well all along and that mutual cooperation was important in facing difficulties.

Session 8 (one week later)

After induction had been conducted in the usual manner, it was suggested to Mrs B that she regress to the traumatic experiences in Indonesia. This time, she said she saw her father throw away her schoolbag and tear up all her books. He yelled at her that "girls do not need to go to school." She could not stop him from doing so, and just cried. She was very anxious, angry, and distressed. I suggested to her to use the remote control to stop him and her "present

self" come out to protect her "past self." The situation was similar to Session 5. A suggestion was then given: *Your "present self" is looking at your father. You discover he is different from the past. His hair turns white and his physical condition is weaker than 15 years ago. He is now a 70-year-old man and is unable to do anything to hurt you. When you look at yourself, you are not a child now. You are a grown-up and you are becoming stronger and stronger …* This process was to restructure her negative feelings and think about the traumatic experiences by helping her to differentiate the past from the present, and by reassuring her that she is a grown-up who could protect herself. The suggestion of ego-strengthening reinforced self-reliance and generated a positive self-image.

A post-hypnotic suggestion was given: that any time a flashback recurred, this new imagery would immediately be coupled with the flashback, resulting in the realisation that she should not be scared by her father anymore. When Mrs B was out of the trance, she said that she had become more emotionally stable after receiving the treatment.

The restructuring of the traumatic event, as experienced in the session, diminished her anxiety and enabled her ego to resolve the traumatic event.

Session 9 (one week later)

Mrs B reported that she felt good recently. Although her eldest son occasionally threw temper tantrums, she was able to handle his behavioral problems patiently. Her relationship with her husband had also improved. She said he even hugged her when he came home from work, which she told him she appreciated. His temper improved and their relationship was better than before.

The induction was followed by further facilitation of emotional processing. It was suggested to Mrs B that she imagine walking up a mountain peak, with a heavy backpack which she had carried for more than 20 years. She fully felt the weight of it. At the top of the peak, she saw a big red balloon with a basket. She approached the basket and saw that it was empty. When she opened her backpack, she found a lot of her negative feelings inside and then she took out all her negative feelings from her backpack and threw them into the basket. She picked up a big stone to cut the ropes. The red balloon carried the basket and it floated up to the sky. She felt relieved when she saw the basket floating upwards, getting smaller and smaller, and finally it disappeared.

This technique was adopted from Hammond's Red Balloon Technique (1990). It was used to help Mrs B release all her previous negative feelings and reassure her that the past had gone. A post-hypnotic suggestion was given

that she could feel the positive feelings any time she needed them. When she was out of the trance, she said she felt a release after throwing all the negative feelings away.

THE FOURTH PHASE

This phase focused on Mrs B's personal growth and future development and therapeutic metaphors were used again.

Session 10 (two weeks later)

While Mrs B was in trance, a metaphor about the early process of a plant's growth from a seed was described in order to facilitate her growth. The suggestion was given as: *You see a plant has grown from a seed. It is growing bigger and bigger, and later it has become a tree. During the process, it encounters the hot sun, strong winds and rain. Yet, it does not weigh down the tree. On the contrary, the tree learns to overcome all the obstacles and develops a hard outer bark to protect the tenderness within. We, like the tree, encounter much happiness and many difficulties in our lives. Our experiences make us become stronger and mature. You are looking at the sky and see the summer's early dawn ["dawn" implies "hope" and "lively" in our culture]. You feel relaxed and you can see your future in it as well.* Ego-strengthening suggestions were made before she came out of the trance.

After the treatment, Mrs B said she felt more confidence in herself, and when she looked at the dawn, she saw her children had grown up and she could enjoy her own time. Considering her good progress, only one more treatment session was arranged with her consent.

Session 11 (two weeks later)

Mrs B reported that she felt peaceful in mind and had become more mature mentally. She mentioned she had received a phone call from her eldest sister, who told her about the current condition of her father in Indonesia. She did not feel angry or distressed when she thought about her father. Conversely, she felt peaceful and relaxed. She also thought about going to Indonesia to visit her parents. She was happy about her improvement, as she had not considered doing so before receiving treatment. Her sleeping condition also improved.

When asked whether she felt confident about herself in the future, Mrs B said "Yes." She reported that she had confidence in handling the difficulties in daily life and that she knew how to love herself and others, which she did not

know how to do it in the past. She felt a positive strength inside and she also found that the changes in herself had led to an improvement in her husband's temper. The children now felt the love emanating from them.

