

# AUSTRALIAN JOURNAL OF CLINICAL AND EXPERIMENTAL HYPNOSIS



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## EDITORIAL

In this edition, you will note some changes on the Editorial Board, you will see the addition of four new names as Associate Editors and a new Editorial Consultant. As well, three Associate Editors now become Editorial Consultants.

Joining us is the well-known longstanding contributor to hypnosis medical practice and research and to the Society, Dr Graham Burrows; medico practitioner and researcher Dr Allan Cyna, who has joined ASH in recent years and continues to amaze us with his work in obstetrics; dental surgeon James Auld, who is best known for his amazing grasp of Ericksonian hypnosis and his role as trainer; and psychologists Dr June Henry, who challenges us with her knowledge of mind–body relatedness, and Dr Graham Jamieson, a longstanding researcher in hypnosis from the University of New England.

The contributors to this edition, which has a practice focus, come from across the world. Barbara Wood commented on last edition's excellent and useful case study contributed by Priscilla Kwan from Hong Kong, and in this edition we have Maggie Wai-ling Poon, also from Hong Kong, telling us about a complicated domestic violence case — it is not a topic that has been addressed much in the hypnosis literature. The Krafts from London have given us the opportunity to refresh our knowledge about the use of hypnosis in psychosexual issues; and Tara Economakis, also from the U.K., offers an interesting case study on urinary incontinence. From the Australian authors, Susan Hutchinson-Phillips and colleagues summarise clinical issues relating to cases of self-defeating eating, John Spring raises interesting questions about the role of hypnosis and trance in religion, and Darryl Mayberry and Andrea Reupert offer a case note on sensory acuity.

The scripts in this edition were all designed for use in experimental conditions but can be modified, where necessary, for use in practice sessions. Graham Jamieson offers one as a general induction, Gerard Kennedy elaborates on his and Harry Ball's Power Break strategy for rest and recuperation, while Allan Cyna and colleagues outline more specific scripts for obstetrics.

Book reviews include hypnotic inductions, ideomotor signals, mind–body healing, and depression. The film review reminds us that fantasy proneness and absorption can be readily used in treating not just children but also adults.

*Kathryn M. Gow  
February 2007*



## THE PLACE OF HYPNOSIS IN PSYCHIATRY, PART 2: ITS APPLICATION TO THE TREATMENT OF SEXUAL DISORDERS

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*This paper is based on a world-wide search of the literature focusing on the application of hypnotherapy in the treatment of sexual dysfunction. The authors review a range of treatment procedures which have been shown to be highly effective for a wide range of sexual dysfunctions listed in the DSM-IV. This paper demonstrates that hypnotherapy is a very valuable tool for a wide variety of sexual dysfunctions. Some of these treatments are behaviourally oriented, in particular the cognitive re-structuring used in the treatment of frigidity; others are more psychodynamically oriented, such as the use of age regression in the treatment of premature ejaculation; and a third group combines these approaches. Detailed accounts of the treatment procedures are given so that hypnotherapy practitioners may incorporate these techniques in their consulting rooms.*

Sexual disorders, according to the *DSM-IV* classification, are divided into four main groups: (a) sexual dysfunctions; (b) the paraphilias; (c) gender identity disorders; and (d) sexual disorders not otherwise specified. This paper will be limited to an exploration of the value of hypnotherapy as applied to the first category — the sexual dysfunctions.

### SEXUAL DYSFUNCTION

This extensive category includes a number of disorders associated with a disturbance in the sexual response cycle or pain with sexual intercourse.

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This article is based on a lecture to the section of Hypnosis and Psychosomatic Medicine at the Royal Society of Medicine, London, on 3 April 2006.

Requests for reprints should be sent to David Kraft at dmjkraftesq@yahoo.co.uk.

## 2 *Kraft and Kraft*

DSM-IV divides the sexual cycle into four phases: (a) Desire, with its associated sexual fantasies; (b) Excitement, sexual pleasure and physiological changes; (c) Orgasm, the height of sexual pleasure with its concomitance; and (d) Resolution, the sense of muscular relaxation and feeling of well being.

In addition, disorders of sexual dysfunction may be divided into seven main categories as shown below:

- 1 *Sexual desire disorders*: hypoactive sexual desire disorder, sexual aversion disorder.
- 2 *Sexual arousal disorders*: female sexual arousal disorder (frigidity), male erectile disorder (impotence).
- 3 *Orgasmic disorders*: male orgasmic disorder (formerly inhibited male orgasm and also known as retarded ejaculation), premature ejaculation, female orgasmic disorder (formerly termed inhibited female orgasm).
- 4 *Sexual pain disorders*: dyspareunia (not due to a medical condition), vaginismus (not due to a medical condition).
- 5 *Sexual dysfunctions associated with medical conditions*: any of the above four caused directly by a medical condition and not accounted for by another psychiatric disorder.
- 6 *Substance-induced sexual dysfunctions*: the sexual disorder as the direct result of medication, a drug of abuse or toxin exposure.
- 7 *Sexual dysfunctions not otherwise specified*: sexual disorders where the clinician is uncertain as to its precise nature, and whether it is associated directly with a medical condition.

The final three categories are beyond the remit of this paper.

### **SEXUAL DESIRE DISORDERS**

The application of hypnosis to the treatment of sexual desire disorders is now elaborated on, as each disorder is listed and discussed.

#### **Hypoactive Sexual Desire Disorder (Also Known as Sexual Anhedonia)**

This term is used to denote a pathological condition where there is low or non-existent desire for sexual activity, or even an absence of fantasies. This can be global in nature or limited to a particular form of sexual activity. When making this diagnosis, clinicians should make sure that the patient is not suffering from any Axis I disorder or is affected by substance abuse. In fact, low sexual interest is frequently associated with inadequate sexual arousal or with



orgasmic disorders, and as a result this often leads to difficulties in maintaining a permanent relationship and may also cause marital disharmony. A low sex drive can be lifelong or acquired, and may be situational or generalised. Several authors have addressed the problem of hypoactive sexual desire disorder, notably Stafano (1982), Bakich (1995), and Araoz (1980).

Stafano (1982) gave a detailed account of a 23-year-old married lady who had no sexual desire for her husband, scoring 0/10 on a sexual desire scale. All sexual activities, including fondling, kissing and penetration, evoked feelings of tension, and she tried to avoid sexual activity by increasing her teaching workload. She would only have sex with her husband in order to please him and wanted it to end as quickly as possible. Stafano focused on age regression and, early in the therapy, it was revealed that she had had a disastrous wedding night. Further work revealed that, from the age of 14 to 16, her controlling stepfather prevented her from dating, insisted that she always had to return home by 10 p.m., and screened all her phone calls. Next, it was uncovered that the only time she had ever touched a male's genitals was at the age of 11 when she saw a boy urinating. At the same age, she happened to walk into the bedroom where her mother and step father were having sexual intercourse, and this had led to her mother hitting her and describing her as a "dirty, filthy young lady."

The treatment of this patient was based on the "elevator technique" (Macvaugh, 1979). In hypnosis, she was instructed to imagine herself in an elevator at the 20th floor, and to regard it as a visually stimulating and colourful experience. The patient was surprised to find that the door handles were replicas of her husband's penis and the author utilised this imagery by giving her suggestions that the door handles were attractive to her, that they were beautiful and completely natural objects. She was encouraged to react favourably to the penises. Gradually her tension lessened as she became more susceptible to these direct suggestions, and her feelings intensified as the elevator descended from one floor to the next. In addition, she was encouraged to imagine bringing her lips to the penises and moving them all over her body.

Subsequently, the author introduced the "desert island experience," in which the patient was encouraged to feel the warmth of the sand and water in order to promote pleasant sensations in the vagina and breasts. Further work using the regressional technique uncovered a sexual experience with her grandfather at age six which, at that time, produced sensations which she could not understand, while the final regression elicited a scene where her mother

wished to destroy the foetus first by hitting her abdomen and secondly by inserting knitting needles into her vagina.

The net result of the therapy was extremely rewarding, as she not only became capable of having an open and fulfilled relationship with her husband, but she was also able to explore and respond to his sexual touch. She later became pregnant and was able to cope with the whole of her labour, without the need for analgesics, by using self-hypnosis and the “desert island technique.”

A similar approach using a regression technique was employed by Bakich (1995) to uncover sexual traumas in a female patient who had a lack of sexual feeling in the last five years of her marriage. She was regressed to the age of 12 when she had experienced her landlord touching her breasts and genitalia. In particular, she experienced flashbacks of the landlord’s “hairy hand.” The therapist encouraged her to “let go” of this “hairy hand” in hypnosis, and he suggested to her that it would only be her husband’s hand that would be close to her. She was also given ego-strengthening (Stanton, 1993) to improve her low self-esteem.

A most unusual case was reported by Araoz (1980), who treated a 37-year-old married man who had never experienced any form of enjoyable sexual activity, even though he had three children. It was clear from the preliminary history taking that he had been primarily concerned with his intellectual pursuits, as this had been strongly encouraged by his family throughout his life, and this might well have had interfered with his sexual enjoyment. As he had never enjoyed sexual activity in the past, he was encouraged to try to invent new, pleasurable sexual scenes during the hypnosis.

Lifelong hypoactive sexual desire disorder is more difficult to treat than the acquired variety; it is far simpler to treat patients who can recapture pleasurable sexual experiences. The focus of the treatment was to build up a pleasure hierarchy, and the patient was asked to list a series of potentially enjoyable aspects of sexual activity with his wife. They were as follows:

- when his wife embraced him,
- when he rubbed accidentally against his wife’s naked body in bed,
- when his wife showed “urgency of desire” while making love,
- when she massaged his chest and abdomen, and
- when he massaged her thighs and buttocks.

Araoz skilfully devised a series of elaborate sexual and sensual fantasies which appealed to visual, tactile, and olfactory sensations. The patient was encouraged to enjoy these sexual fantasies and to associate these with feelings of relaxation and well being.

An important strand of the treatment was the two post-hypnotic suggestions. The first was that the patient would experience these good feelings before going to bed with his wife, and the second was that these feelings would be initiated by his wife's embrace. He was also instructed to use self-hypnosis with the aid of an audio tape and this was to be used on a daily basis. The whole of the treatment was achieved in only two sessions; however, there were also two mini sessions on the telephone where the post-hypnotic suggestions were reinforced. This patient made a remarkable recovery in a very short space of time and was able to enjoy sexual intercourse with his wife three times a week.

### **Sexual Aversion Disorder**

This is a disorder in which the patient is repulsed by sex, and this ranges from a mild anxiety to a severe disgust and avoidance of all sexual activity. The sexual aversion may be limited to certain aspects, such as kissing or vaginal penetration, or may be more global. In severe cases, the aversion is so strong that the mere prospect of sexual contact can lead to panic attacks.

Bakich (1995) described a 31-year-old married lady who met the criteria of sexual aversion disorder. She came from a happy background and had no idea why she should find sexual activity with her husband disgusting. All forms of sexual activity — viewing or touching the penis, as well as sexual intercourse — made her feel “yucky,” and she stated that she would do anything to correct this disturbance. In particular, she hated the wetness and stickiness of the seminal fluid.

The author used the “diary technique,” in which the patient was asked in hypnosis to imagine a page with the numbers 1–31 running backwards, each number representing a year of her life. Using ideomotor signalling, she stopped at the age of 16, at which point she became visibly nervous. On enquiry, she said that she had had her first sexual encounter with a man several years her senior. She went on to describe the sexual activity which consisted of the man ejaculating and spreading the seminal fluid over her body, and then urinating over her. She sobbed and was unable to touch any part of her body at this point.

In order to combat her feelings of disgust, a systematic desensitisation approach was employed in which the patient was asked to visualise being naked with her husband. Gradually, in hypnosis, sexual contact was increased and, whenever she felt distressed, she was returned to her special place.

A telephonic enquiry a few months later indicated that she was now able to cope with sexual intercourse with her husband. The whole treatment was achieved in four sessions.

## **SEXUAL AROUSAL DISORDERS**

### **Female Sexual Arousal Disorder (Frigidity)**

The essential components of female sexual arousal disorder include a persistent inability to produce an adequate lubrication-swelling response to sexual excitement, inadequate vasocongestion in the pelvis, and a deficient swelling of the external genitalia. In order to make this diagnosis, it is important to exclude patients who have any medical condition which might interfere with adequate sexual arousal such as diabetes mellitus and atrophic vaginitis.

Several approaches have been used in the treatment of frigidity, notably that of Araoz (1983), who obtained high success rates with cognitive restructuring in the treatment of sexual arousal disorders. When treating patients suffering from frigidity, he observed that frequently these women made negative statements about themselves, which, in turn, led them to believe that they were “sexual failures” and that they could not do anything about their problem. As a result, they developed a very low self-image. In the treatment, he emphasised the importance of changing strong, negative statements such as, “I’ll freeze all over next time he touches me” to more positive statements (“counteractive cognitions”) which are elicited by the patient. These might include the following:

- I’ll experience new sensations next time he touches me.
- I’ll become more aware of what it feels like to be touched.
- I can learn to react positively to his touch.
- I can see myself enjoying his touch, feeling nice and warm.
- I’ll become more directive, so that he touches me the way I want.

In addition to using these phrases during the treatment sessions, it is important to reinforce these statements in self-hypnosis. The value of hypnosis and self-hypnosis was established by Araoz in a large study involving 200 couples, of whom 50 had traditional sex therapy and 150 were treated with hypnosis in addition to the traditional sex therapy. At one year follow-up, there was a large difference between the non-hypnosis and hypnosis groups: He found that only 10% (5/50 patients) who had received traditional sex therapy were satisfied with their treatment, whereas 70% (105/150 patients) of the hypnosis group were happy with the treatment results and continued to

use self-hypnosis regularly. Interestingly, many of these patients used hypnosis to help them with other problems such as flying phobia, going to the dentist, and migraine attacks.

An alternative approach to the treatment of frigidity is the “red balloon technique” described by Walch (1976). The patient was a young married woman who was well aware that she had guilt feelings regarding pre-marital sexual intercourse, but felt completely at a loss to know how to deal with them. This technique is particularly helpful for those patients who experience a lot of guilt and where this is central to their frigidity. The “red balloon technique” was described by the author as being “hypnocathartic.” It was suggested in hypnosis that the patient should visualise a sturdy container where she should off-load a large proportion of her guilt feelings and other unpleasant thoughts. She was also instructed to imagine a large red balloon and to fill it with helium. When the balloon was filled, she was encouraged to fasten the container to the balloon, to loosen her grip and to watch both balloon and container floating into the distance. It was suggested to her that, as the balloon receded into the distance, her feelings of guilt would be greatly diminished. During hypnosis, the therapist noticed the patient smile and her head move in an upward direction as the balloon drifted off into the distance. A week later, when she came for her next treatment session, she was obviously feeling a lot better, and she asked to “send up another balloon.” After two additional treatments, she reported being able to achieve sexual climax.