Mrs B was then led into trance and ego-strengthening suggestions were made that emphasised that she could further sustain her self-efficacy. When she was out of the trance, she said that she had more confidence in herself and she held my hands and thanked me for my help. Considering her stable psychological condition, the treatment was terminated.

The psychological inventories (IES, BDI, and BAI) were re-administered, and the findings (IES = 0; BDI = 0; BAI = 0) all indicated that Mrs B's symptoms had been eliminated.

Follow-Up

Mrs B was contacted by phone six months after the last session. She and her husband reported they were getting on well. Mrs B said that she was doing well and did not have any uncomfortable feelings when she recalled her past experiences in Indonesia. Moreover, she no longer cared about the gaze of passers-by when her eldest son threw temper tantrums in public. She was able to assert herself and felt more love in the family.

DISCUSSION AND SUMMARY

Hypnosis is a useful adjunctive technique in the treatment of post-traumatic symptoms, as it can shorten the length of treatment and produce a more favourable prognosis. The effectiveness of hypnosis can be noted from the remarkable treatment outcomes of Mrs B. By understanding the formation of her problem and applying the technique of hypnosis appropriately, her progress was vivid and rapid.

The identification of Mrs B's inner resources, which were used in conjunction with age regression in the hypnotic state, were crucial, as they allowed her to regain her feelings of pleasure, contentment, and control which were contrary to those associated with her traumatic memories. Through regression to the past traumatic experiences, she could focus on managing the distressing memories and facilitate the healing process. At the end of the treatment, Mrs B had achieved her goals of living happily with her family. The symptoms of PTSD which she had experienced for years had been ameliorated and her relationship with her husband had also improved.

I contacted her six months later, and no relapse had occurred.

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Scripts

Tricking Trichotillomania

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According to Christenson and Mansueto (1999), Hallopeau suggested the name trichotillomania, which he derived from the Greek words *trich* (hair), *tillo* (to pull), and *mania*, the last denoting an abnormal love for, or morbid impulse toward, some specific object, place, or action or, as Hallopeau (1894) implied, insanity. http://www.geocities.com/ttmlarchive/history-whatsinaname.html

The following script was used in the successful hypnotic treatment of trichotillomania (eyelash pulling) in a 12-year-old, named Ann. The patient came for treatment in order to stop pulling out her eyelashes. The stress-related problem was solved in two sessions. The challenge was to not only remove her symptoms, but to provide her with the necessary insight and processes to be able to come to terms with her changing life situation. It was also clearly going to be important to provide her with the necessary skills to cope with any relapse which she might experience when further direct professional help was not readily available.

After induction by arm catalepsy, a simple sand-bucket deepening technique was used. Within a couple of minutes, Ann was in a very deep trance, to the point where her head required repositioning to prevent it falling forward on her chest.

You have many things happening in your life right now, Ann, and sometimes it seems like it's all just too much. You're about to leave your family home, your old school, all your friends and familiar surroundings, and maybe it feels like your world's falling apart, and of course it's stressful; but, you know, this is kind of like what happens

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to a caterpillar when it turns into a butterfly. The caterpillar knows when it's time to change, and it finds a safe place to make itself a little cocoon for those changes to occur, and where it can learn about how those changes affect its body. And when the time is right that metamorphosed caterpillar comes forth again, into the world as a glorious butterfly able to enjoy the full freedom of flight, and never again be confined to crawling along the ground. And every boy and girl goes through that metamorphosis. Like the caterpillar, we don't need to know how to make those changes, because our unconscious mind and our body take charge, and know exactly what to do at the right time. Our job, in our conscious mind, is like that of the caterpillar. We can't spin a cocoon and hide from the world, but we do need a safe place to go when we need to be alone, to absorb those changes and incorporate them into our new being.

Perhaps you have a special place where you like to go when you want … to just sit and think. Maybe it's a real place, or maybe it's just somewhere in your imagination. Wherever that place is, I would like you to go there now, in your mind, and remember just what it feels like, to sit there quietly, safely, and absorb the serenity that you can enjoy in that place. It can always be your safe place, even when you are a long way away … if it is a physical place, it is always just as close … as resting back, closing your eyes, and taking five deep breaths, as you let yourself quietly slide into that special, safe place of your own. And you can go there now. [Pause]

When you look back to where you came from, you can remember being a little girl, and having to stretch so high to reach the tabletop, to climb on Mummy's knee. And as you look into that mirror of your past, you can see all those things … that happened before … behind you. And you can go through that mirror into your future and find those things that happened to you that you don't remember yet, when you are 17 or 18 years old. You can feel the difference, really feel the difference, of being in a woman's body, now. Understanding and feeling things in new ways, having new experiences, perhaps doing your hair in different ways, maybe wearing nail polish, lipstick … and other make-up. And you can remember all the things that you had to do to get to where you are now, all the things you had to change as a little girl to grow to be a woman, and how it felt to make those changes. [Pause] *And you can go back now and find that 12--year-old self, and take her hand and comfort her, and tell her all things that she needs to know to get from where she is now to where you are. And just take a little time to be with her* [pause] *… and your 18-year-old self can remember fully what it's like to grow up through those years, past all the doubt and uncertainty, to feel again the strength of being a grown woman, confident and capable. And I don't know whether your conscious mind will want to remember all these things, or whether it'll be comfortable in forgetting to remember consciously, knowing that your unconscious will be aware of all things that will happen to you, the things that you haven't remembered experiencing*

yet, or maybe you can just remember to forget the things that are unimportant for you to know about just now, while you focus on growing and changing … and you can take all the necessary memories back with you to your 12-year-old self, remembering what it will be like to be grown up, and remembering the things that you can look forward to experiencing on the way.

You know that you are not aware, in your conscious mind, of plucking at your eyelashes, but your unconscious mind knows what is happening, and has control over it. I'm talking now to your unconscious mind: You are to be aware of any time one of the hands comes up to the eyes, and stop those fingers pulling out eyelashes. You are not to let the fingers pull those eyelashes at any time. If this happens during sleep, you will wake Ann and let her be aware of what has been happening, or what she has been dreaming about, before she goes comfortably back to sleep. And during the day, if one of the hands comes up to pull at the eyelashes, you will make her aware immediately her hand touches her face, so that the fingers do not get a chance to pull those eyelashes, and when you become aware, Ann, you can take a deep breath and remember the feeling of peace that you have right now. You can let go of whatever it was that started the movement of your hand, and feel very pleased with yourself for again winning in this little game.

And while you're in that special place, nothing can hurt you, nothing can worry you, because it's your special place, and no one knows about it except you, and you can go there any time you need to, to find the peace you need to think things through, and understand where you are, and where you are going, and what you really need to do to get there. You can take a little time, right now, to really see your special place, to feel the comfort and hear the sounds that belong in that place. [Pause]

Ann, before you come back here into the room now, you can know in your unconscious mind that everything that I have said will come to pass. That you really can learn, and grow, and change, in just the ways that you want to. It may not always be in the way that you think it will be, and it may not always be comfortable, but you will always win through in the end, and feel better and stronger for it. In a moment you can wake up, but before you do just know that you will feel more alert, more alive, than you have for a long time, and that when you go to bed tonight, you will be able to sleep soundly, and look forward to having good dreams about all the things you have done and all the things to come.

So come back now, to the here now, with me and your mother in my office, feeling awake and alert, and really, really confident about the way you have changed.

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Sailing the Little White Boat: A Script for Mastery and Overcoming Difficulties

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The following script can be useful for people who find it hard to cope with difficulties. It was designed for a person who loved the sea and sailing. Please ensure that your client does not have a phobia about water or the sea and that they can swim, and they do not suffer from panic attacks of any kind, if you use this script. Note that where you see '[Insert brief therapeutic suggestion direct or indirect],' it is only a suggestion for a possible place to insert statements about taking control, solving problems, etcetera.

Imagine yourself standing on a beautiful beach on a bright, warm sunny day. You begin to walk along the beach and you can feel the warmth of the sand, as it gently caresses soles of your bare feet.

Every step you take seems to make you feel more and more calm and the whole experience is very, very, pleasant.

Walking further and further along the beach, you become aware of all the smiling people sitting under their brightly coloured umbrellas, splashing about in the water and lying on beach towels. Children are building sand castles, playing games, and running up and down the beach. All the people there seem to be very, very, happy and enjoying themselves. You begin to smile and also feel the happiness that pervades the whole scene. All your worries and cares seem to be lifted from you and you feel completely free, like you used when you were a child.

Looking out over the bright emerald green sea, you see the sails of small boats moving slowly across the water. This makes you feel more and more … deeply calm and relaxed. The sun shining on your skin relaxes you more and more. It's almost as if you are in a dream of the perfect day.