A completely different treatment approach is that used by Metcalfe (1988), in which patients were encouraged to imagine a ball of clay in hypnosis — he referred to this as the “modelling clay technique” or “hypnoplasty.” The aim of the treatment is that the clay should take on a form which is significant to the cause of the symptoms. In particular, this technique is extremely helpful in allowing patients to abreact their angry feelings towards parental figures. When the patient has been able to release her feelings of anger towards her parents, it is no longer necessary for her to project these feelings onto her partner. This, in turn, relieves her of her frigidity.

An alternative approach is one used by Oystiragh (1980), who employed automatic writing in hypnosis as a way of unearthing a number of problems relating to frigidity. The author gave a detailed description of a 28-year-old married lady who had had a rather unhappy childhood, in which she was moved from one foster home to another, and was also raped at the age of nine and again at the age of 11. Ostensibly, the problem was one of obesity, but it was soon established that she had a series of psychosexual problems

— she didn't like undressing in front of her husband, had difficulty touching her husband's penis, and did not particularly enjoy sexual intercourse. The treatment strategies included age regression, abreaction and, in particular, automatic writing in which the patient was given a pen and paper in hypnosis and asked to write down what she felt. It was suggested that she "let her hand do all the work" and that she should write down whatever was troubling her.

In one of these sessions, she wrote down some words and phrases, and later she was asked to decipher them. The key words and their connotations are shown below exactly as written by the patient:

- Hurts me — during penetration.
- Dirty — sweaty, wet, sticky feeling, smell of body.
- Animals — men use ladies like animals. All they want is physical release. They don't care whether they hurt.
- No love — remembers mother and all the different men. How can all these men love mum. They only want to use her body. They want to use my body.
- Ugly body — mother's body got ugly, got fat and I'm fat.
- Can't love — wants to love people, but is frightened that she will be all alone again.

This patient made an excellent recovery: she no longer needed to switch off the light when undressing, she enjoyed and initiated sexual intercourse and could also cope with fondling. A six month follow-up showed that her considerable improvements were maintained.

### **Male Erectile Disorder (Impotence)**

This is defined by a persistent inability to obtain or maintain an adequate erection and must not be associated with any medical condition such as spinal cord injury, vascular conditions involving the penis, diabetes mellitus, and multiple sclerosis. When making the diagnosis, one must take into account that, in older age groups, more stimulation is required to achieve adequate erections.

Impotence which is present from the onset has been termed "primary impotence" (rare), whereas impotence occurring after normal sexual function has been called "secondary impotence"; however, in the *DSM-IV* classification, these phrases were replaced by the terms "lifelong" and "acquired" respectively. In clinical practice, it is important to distinguish these, as it is much easier to treat patients who have had normal erectile function in the past than those who have not.

Frederick (1991) described the successful treatment of a 38-year-old male patient who sought treatment for an impotence problem which was causing him distress in his second marriage. The therapist employed a hypnoanalytic approach to the problem, and, during the course of the therapy, a number of important issues came to the fore:

- His mother was the major influence in his life.
- His mother caught him masturbating as a teenager.
- His mother gave him negative cues about girls and the evils of sex.
- He often visualised his mother while masturbating.

He had projected his feelings about his mother onto his wife (who bore a close resemblance to her in many respects), and this echoed the feelings of sex being taboo.

In the treatment sessions, Frederick, using a combination of psychotherapy and hypnotherapy, concentrated on separating the mother/wife identification. A number of treatment strategies were used including cognitive restructuring, ego-strengthening and the “sensate focus” approach of Masters and Johnson (1970). At the 10th treatment session, the patient reported that he was able to have full sexual intercourse with his wife, and this improvement was maintained at three month follow-up.

An entirely different approach was used by Stanton (1990), who described a method of treatment which he referred to as “double dissociation.” The patient was asked to imagine sitting in the middle of a cinema watching a black-and-white snapshot of himself prior to a failed sexual experience. He was then instructed to float out of his body into the projection booth where he could “watch himself watching the screen.” In this way, the patient was able to distance himself from the experience and became less upset about it. Next, he was encouraged to watch a black-and-white film of himself having a failed sexual experience; at this point, the film was converted into colour and was played backwards. Finally, the therapist used a re-framing technique where the film was run forwards again, this time depicting a successful sexual outcome.

In treating such cases, some therapists prefer to concentrate on producing powerful arm rigidity in hypnosis, with the view to transferring this to the penis. Crasilneck (1992) used this direct approach when treating impotence. During the hypnosis session, the patient was asked to extend his dominant arm and told to feel the muscles in his forearm; the patient was then repeatedly given direct statements that the arm was completely rigid and made of steel. The patient was then asked to open his eyes and to observe the strength in the muscles of his arm, before closing his eyes again. He was then told that if

he could produce this rigidity in one part of the body he could reproduce it in another, that is, in the penis.

It has been suggested by Fuchs, Zaidise, Peretz, and Paldi (1985) that the arm levitation technique has symbolic value for these patients and might well enhance the effectiveness of the treatment.

## **ORGASMIC DISORDERS**

### **Female Orgasmic Disorder (Formerly Inhibited Female Orgasm)**

The essential feature of this disorder is that there is a delay or absence of orgasm after an adequate amount of sexual stimulation. The therapist must assess this in relation to the age of the patient, past sexual experiences, and the amount of sexual stimulation she received prior to, or during, intercourse. Again, this disorder may result in low self-esteem and might have an effect on interpersonal relationships. Generally, orgasmic disorder is lifelong rather than acquired; however, once women have acquired the ability to reach orgasm, this tends to be maintained, unless they have had a traumatic experience, a mood disorder, or have suffered from a general medical condition.

Smith (1975) reported a case of a rather immature woman aged 28 who had failed to reach orgasm at any time throughout the eight years of her marriage. An exploration revealed that, having had a very close relationship with her father, and having referred to herself as "Daddy's little girl," she considered herself more as a daughter to her husband rather than a wife. Indeed, her father bore a very close resemblance to her husband. During the hypnotherapy session, the therapist emphasised that she was making love to her husband and not to her father. The treatment was highly effective and she was able to reach climax with her husband when having sexual intercourse. This was maintained at follow-up, and she continued her psychotherapy which focused on ensuring that her own desires were met in the bedroom.

Smith described two other female patients who had an acquired orgasmic disorder, both of whom made an excellent recovery. One of these patients was a highly dependent and immature female, aged 36. Her problem could be traced to her in-laws and the fact that her husband did not support her adequately. She could not cope with criticism from her in-laws and she turned to alcohol and drugs as an escape route. In addition, she used the lack of orgasm as a way of punishing her husband. In the hypnotherapy sessions, her attention was drawn to the fact that she was not only punishing her husband, but that she was also punishing herself, and that more mature patterns of behaviour could



be learned. As a result, her husband became more supportive, and once these issues had been resolved she was able to be orgasmic once more.