In the distance, you can see a small wooden jetty extending out into the sea from the shore. As you begin to get closer, you can see the weathered structure of the jetty. It has

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been worn by years of exposure to the sun, wind and water, but yet it seems strong and sturdy. You can see a little white sailing boat with red sails tied up to the jetty.

Now that you are closer to the jetty, you can see the details more clearly. Walking down the jetty, you become acutely aware of the rough texture of the worn wooden planks under your feet. It feels good to walk on the warm wooden planks and feel the splintery wood beneath your feet.

You can see the little boat more clearly now, with its white painted hull and red sails. It looks well cared for and maintained and it is just big enough for one or two people. Now you are next to the little boat and, as you climb down into the boat, you see the worn wooden handle on the rudder and the weathered wooden interior. The boat somehow seems friendly and comforting. Although it looks very strong, at the same time, it seems quite small and frail in comparison the vastness of the sea that stretches before you and seems to go on forever to the horizon and beyond.

There is a gentle wind blowing and as you untie the little boat and cast off, the wind catches the sails and carries you silently, but forcefully, away from the jetty in a serene gliding motion. You take the rudder and guide the little boat out towards the more open, deeper, waters. It feels great to have control and navigate the boat in the direction you want to go in. [Insert brief therapeutic suggestion, direct or indirect]

Soon you are sailing further and further out, away from the shore. Looking back, you can see all the people on the beach becoming smaller and smaller, as you sail away.

The waves are starting to get bigger and the little white boat seems to be smaller somehow. You decide to keep going, sailing up the waves and over the crests and down the other side. It feels good to have control over the little boat and to navigate in whatever direction you want to go in. [Insert brief therapeutic suggestion, direct or indirect]

In the distance, you are aware of some dark grey clouds. It looks like a storm is brewing and you have to keep your eye on it, because you wouldn't want to be caught out in the open deep waters. [Insert brief therapeutic suggestion, direct or indirect, e.g., analogous with threats in real life]

You sail further and further out into the deep water. When you look back towards the shore, it's difficult to see it. The waves have become very big and when the little boat is in a trough, you can't even see the shoreline any more.

Suddenly, the grey storm clouds have become black and menacing and the wind is getting stronger and stronger. You need to make a decision about turning back, or the storm will be upon you. [Insert brief therapeutic suggestion, direct or indirect]

Too late, the storm is upon you and the waves are like mountains rising up before your tiny boat. You must stay in control. If you don't stay in control, you will be lost to the sea. You have turn and head for land. [Insert brief therapeutic suggestion, direct or indirect] *The waves are so big that it would be very dangerous to turn the boat about*

without perfect timing. Your heart is pounding and you grip the rudder waiting for the perfect moment to turn, lest you be swamped or capsized. With pounding heart, you wrench the rudder around, and to your great surprise and relief, the little boat responds and comes about quickly, riding down the crest of the enormous wave. [Insert brief therapeutic suggestion, direct or indirect]

Just when you thought you were out of danger, you are faced with another problem. The wind direction has changed and you can't sail straight back to safer waters. You have to tack right and then left, riding down the waves being very careful not to turn side-on the huge waves that threaten to engulf the little boat. [Insert brief therapeutic suggestion, direct or indirect]

It seems like hours have gone by and the shore does not seem to be any closer to you. You are getting tired and are thinking that you might not make it. But no, from somewhere deep within you comes an enormous surge of energy and strength, the like of which you have never experienced before. You won't let the sea take you without a fight. You will keep sailing the little white boat with all your strength and try to survive. You ride the huge waves and are lashed by the spray from the bow of the boat. You sail up and over dozens of huge waves, searching for the shoreline. [Insert brief therapeutic suggestion, direct or indirect]

As if by magic, you burst forth out of the storm and the waters become calmer, the wind dies to a gentler stream and the sun comes out of the clouds. Land! You can see the shore. You feel your confidence and pride grow as you realise that you did it all by yourself. You sailed the little white boat into and out of the fierce storm all by yourself. [Insert brief therapeutic suggestion, direct or indirect]

The little boat glides over the water and you can see all the people on the shoreline again. The sun is shining and you are very very happy. You took your own destiny in your hands and you triumphed against the storm. [Insert brief therapeutic suggestion, direct or indirect]

Gliding towards the jetty, you can see all your friends and relations waiting for you. They are all smiling and are very happy to see you safe and sound.

The little boat bumps to a stop against the aged black tires acting as buffers on the jetty. Many hands reach down to help you out of the boat and hands are slapping you lovingly on the back as you walk back along the jetty to the beach. You are happy and you feel very confident that you will be able to navigate your way through any difficulties that may come your way in the future, just like you navigated your way out of the storm in the little white boat. [Insert brief therapeutic suggestion, direct or indirect]

Postscript: You should feel free to shorten or lengthen (e.g., add more stormy weather, etc.) to the first and second parts of this script to achieve the mutually agreed upon goals of the client and therapist.

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Settling in Australia: A Metaphor

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When we are choosing what sort of story to use with a client in hypnosis, we have to take note of what people have described — in what tone and emotional state — and study all their nonverbal signals. If we can pick up a fragment of their story, this can be developed into a metaphor. Here is an example designed for a Spanish-speaking student. I took Kathryn Gow's travelling seal story and adapted it to suit this mature-aged international student, all the way from South America, who was undertaking the hypnosis course in Australia. Here I pace the student's model of the world and also demonstrate that she has accessed her emotional states and attitudes.

I once knew a lady who decided she wanted to travel and settle in a new country. She wanted to study and develop a career. This meant that she had friends and family back in her home country whom she loved and missed. This was a sacrifice she had made, yet at the same time she still enjoyed the excitement of moving to a different country and learning all the new amazing things.

In the new country, people did not speak the same language as she did. This made her feel different and isolated. Learning the new language and culture was very challenging. The strange thing was that this lady found herself being quiet with the people in the new country. She found herself feeling embarrassed and uncomfortable when the people in the new land couldn't understand her, or when they laughed at her when she said their words in an unusual way. This made her retreat even more.

During her classes, she had to focus so carefully on what the lecturer or classmates were saying, she looked intently at their faces and mouths to follow their spoken words. When they talked fast, it was so difficult to make sense of what they were saying. She felt so frustrated with the effort it took to speak and listen to people in this new land.

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They didn't seem to understand how much of a challenge it was for her to talk and listen in the new language … they just thought she was quiet.

What was so amazing, however, was that she was not quiet with people of her own culture and language. She was normally bright and bubbly and found it easy to chat to people. She found others who had come from different cultures to settle in the new land. These people seemed to appreciate the effort it took to speak the new language and to deal with all the cultural differences. They had something in common, so when they asked her to repeat what she was saying it seemed all right. They were all learning the new language and it was a tricky language to learn, because you couldn't speak it phonetically … there were all these rules to learn about how to speak the language.

After listening to her story, I couldn't help but think what a resourceful person she was … how much courage she had to live in this new country … how clever she was to learn this new language … the patience she had to "have a go" …. to take that step … to keep on learning how to speak the language. If only the people of the new land had a chance to get to know her, they would appreciate her strength and courage and creativity.

Before long, she found herself reaching out to get to know these people in the new land. She found that, just like her friends from different cultural backgrounds, the people of the new land also had things that they were learning. They had their own challenges, worries and frustrations. Soon she found it didn't matter that they asked her to repeat what she was saying to them. She began to feel more and more comfortable letting them know that she was learning the language. She found herself finding it easier and easier to speak and listen to the new language. She grew more and more confident each day and felt more and more relaxed each day. She noticed that she began to be her normal bubbly self with the people of the new land, just like she was with people from her own culture. The more she shared of herself with these new people, the more fun they had together and the more relaxed and confident she became.

She began to find new and interesting ways of learning the new language … of handling the challenges that she faced each day. She began to find herself feeling more and more relaxed during the times when she was listening to others. She found it took less and less effort to understand and to be understood. Gradually everything fell into place and she found her life very fulfilling in the new land.

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Writing Songs: Positive Suggestions

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Here is another story which was devised by Linda, who is a singer and who knows a lot about singing, but she is also a psychologist and hypnotherapist. She seems to be quite clear that she is suggesting ideas here, as she has called it positive suggestions, and then goes on to tell the story of the singer.