An alternative approach was one employed by Stewart (1986), who used hypnoanalysis in the treatment of a 33-year-old woman who had lifelong anorgasmia. This was caused by underlying conflicts in her early childhood. She stated that she felt that she was unable to “let go,” that she never really enjoyed sexual intercourse, and that she became distracted shortly before orgasm. Hypnoanalysis revealed that her parents were undemonstrative and never showed any affection towards one another. In hypnosis, she revealed that, at the age of five, she had a doll on which she lavished her affections and used as a lover. She described putting lipstick on and transferring this to the doll; her mother caught her doing this and scolded her embarrassingly in front of her family and friends. From the age of five onwards, and into adolescence, she used the doll for masturbation purposes and this remained her “secret” for 27 years; in fact, this had had a profound effect on her sexual development. She had associated the doll with punishment and the fear of further punishment, and this then interfered and perpetuated her inability to reach orgasm in her adult life.

During the course of the therapy, the patient began to understand the unconscious processes which had interfered with her reaching orgasm, and this proved to be very helpful in her recovery. The outcome was that she not only felt more comfortable with men in general, but was also able to enjoy sexual intercourse and orgasm.

Crasilneck and Hall (1985) favoured a combined approach of direct suggestion — focusing on the sensitivity of the vagina and clitoris — and psychodynamically orientated psychotherapy. They also stressed the importance of bringing the husband into the treatment sessions, as the wife’s lack of orgasm may well undermine his sense of masculinity (Degun & Degun, 1991).

## **Premature Ejaculation**

The term premature ejaculation denotes a rapid male orgasm which may occur either before penetration takes place, or during sexual intercourse. This condition is distressing for both partners because it does not give the female any chance to enjoy the sexual experience. Important variables include the age of the patient, the novelty of the sexual partner or situation, and frequency of sexual activity.

The standard approach to the treatment of premature ejaculation is the “squeeze technique” (Kilmann & Auerbach, 1979). This technique does not

require the assistance of hypnosis. Here, the woman is instructed to squeeze the frenulum with the thumb and to use her two fingers to grip the penis for 15 to 30 seconds. This has the effect of reducing the erection, and is followed by further stimulation. This cycle is repeated many times over a period of 20 minutes and, as a result, it has a delaying effect on orgasm.

Erickson (1973) described the successful treatment of a 38-year-old male patient who had suffered from premature ejaculation for 19 years. The technique that he employed with this patient — which we will refer to as the “wrist watch technique” — was to use a series of post-hypnotic suggestions involving symbolism, and an enormous amount of emphatic and repetitious language. First, he was instructed to buy a wrist watch with illuminated hands, and Erickson insisted that it had a second hand; second, he was told that he would fail to reach orgasm for 10, 15, 20 minutes, and then later 25, 25½ and 26 minutes. Third, he was told that, however much he strived, he would be unable to reach orgasm and that he should concentrate all his attention on the wristwatch. Later, he was asked to imagine bringing a girl home to his apartment, and he was told to concentrate on the cracks between the paving stones with a feeling that the path to his home was never-ending. The length of the walk home had symbolic value for the patient and this had the effect of holding off the orgasm. Erickson reported that the patient married 18 months later and had made an excellent recovery from his premature ejaculation.

A 23-year-old male patient suffering from premature ejaculation was successfully treated by Stricherz (1982) using a combination of age regression and abreaction. He was regressed to the age of six and this released a great deal of emotionally charged material. During this abreaction, he described a scene in which he was in bed with his mother who was caressing him in a sexual manner at a time when his father was out of the house. When his father returned, the patient felt blows to his body and could hear a loud, vibrating voice shouting at his mother. As the therapy progressed, attention was focused on his repeated failures throughout his childhood and the therapist made the direct suggestion that he would “fail to fail.” The following week, he was able to maintain an adequate erection during intercourse and this was maintained for a period of 2½ years.

### **Male Orgasmic Disorder (Formerly Inhibited Male Orgasm or Retarded Ejaculation)**

This is a condition where the male partner experiences extreme difficulty in reaching orgasm during sexual intercourse, although it may be possible for him

to reach orgasm in sexual activity not involving intercourse, such as manual or aural stimulation. Some men, however, can experience orgasm during coitus, if they have received a great deal of prior stimulation.

Pettitt (1982) used a series of approaches when treating a 33-year-old man who had suffered from retarded ejaculation for many years. The patient had 30 hours of therapy over a six-year period. The treatment strategies included:

1. Ego-strengthening and improving feelings of warmth towards his wife.
2. Re-capturing times when sexual activity had been enjoyable.
3. Hallucinated hypnoplasty which involved imagining modelling with clay — first, releasing angry affect and, second balancing this by creating a piece of beautiful sculpture.
4. Time distortion.
5. Use of imagery and symbolism, focusing on the germination of seeds into a golden flower, symbolising the awakening of sexual arousal.
6. Dream interpretation.

In the dream work, the author employed a gestalt approach in which the patient was required to take on all the respective parts of the dream. He was then encouraged to describe the life of each character and to offer his own interpretation. In addition, he was instructed to project himself into the future at a time when he no longer had these problems: Here, he decided to give himself two targets — first, to become closer to his wife, and second, to take life less seriously. At follow-up, he reported that he was now able to have simultaneous orgasm with his wife, although he still required some manual stimulation prior to sexual intercourse.

## **SEXUAL PAIN DISORDERS**

### **Dyspareunia**

Dyspareunia, a term which was first introduced by Dupuytren in 1839, denotes pain which some women experience during sexual intercourse: This pain is not associated with either vaginismus or a lack of lubrication. The pain which the women experience may range from mild to severe, sharp pains. Patients who complain of dyspareunia tend to go to their general practitioners for advice, but examination fails to reveal any physical abnormality; nevertheless, individuals who suffer regularly from this condition often avoid sexual experiences or meeting potential new partners.

Kandyba and Binik (2003) described in detail the treatment of a 26-year-old single woman who had been suffering from dyspareunia for three years.

The main feature was that she suffered pain on penetration — stabbing and burning sensations — which lasted for one minute and then would subside during sexual intercourse. Following coitus, again she would experience burning sensations when passing urine. Interestingly, her dyspareunia did not affect her sexual desire: There was no evidence of vaginismus and she was motivated to come for treatment to alleviate this pain.

The first aim of therapy was to ensure that she could insert two fingers into her vagina without any pain, and this was achieved with the use of pelvic floor physiotherapy. The patient received 12 sessions altogether in which the therapist used a combination of psychotherapy and hypnosis. The emphasis of the hypnotherapy was to counteract anticipatory anxiety and this was achieved by the use of the special place. This approach was effective in reducing pain.

During assessment, it was established that the patient's mother suffered from a bipolar affective disorder and that she constantly berated her daughter, as she did not like the close relationship that she had with her father. It was also established that, at the age of 12, her parents divorced and she had to spend several years in a foster home because her mother was unable to look after her.

In the hypnotherapy, the patient was encouraged to imagine a special place where she felt comfortable and relaxed; she was then asked to imagine having sexual intercourse in that place with her present partner. Positive suggestions were then given to encourage feelings of comfort and satisfaction. The next treatment objective was to reduce the pain. She was asked to imagine the pain and to switch it off like a light switch. She also was instructed to visualise the light switch and to see herself turning it off; this was important as it gave her the feeling that she was now in control of her own pain.

Even after the first hypnotherapy session, there was a dramatic improvement with regard to her pain, but this returned when she had sexual intercourse for the second time. However, at this point, she was able to use the electric light switch approach to eliminate the pain. She did not re-experience any pain from then on, and gradually anticipatory anxiety was reduced to a minimum and she reported that she had “control” over her pain.

A telephone follow-up interview after two months showed that she had been pain free, and that she only had brief thoughts about experiencing pain; a further telephone interview at 10 months confirmed that she had remained symptom free.

The authors pointed out that the excellent prognosis for this patient may, in part, be due to the very brief duration of pain during intercourse and also

that she had no interference with sexual desire. It was postulated that, women who have always experienced pain during sexual intercourse might require a more lengthy treatment program.

## **Vaginismus**

This term, first described by Huguier in 1834 as the title of his MD thesis, is used to denote a spasm of the perineal muscles surrounding the outer third of the vagina. Vaginismus or vaginal spasm may be precipitated by sexual intercourse, the insertion of a finger or speculum, or merely the prospect of any of these taking place. The spasm may range from slight pains or may be so severe that sexual penetration becomes impossible. Women who suffer from vaginismus tend to have normal sexual arousal and an adequate amount of lubrication but still experience vaginal spasm on penetration.

Aetiological factors which may lead to vaginismus include previous sexual traumas, such as rape or incest; a reluctance to accept sexual intercourse within marriage when punitive attitudes have been expressed to pre-marital sex; homosexual orientation; previously traumatic pelvic examination by gynaecologists; and fear of pregnancy. An important feature of vaginismus is a faulty psychosexual development leading to a phobic reaction to sexual intercourse.

Fuchs (1980) described a 23-year-old married woman who had vaginismus, a fear of pain and a resistance to any attempt at having sexual intercourse. He treated this patient using the “in vitro” method which involved the construction of a graded anxiety hierarchy of increasingly erotic sexual situations. After an initial history taking, she was introduced to hypnosis and was asked to imagine this graded series of sexual situations. Finally, she was asked to visualise having sexual intercourse. After the ninth session, she reported that she was now able to have full sexual intercourse without any vaginismus, and she also commented that she had lost her other three phobias — claustrophobia, the phobia of the dissection of fish and chicken, and phobia to the pictures of childbirth.

Fuchs went onto describe another patient who previously had had a hymenectomy and who had subsequently developed a fear of gynaecologists as well as an acute awareness of her vaginismus. After being taught self-hypnosis, she was invited to insert a series of dilators into her vagina and, after three weeks, she was able to achieve sexual intercourse without any vaginal spasm. This technique was described by Fuchs as the “in vivo” technique.

The outcome was excellent in both categories. Good results were obtained in 16 out of 18 patients by the “in vitro” technique and 53 out of 54 patients using the “in vivo” technique. Fuchs (1980) emphasised the importance of not carrying out surgical procedures on these patients, because this does not improve the situation and, if anything, it intensifies the symptomatology. Apart from causing scarring from the surgical incision, it also causes psychological damage.

Delmonte (1988) described the case of a 32-year-old married woman, Mary, who was suffering from vaginismus. Here, there was evidence of previous sexual trauma and she associated coitus with violence. Indeed, this trauma consisted of a combination of sexual abuse and violence. A number of treatment strategies were employed, including hypnotherapy, Jacobson’s (1938) progressive muscular relaxation, yoga, and a number of breathing exercises.

She made a good recovery in five treatment sessions and this was maintained at six month follow-up. After one month, she reported that she practised relaxation daily and was able to have sexual intercourse every night without pain. Six months later, Mary reported that sexual intercourse was now satisfactory and that she had a good relationship with her husband.

## **CONCLUSION**

This paper has demonstrated quite clearly that hypnotherapy is an extremely valuable tool in the treatment of sexual dysfunctions, a treatment approach which does not involve the use of any medication. A recurring theme throughout this paper is the role of sexual trauma in the psychopathology of sexual disturbances; for example, sexual trauma may be a cause of hypoactive sexual arousal disorder, sexual aversion disorder, frigidity, impotence, female orgasmic disorder, premature ejaculation, and dyspareunia.

On reviewing the global literature, it is apparent that some authors restrict their treatment to a behavioural approach, such as the use of cognitive restructuring for frigidity (Araoz, 1983); other authors prefer to concentrate on the causation of the problem, such as the diary technique used by Bakich (1995) in the treatment of sexual aversion disorder; while a third group uses a combination of these, for example, Crasilneck and Hall (1985), who employed a combination of psychodynamically orientated psychotherapy and direct suggestion. Excellent treatment results have been obtained with all of these approaches and this demonstrates that there is no real antagonism between the behavioural approach and the psychoanalytic approach (Kraft, 1969). The advantage of hypnosis, compared to psychotherapy, a much lengthier process,

is that it can focus quickly and immediately on the causative factors which have been responsible for the sexual disorder and effectively pinpoints the date, time, and precise nature of the disturbance. Hypnotherapy offers a rapid and cost effective form of treatment for sexual disorders, and it is recommended that these procedures are used in therapy.

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## **A CASE STUDY ANALYSIS OF MEASURES OF SELF-DEFEATING EATING AND HYPNOTISABILITY**

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*In this article, in-depth examination of a number of cases in eating behaviours and hypnotisability has been undertaken to emphasise the complexity of some of the issues involved in self-defeating eating. These case studies further highlight the fact that no single measure, used in isolation, can accurately reflect the complex attitudes and capacities which are currently under scrutiny and that measurement of eating pathology is not a straightforward matter. The analysis reveals an emergent emphasis on those factors which indicate possible differences in self-perception in relation to control and regulation of the self.*

These case studies were part of a wider study of a larger cohort of participants, the results of which have been published in *Contemporary Hypnosis* (Hutchinson-Phillips, Jamieson, & Gow, 2005). A literature review covering aspects of hypnosis as an adjunct to CBT in the treatment of self-defeating eating was published in the *Romanian Journal of Cognitive and Behavioral Psychotherapy* (Hutchinson-Phillips & Gow, 2005) and an article relating to issues of appropriate measures of hypnotisability has recently been published in the *International Journal of Clinical and Experimental Hypnosis* (Hutchinson-Phillips, Gow, & Jamieson, 2007).

Thus, in this article we concentrate on the data from the case studies. Firstly we introduce the model that the overall research approach explored, then

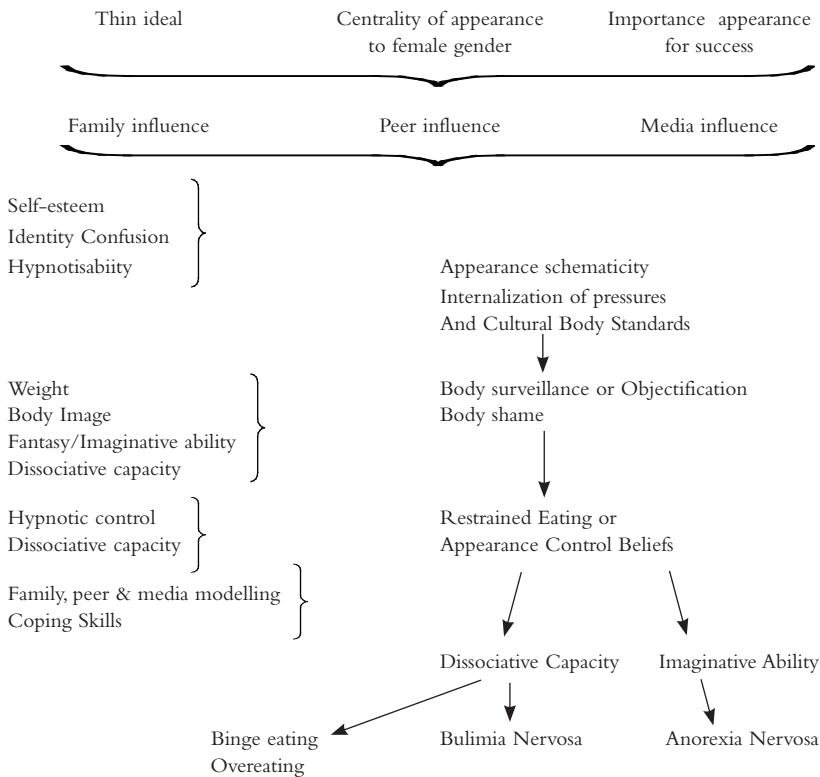
delineate the measures and the procedure for collecting the case study data and outline the rationale behind the reporting of the case studies.