And now you find yourself in this quiet, peaceful place. You can imagine this special place and perhaps you can see the green hills and the jersey moo cows with big shiny noses and big eyelashes. The smells of this special place drift by and you can hear beautiful sounds around you. You find yourself enjoying touch in this special place. Feel the sense of peace flow through you … a great sense of well-being … enjoy these positive feelings and keeping them with you long after this session is completed, for the rest of this day and evening, and tomorrow. Soon you will allow these positive feelings to grow stronger and stronger, feeling at peace with life — flowing, flowing, flowing. And you know that when you flow, words just pop into your mind and they're good words. Inspiration just comes to you with good ideas. Songs just come out and they're good songs. Flowing is available to you any time of the day or night, anywhere. You can see and feel the flow whenever you choose. You know that you can feel loose, free, with not a care in the world; and in this space of flowing, words just pop into your mind and they're good words. Inspiration just comes to you with good ideas. Songs just come out and they're good songs. Flowing embraces you and the songs write themselves and they're good songs … songs of life and power and passion … good songs. And you'll find it easier and easier to be in this flowing space, whenever you choose … where peace and joy well inside you, where the song in your heart comes forth, just as it always has. You remember, you remember, you know what it's like to not have a care in the world … flowing with whatever … moving along whichever way seems best at the time. Regardless of the stress and tension that may surround your life, you may

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now remain more at peace, more calm, more relaxed, and allow the tension and stresses to bounce off and away from you, just bounce off and away from you. You know that you will be safe whichever way the river flows … everything will be all right. And these positive flowing feelings will stay with you and grow stronger and stronger throughout the day, as you stay comfortably relaxed and appropriately alert in carrying out actions in everyday life.

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Reviews

Advanced Skills and Interventions in Therapeutic Counselling

Gordon Emmerson

Carmarthen, Wales: Crown House Publishing Ltd. 2006. 272 pages, paperback

The work of John and Helen Watkins will be well known to many long-term ASH members, not the least because they were guest presenters at the ASH National Congress in South Australia in 1993. Gordon Emmerson spent the summer of 2000 studying with them during his sabbatical and writing his first book, *Ego State Therapy*, which comprehensively dissects and expands upon the theory and practice of this approach.

Subsequently, Gordon realised the need for a broader text, aimed at a wider range of professionals than those informed strictly by hypnosis practice and literature. His day job, as a Senior Lecturer in Psychology at Victoria University in Melbourne, teaching graduate counselling students, plus having a small private practice, makes him eminently able to provide a really clear, methodical understanding of personality and a guide to counselling, using ego state therapy as the therapeutic orientation.

As a practising clinician, I was thrilled to read this book. The style and content make the subject matter very accessible and Emmerson's skills as a teacher are evident. He builds on each point methodically and sequentially with clear explanations and a multitude of examples.

It was refreshing to note that this guide for therapy begins at the beginning … at the very foundations of any therapy … with ethical guidelines. So, Chapter 1 is "Therapeutic Counselling and Ethics." The whole approach focuses on the relationship between client and counselor, with content being determined by the client rather than the counsellor. Thus Emmerson begins with a discussion of confidentiality, boundaries, and duty of care, and gives clear examples of what to do and what not to do for each issue.

Chapter 2 focuses on the "Theoretical Orientation." In this chapter,

he expounds on ego states, as developed last century and popularised therapeutically by John and Helen Watkins, Maggie Phillips, Claire Fredericks, and others In this formulation, personality is made up of different parts or ego states, that are sometimes in conflict with each other. A neurophysiological basis in one's development is even expounded, as well as comparisons with other theoretical approaches. Ego state therapy involves accessing the ego state with the problem, then resolving the problem with help from other ego states, each with their own needs, so that all states are happy with the resolution, and the person can function with all states "integrated." This seems rather like a mediation session, only with internal parts or states.

Chapter 3 addresses the "Basic Counselling Skills and Techniques" — in particular listening skills. Emmerson emphasises that ego state therapy focuses on the client's world, advising acceptance and respect always for where the client is at, and for the state/part that is presenting. The respect and genuineness of the author for clients constantly emerges in these pages: "It is an honour to be trusted with the innermost thoughts of another person," he reminds us. This chapter reminds us of basic attending skills through to more advanced listening skills, with many clinical examples of good and even better responses. This chapter could stand alone in any counselling course.

The practice of ego state therapy is presented in Chapter 4, "Advanced Counselling Skills and Techniques." In this section, accessing, naming, and speaking with ego states is thoroughly presented — again clearly and with great respect for each ego state encountered. Bridging from the unwanted symptom to the cause of the problem is explained here — an expanded version of "Affect Bridge" by Hammond (1990, p. 523.)

In Chapter 5, Emmerson presents a flow chart for quick reference on the possible processes for ego state therapy depending on whether the presenting issue is diagnosed as one of internal dissent (cognitive dissonance) or a situational concern. He compares this to diagnosis by DSM-IVR.

In the next two chapters, treatment approaches for each of these diagnostic categories are presented, with clear step-by-step instructions. He builds from basics (e.g., use of chairs), to the complexities of negotiations with each ego state, always reminding the reader of respect and awareness of professional ethics. Issues involving cognitive dissonance are dealt with using two-chair work. Situational concerns may be either current or involve an unresolved issue in the past. Steps to facilitate a resolution of trauma using this model are easy to follow, and promise to be a very powerful way of dealing with a common counselling situation. These involve: locating the current ego state

with the problem, bridging (very carefully, avoiding a number of pitfalls) to the origin of the problem, having the ego state express their original concerns, utilising other ego states to then remove the traumatic part of the issue and feel some relief. This allows the client to tap their own internal resources, so that the appropriate part can be used for a specific situation. The current situation is then revisited using imagery, hopefully without the problematic ego state being dominant in response.

At the end of each section, Emmerson gives a summary of the steps previously outlined and often a diagram to further clarify the process. Emmerson constantly emphasises that this approach is entirely client-centred, with no interpreting by the therapist.

Chapter 8 is entitled "Application of Skills," and the author goes on to explain many common presenting issues in terms of ego states. He presents: crisis intervention, grief and loss, anger, relationships, depression, addictions and OCD, eating and smoking problems, sexual abuse, and suicidal ideation. In ego state therapy, the same process is followed for each issue — in order to diagnose each problem state and then to utilise the client's other internal states to resolve the problem situation. It seems to cover everything, all in the one book!

There are so many mini and maxi skills contained in this book that it certainly warrants several readings to absorb it all thoroughly.

At the end of the book, there is chapter of FAQs — "More Training, for Difficult Circumstances" — which contains some comments on the use of hypnosis and the occurrence of spontaneous hypnosis during the process of ego state therapy.

For me, this was a very exciting model to work with. It ties together my training in family therapy, conflict resolution, and hypnosis — often perceived as very disparate approaches. Ego state therapy allows me to integrate ideas and methods from all of those approaches (and more) to provide very powerful techniques for assisting clients.

The thought occurred to me that it is only when we can resolve the differences *within* ourselves first, that we can hope to resolve those at an interpersonal and even international level. The model expounded in this carefully crafted book certainly shows the way.

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Hypnotic (Close Your Eyes)

2004, USA. Directed by Nick Willing. Motion Picture

This film was based on the novel *Doctor Sleep,* written by Madison Smartt Bell, and is another depiction of what the general public is exposed to in terms of learning about hypnosis. It addresses its perceived forensic uses and strongly intimates that images cross over from client to hypnotist during the session.

The film opens up with a young girl running through an industrial estate in a long night dress, and a man chasing her. She runs onto a train track and then jumps off the railway bridge into the river below. The eerie music by Simon Boswell helps the audience capture the mood of terror.

At £150 an hour, in an office in Hackney, Croatian actor Goran Visnjic (of *E.R.* fame) plays Dr Michael Strother, a reluctant hypnotist, who is entrapped by Detective Inspector (DI) Janet Losey (played by Shirley Henderson), who pretends that she is consulting him to stop smoking, but is really assessing his ability as a forensic hypnotist. She becomes convinced that he is the answer to the problem they are having with the case of a mute child who has been kidnapped and traumatised, when during his usual patter detailing anti-smoking visual imagery with her, he psychically catches a glimpse of what she is imagining — a young girl floating under water.

Those of you who are skeptical about such a possibility may be interested to know that some health professionals have reported similar experiences, at times, in their treatment sessions. Indeed, Eva Banyai refers to such phenomena when she describes her social-psychological model of hypnosis in *Theories of Hypnosis: Current Models and Perspectives* (Lynn & Rhue, 1991).

Police departments, world wide, have been known to call on psychics to help with unsolved cases, and in some countries use hypnotists themselves in the belief that they can help the victim or witness retrieve important information which is outside conscious recall. However, there are no data on what level of confidence they place on the accuracy of such recalled details.

This would be a good film to show in hypnosis training sessions.

It demonstrates a number of examples of "what not to do" with traumatised clients in hypnosis. Dr Strother is not even board certified, and apparently has no health qualifications.

Whether or not he thinks the DI is blackmailing him because he has no work permit, he is nevertheless cajoled into wandering outside his area of competence — "Sorry, I just do cigarettes!" — into dealing with a highly traumatised young girl and he starts off by regressing her to scary memories without setting up a safe place for her, or even setting up SUDS signals or any form of security or escape.