**AIM OF THE RESEARCH**

In her thesis on *Self-Defeating Eating: The Role of Hypnotisability and its Correlates in its Aetiology and Treatment*, Hutchinson-Phillips (2004) proposed a model that might help to explain the links between hypnotic susceptibility and eating disorders. This model was labelled the Hypno-Socio-Cultural Model of Self-Defeating Eating (see Figure 1) and suggested

links between the aetiology of dysfunctional eating behaviours and higher levels of hypnotic susceptibility, fantasy ability and dissociative capacity, as well as acknowledging the social genesis of the self-defeating approach to diet. Empirical evidence has supported the socio-cognitive theory of causation and remediation, on which the lead author's research was based. (p. iv)

**Figure 1:** The Hypno-Socio-Cultural Model of Self-Defeating Eating



It was this conjectured model that led to the larger research project and the in-depth analysis of the cases described herein. (Further information on the Hutchinson-Phillips model can be obtained from the Queensland University of Technology library electronic thesis catalogue system [<http://www.qut.edu.au>].)

## **CASE PARTICIPANTS AND ASSESSMENT TOOLS**

### **Participants**

As many university students are in the age group between 18 and 22 years (Sanders, Gaskill, & Gwynne, 2000) which is most usually afflicted by the eating disorders of interest, it was assumed that there might be a number of participants whose profiles were close to those with dysfunctional eating behaviours. Thus a group of undergraduate and postgraduate students involved in hypnosis studies at the Queensland University of Technology were surveyed. Of these 80 participants, whose ages ranged from 18 to 57 years ( $M = 30.3$ ,  $SD = 11.1$ ), 20 were males and 60 were females, which is the usual ratio of males to females enrolled in hypnosis units. The results of 12 participants selected from this larger group were subjected to in-depth scrutiny from a clinical perspective and these analyses form the basis of this article. It is acknowledged by the authors that the responses of people electing to undertake hypnosis units may be different from those who do not and that future research would need to have a comparison group to check for such a bias.

### **Assessment Tools**

To test hypnotic susceptibility, two hypnotic susceptibility scales were employed, the Harvard Group Scale of Hypnotic Susceptibility: Form A (Shor & Orne, 1962) and the Creative Imagination Scale (Wilson & Barber, 1978, 1979). The Phenomenology of Consciousness Inventory (PCI: Pekala, 1982, 1991) was used to check for subjective experience in relation to sensations, perceptions, feelings, thoughts, imagery, and impressions. The inclusion of this assessment is of particular relevance, given that it is a measure of self-perception in relation to individual responses to a hypnotic situation.

To assess imaginative/fantasy ability, the Short Imaginal Processes Inventory (SIPI: Huba, Singer, Aneshensel, & Antrobus, 1982) and the well-known Inventory of Childhood Memories and Imaginings (ICMI: Wilson & Barber, 1983) were employed. To assess dissociative capacity, the Dissociation

Questionnaire (DIS-Q: Vanderlinden, Van Dyck, Vandereycken, Vertommen, & Verkes, 1993) was utilised.

Assessments of eating behaviour were undertaken by the inclusion of the Three-Factor Eating Questionnaire (3-FEQ: Stunkard & Messick, 1985), and the Eating Attitude Test (EAT: Garner & Garfinkel, 1979). In addition to providing the scores described above, this latter scale also requests information relating to current weight, lowest and highest weight, and height. From these measures, it is possible to compute Body Mass Index (BMI) scores.

Intrinsic to the socio-cultural interpretation of the aetiology and maintenance of self-defeating eating is the centrality of objectification of the body and intense dissatisfaction with body image. And thus the Contour Drawing Rating Scale (Thompson & Gray, 1995) and the Physical Appearance State and Trait Anxiety Scale (PASTAS) Trait Version (Reed, Thompson, Brannick, & Sacco, 1991) were chosen to highlight those body parts which were particularly the focus of dissatisfaction. The CDRS utilised 9 male and 9 female drawings, with detailed features that represent precise graduated sizes.

Space does not permit a full elaboration of the scales utilised, but readers will find that details in the following case studies give sufficient parameters for the purpose of comparisons for all scales involved.

## **Analyses**

Overall, correlational analyses were undertaken and the data were explored via ANOVAs to check for significant differences both within and between the groups for comparison purposes, as reported in Hutchinson-Phillips et al. (2005). Case results follow. Please note that the keys to abbreviations in the tables can be found at the foot of Table 12 (on p. 37).

## **What the Case Studies Revealed**

Twelve cases have been chosen to represent data from males and females, younger and older participants, those who were classified as underweight and overweight, and those of normal weight with higher scores on the eating behaviour questionnaires. The chosen respondents were closest in weight and shape to people whose eating behaviours would be diagnostically dysfunctional, or who had obtained high scores on the eating behaviour inventory measures. Eleven females were below the BMI cutoff of 20 denoting underweight, although no one in the sample reported a BMI of 17 or less, which would have been indicative of anorexic problems. Three young men

also reported a BMI below 20. Seventeen members of the sample were above a healthy BMI (25+) and of those, one male and four females were in the obese classification (over 30 BMI), while 12 were overweight to varying degrees (4 males and 8 females). All participants were designated by the code names allocated for the study.

The 12 case studies are now outlined. Obviously, the names are not the research participants' real names and full ethical clearance was obtained for the research and the publication of the results. Some of the case studies are extended examples, while others are quite short, indicating the nature of the individuals' results.

Some of the cases recorded quite wide disparities in adult weight, while others were relatively stable in terms of their shape and size. Because the ratio of males to females in the study was quite low, only two males were included in the cases which were subjected to more intensive study.

### **Case 1: Effie — Young, Underweight, Female**

Effie had a body mass index of under 20 ( $BMI = 18.75$ ) which is 94% of a healthy body weight, as currently defined. Adult weight variations were small at approximately 2.5 kilograms. She was one of the younger participants in the sample, as were the majority who registered a BMI below 20 (the exception was one 45-year-old, Kat, whose BMI was just below 20). Despite the fact that she was considerably underweight, and registered both her felt and actual weight as a 4 (from a choice of 9 silhouettes), she still desired to reduce that number to a 3, which she indicated was her ideal body shape and size. Her score on the Body Shape State and Trait Anxiety Scale — Weight Related was 14 (of a possible 32), compared with the overall mean of 14.19 ( $SD = 6.7$ ), and the mean for 20-year-olds which was 11.43 ( $SD = 7.9$ ). This was comparable with the mean non-eating disturbed score of 15.92 ( $SD = 6.0$ ) obtained by the authors of the instrument (Reed et al., 1991), as contrasted with their reported mean of 26.7 ( $SD = 3.6$ ) for the eating disordered in their sample. However, considering her underweight condition, this was an extremely high total. On the non-weight part of this scale (maximum score 32), Effie scored 7, compared with her age-group mean of 2.14 ( $SD = 3.7$ ), and the group mean of 2.5 ( $SD = 3.5$ ). This was comparable with the score of 6.6 ( $SD = 4.6$ ) for eating disordered individuals reported by those who developed the scale. It was possible that Effie had an attitude to her body indicative of body schematicity, as proposed by the cognitive-behavioural

theorists. Her scores on the Eating Behaviour tests are outlined in Table 1.

**Table 1:** Scores on EAT and 3-FEQ for Effie

Dieting	Food preocc/ bulimia	Oral control	EAT	Dietary restraint	Disin of eating	Sus to hunger	3-FEQ
2	0	1	3	1	6	10	17

Comparatively, mean scores for 20-year-olds on these two instruments were 4.43 (EAT) and 14.29 (3-FEQ), while for the total group the means were 7.54 ( $SD = 8.9$ ) and 18.34 ( $SD = 9.5$ ) for the EAT and the 3-FEQ, respectively. While the EAT score was well below the cutoff point (20) for consideration of further investigation in relation to disordered eating, the score on the 3-FEQ was relatively high, although once again there are no implications for a disordered eating diagnosis. However, Effie was obviously ignoring or controlling hunger substantially, in order to present with a significant degree of disinhibited eating and very high susceptibility to hunger.

For this participant, scores on the Dissociation Questionnaire were in the normal range, apart from the score for loss of control which was slightly elevated. However, her scores were higher than the means for her age group, as well as being higher than the mean for the whole group, as set out in Table 2. The high loss of control score may be related to her higher disinhibition of eating score. Possibly dietary restraint had become such a habit with Effie that she no longer acknowledged that she was actually carefully controlling her eating and this means that her occasional hunger/eating outbursts are noteworthy. As many experts in the field have indicated, Westernised women believe limited kilojoule intake is normal eating.

**Table 2:** Scores on DIS-Q for Effie Compared with 20-Year-Old Means and Those of Whole Group

	Identity confusion	Loss of control	Amnesia	Absorption	DIS-Q
20-year-old mean	1.6 (.3)	2.5 (.4)	1.8 (.4)	2.3 (.5)	1.9 (.3)
Group mean	1.8 (.6)	2.2 (.6)	1.8 (.6)	1.2 (.7)	1.7 (.5)
Effie	1.5	3.1	2.7	2.7	2.3

Effie's score on the Inventory of Childhood Memories and Imaginings (20) places her in the low average range, and was comparable with the 20-year-old mean of 23.4 ( $SD = 9.8$ ) and with the group average of 22.6 ( $SD = 7.6$ ), while her scores on the Short Imaginal Processes Inventory, especially on the

guilt-fear-of-failure daydreaming style, were somewhat elevated. Her scores of 50 (pleasant constructive daydreaming style), 62 (guilt-fear-of-failure) and 58 (poor attentional control) must be compared with the following means for the 20-year-old group and the total sample. These were 57.6 ( $SD = 5.3$ ), 54.7 ( $SD = 4.6$ ), and 49 ( $SD = 7.9$ ) for her own age group, and 54.5 ( $SD = 8.8$ ), 52.3 ( $SD = 8.6$ ), and 47.1 ( $SD = 11.6$ ) for the entire group. Her score on the Creative Imagination Scale (30) was in the high range, and was well above the mean for her age (20.5,  $SD = 10.7$ ), as was her result on the Harvard Group Scale of Hypnotic Susceptibility (9) compared with the group mean of 6.6 ( $SD = 2.9$ ) and the mean for her own age-group 7.2 ( $SD = 2.1$ ). Her score on the predicted Harvard Group Scale of the Phenomenology of Consciousness Inventory suggests that she was moderately hypnotisable, with a score of 5.78, compared with 4.5 ( $SD = 1.9$ ) and 4.9 ( $SD = 1.6$ ) for the 20-year-olds and the whole group respectively. Intensity scores on the other dimensions are as follows, tabulated to highlight both Effie's scores and those of the other six 20-year-olds, as well as the means for the entire group.

**Table 3:** Scores on PCI Dimension Intensities for Effie 20-Year-Old Group and Entire Group

	Alsta	Imam	Imviv	Imag	Altex	Bodim	Timsen	Absorp	Volcon
20's	2.6	2.2	2.4	2.3	1.93	2.13	3.26	3.6	4.00
	(1.9)	(1.6)	(1.4)	(1.4)	(1.4)	(1.9)	(1.4)	(.9)	(1.3)
Group	3.07	2.2	2.3	2.3	1.8	2.06	2.7	3.8	3.5
	(1.6)	(1.7)	(1.7)	(1.5)	(1.2)	(1.8)	(1.7)	(1.3)	(1.3)
Effie	4.67	3.5	3	3.25	2.46	2.33	4.33	3.5	3.33

From Table 3, it can be observed that Effie's scores are in the highest bracket, both for her age group and for the entire group.

Effie was a young lady who, according to her scores, had internalised quite effectively the kinds of body concerns about which the Hypno-Social-Cultural Model (see Hutchinson-Phillips, 2004) was hypothesising. Her relatively high scores on hypnotisability scales, imagination, and one factor of the dissociation scales suggest that the model may have some merit, although neither the ascription of causality, nor its direction, can be inferred from these data. Of especial interest was her relatively high score on the GFF factor (SIPI), which adds further evidence to an overall profile which suggests a relative inability to self-regulate negative imaginings and self-perceptions.

**Case 2: Zach — Young, Underweight, Male**

A 19-year-old, Zach, also had a BMI of under 20 (19.93), but unlike Effie whose weight had only varied by about two kilograms since she had reached adulthood, his weight had been considerably higher at times, varying about 8.5 kilograms above his current weight, which placed him in the overweight category at that time in his life. Despite the fact that he was just under what is considered a normal BMI, he believed that his actual size was a 5 on the silhouette rating scale, and that he felt around that size as well. His ideal body size was a 4. However, his weight-related concerns only reached a score of 5 (compared with the mean for his age-group, 13.25,  $SD = 5.8$ ) and his non-weight-related worries scored a low 2 (mean for the eight 19-year-olds 2.88,  $SD = 2.6$ ). It seemed that Zach did have considerable interest in his weight, shape and size, but may have been dealing with those in a non-self-aware manner. His scores on the EAT were low, apart from those on Oral Control, on which his score was 10 (compared with means for 19-year-olds, 2.13,  $SD = 2.0$ ; and group means, 1.68,  $SD = 2.3$ ). For the 3-FEQ, his total score of 9 was well below the mean for his age-group (19.25,  $SD = 10$ ) and for the entire group (18.34,  $SD = 9.4$ ). However, the high Oral Control suggests that he was probably carefully monitoring his food input in perhaps habitual ways, which he does not consciously think about. Or perhaps, given Zach's very high dissociation scores to be reviewed shortly, he may fall into that category of persons described by Steinberg (1994) who may be amnesic for some experiences.

All of his DIS-Q scores were considerably elevated, and a comparison between group, age group, and Zach's own scores revealed the size of the discrepancy, as depicted in Table 4. Fantasy scores for Zach were also high, as Table 5 demonstrates. His scores on the hypnotisability and related measures were also higher than average, as tabulated in Table 6. Zach was potentially in that group of hypnotisable subjects classified as virtuoso.