Most importantly, he appears to be willing to hypnotise the child without her consent and against the better judgment of the mother and father; in fact, the only person who wants the hypnosis session is the DI who cannot handle her level of distress about a number of unsolved child murders.

From the perspective of the film being a demonstration of the dangers of using scripts without observing the reactions of the client, this is a brilliant example; Strother keeps up his patter about dark clouds and water without observing that his client's physiological signals are indicating that she is becoming distressed.

Later in the movie, this oversight appears to be corrected, but even then he commits boundary violations by moving too close physically to the child in her bedroom and associating his physical self with her safety, etcetera, when he cannot be there with her 24 hours a day, every day.

The child, who is already in a catatonic state and is thus totally mesmerised, is taken into a trance where she is told to go deeper and to think back. There is no understanding that such actions may put the child further into a traumatised state or even send her over the edge. She is told to close her eyes, even though she is safer with her eyes open, as any abused person would tell him.

Finally, Strother uses imagery of seeing a very bright star; he is assuming that taking her higher and far away from the current world will be safer for her than being in the world. In this way, he sets up an escape, in an unknown place for her — or at least he is assuming that is what she is doing. She may not appreciate a light swallowing her up, especially if she was tortured or terrorised where there was a bright light. However, he suggests she sees the light to let her see the place where she lost her voice.

From a positive perspective, Strother engages Erickson's utilisation principle by observing her fixed gaze on the TV screen and using the colour and movement and the tap of his hand and colour rhythm to hypnotise her

(even thought she is already totally disoriented) and makes the beat go faster and faster.

Later the child acts out in pantomime — slow motion psychodrama — something of what had happened to her. At this stage, the police usage of the hypnosis session turns more to the use of his psychic skills than his hypnosis ones.

Michael Strother then sees flashes of what the child is recalling and is disturbed by this. The question for the viewer is: "Was he regressing to a previous experience of his own in war-torn Croatia, or is he physically and emotionally feeling and seeing her pain?" There were hints by his American wife (played by Miranda Otto) that he may have had serious mental health problems and that he was risking what could have been another breakdown (nothing was spelled out — just hinted at): "Take a pill, Michael!"

At some point in the film, a poor demonstration of self-hypnosis is given when Strother relaxes in a hot bath and plays a deepening script to himself via a tape recorder; drowning is possible in such circumstances and while the director may have been showing this, tongue in cheek, it is one of those instances where the public portrayal of hypnosis is out of touch with real therapy.

It was not all minuses for the film. At least hypnosis was meant to be investigative, rather than a tool of evil, and it raises the issue of the possibility of the transmission of synaesthesias during a rapport-filled hypnotic treatment session.

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INFORMATION FOR AUTHORS

1. Contributions should conform to the style outlined in the *Publication Manual of the American Psychological Association* (5th ed., 2001), except that spelling should conform to the *Macquarie Dictionary*. Page references in the following notes are to the *Publication Manual*. The attention of authors is especially drawn to the organizational overview in the fifth edition (pp. xiii–xxviii).

2. Manuscripts (pp. 283–320), not usually to exceed 4500 words, should be typed clearly on quarto or A4 paper, double-spaced throughout and with margins of at least 4 cm on all four sides. Three copies are required. Duplicated or photocopied copies are acceptable if they closely resemble typed copies.

3. Title page (pp. 296–298) for the manuscript should show the title of the article, the name(s) and affiliation(s) of the authors, and a running head. The bottom of the page should also include the name and address (including postal code) of the person to whom proofs and reprint requests should be sent.

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5. Abbreviations (pp. 103–111) should be kept to a minimum.

6. Metric units (pp. 130–136) are used in accordance with the International System of Units (SI), with no full stops when abbreviated.

7. Tables (pp. 147–176) should be typed on separate sheets with rules (if any) in light pencil only. Please indicate approximate location in the text.

8. Figures (pp. 176–201) should be presented as glossy photographic prints or as black-ink drawings on Bristol board, similar white card, or good quality tracing paper. Diagrams and lettering must have a professional finish and be about twice the final size required. On the back of each figure there should appear in light pencil the name(s) of the author(s), the article title, the figure number and caption, without the front of the figure being defaced. Indicate approximate location in the text. The two copies of figures may be photocopies.

9. References (pp. 215–281) are given at the end of the text. All references cited in the text must appear in the reference list.

10. A copy of the MS must be kept by the author for proofreading purposes.

11. Send submissions by email to k.gow@qut.edu.au

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