**Table 4:** Scores on DIS-Q for Zach Compared with 19-Year-Old and Group Means and Standard Deviations

	Identity confusion	Loss of control	Amnesia	Absorption	DIS-Q
19's	2.29(.8)	3 (.8)	2.2 (.7)	2.6(.6)	2.5 (.6)
Group	1.8 (.5)	2.5 (.6)	1.8 (.6)	2.4 (.7)	2 (.5)
Zach	3.48	3.78	3.4	3.5	3.54



**Table 5:** Scores on Fantasy and Imagination Measures for Zach Compared With 19-Year-Old and Group Means and Standard Deviations

	ICMI	PCD	GFF	PAC	CIS	Imag	Imam	Imviv
19's	26.36 (7.9)	53.4 (6)	56.9 (7)	55.2 (12.5)	17.7 (6)	2.7 (1.9)	2.7 (2)	2.7 (1.9)
Group	22.6 (7.6)	52.5 (8.8)	52.3 (8.6)	47.1 (11.6)	18.1 (7.5)	2.3 (1.5)	2.2 (1.7)	2.3 (1.5)
Zach	29	50	62	58	30	5.5	3.5	6

**Table 6:** Comparison of Zach's Scores on HGSHS:A and PCI Dimension Intensities With 19-Year-Old and Group Means and Standard Deviations

	HGSH	pHGS	Alsta	Altex	Bodim	Timsen	Absorp	Volcon
19's	7.56 (3.6)	5.1 (1.2)	3 (1.2)	1.6 (1.2)	1.7 (1.7)	3 (2.2)	3.5 (1.4)	3.5 (1.2)
Group	6.6 (2.9)	4.9 (1.6)	3 (1.5)	1.8 (1.2)	2 (1.5)	2.8 (1.7)	3.8 (1.3)	3.5 (1.3)
Zach	12	8.07	6	3.68	4	6	6	4

This profile was very different from that of Effie. While her highest scores were for imagery and related variables, Zach's scores on all of the imagery, dissociation, and hypnotic susceptibility measures were in the high to very high ranges. However, his weight-related and eating behaviour scores, apart from those for oral control, were in the lower ranges, although he obviously had some issues around weight and shape concerns, but these did not seem to influence his behaviour in the same way as they did Effie. Or perhaps his dissociative capacity had diminished his awareness of the amount to which he did monitor his weight, shape, and size, and the extent to which he had internalised the need to be thin. He admitted to the author in a post-study conversation that he had been "fat" when he was younger, an experience he disliked. Again, this participant's scores on the GFF (SIPI) were quite elevated, perhaps an indication of his general inability to regulate negative imaginings.

### Case 3: Molly — Older, Underweight, Female

Molly, code name for a 30-year-old participant in the study, was likewise under the 20 BMI healthy body weight, with her reported current Body Mass Index of 18.68. With a weight difference of approximately 3.5 kilograms in her adult life, she rated her actual and felt silhouette at a 3, and stated that this was also her ideal weight/shape. Her weight-related concerns scored an 8, with a zero

score for non-weight-related concerns. This was well below the group average, but as there were only two people of her age, comparisons with her same-age peers will be omitted. Her scores on the EAT were extremely low (total of 1), while her score on the 3-FEQ, at 19, was somewhat lower than the group norm, apart from her susceptibility to hunger score which was 9 (group norm 5.5, *SD* = 3.5). Perhaps, like Effie, dieting had become such a way of life that it was not a conscious concern, and therefore had not called forth a response. However, her susceptibility to hunger suggests that she might have been eating less than her body actually needs for energy balance, as did her lower BMI.

Likewise, Molly’s dissociation scores were average, apart from her absorption score, which was 3.16 (group norm, 2.4, *SD* = .7). Scores on fantasy measurements were relatively high, with an ICMI score of 29, and scores on the first two factors of the SIPI were somewhat elevated (pleasant constructive style of daydreaming, 59; and guilt-fear-of-failure style, 65). Unfortunately, there were no CIS scores for this participant; however, her score on the HGSHS:A (10) placed her in the highly hypnotisable range. Her pHGS (5.98) did not exactly reflect this high score; nevertheless, her phenomenological intensities were quite high, as Table 7 illustrates.

**Table 7:** Comparison of Molly’s Scores on PCI Dimension Intensities With Group Means and Standard Deviations

	Imam	Imviv	Imag	Alsta	Altex	Bodyim	Timesen	Absorp	Volcon
Group	2.2 (1.6)	2.3 (1.6)	2.3 (1.5)	3 (1.5)	1.8 (1.2)	2 (1.5)	2.8 (1.7)	3.8 (1.3)	3.5 (1.3)
Molly	4	5	4.5	4.67	3.46	3.33	5	4.5	4

Molly’s scores, particularly on both the imagery dimensions and the altered state dimensions (altered state, altered experience, and time sense) were quite elevated compared with the group mean. In common with the previously discussed participants, a high GFF (SIPI) score had been gained.

**Case 4: Kat — Middle-Aged, Underweight, Female**

Kat, a 45-year-old woman, had a BMI of 19.59 for that age range (20–25 is recommended), and had had weight fluctuations of about 7.5 kilograms in her adult life. Her body weight concerns scored 14, which was about average for the group, but her non-weight scores were considerably above the group average, at 5. Given her slight frame, these concerns again seem indicative of over-concern with body dimensions. She credited her silhouette as matching

a 6, although she felt like a 7, and her ideal body shape was a 5. This was definitely out of proportion to her actual size, given that she was underweight by about 10%. Her internalisation of the thin ideal seemed probable.

Her scores on the EAT were below the group norms, while her 3-FEQ score was equivalent to the group average. However, her susceptibility to hunger score was considerably elevated, and again, it may have been a case of her dieting having become such normal practice that it was not credited as such. Her dissociation scores were well within the average range, and her ICMI score was in the medium low range.

However, Kat's score on the CIS was high, as were her guilt-fear-of-failure and poor attentional control scores on the SIPI. Hypnotisability scores were in the high average range, with higher than average scores on the PCI dimension of altered time sense being noted.

### **Case 5: Ally — Normal Weight Range, High Scores on Eating Behaviour Inventories**

The participant, Ally (24 years of age), obtained scores that were relatively high on both eating behaviour inventories, with 23 on the Eating Attitude Test (3 above the recommended cutoff of 20), and 43 on the Three-Factor Eating Questionnaire, which was the highest score achieved by any member of this group. Her scores reflecting concerns with weight and shape were also high, although her Body Mass Index was in the lower part of the normal range, with a variation in weight of about 2.5 kilograms in her adult life. Additional insight into her attitude to her weight and shape was afforded by her rating of her shape as a 5 on the contour rating scales, with an ideal body weight of 3, and a felt body shape of 6. With a Body Mass Index of 21, these ratings are somewhat biased in the direction of acceptance of societal ideals of appropriate body size and shape, rather than a reflection of what might be expected for a healthy body size. Her actual size would be closer to a rating of 4 than to a 5. On the PASTAS (Physical Appearance State and Trait Anxiety Scale), her weight-related concerns totalled 25, which was close to the 26.7 mean score reported by Reed et al. (1991) for their eating disordered group.

Scores on dissociation, fantasy, and hypnosis scales were all above average for this participant. In particular, her scores on identity confusion, loss of control and absorption, as well as her total score on the Dissociation Questionnaire, which were 3, 3.7, 3.4, and 3, respectively, were above the normal limit, and much higher than the group norm of 2.06 ( $SD = .54$ ). Hypnotisability and

imagination scores were only slightly above average, although her scores for altered state, altered time sense, absorption, and amount of imagination (Phenomenology of Consciousness Inventory) were also higher than average. Pleasant constructive ( $M = 52.6$ ,  $SD = 8.8$ ) and guilt-fear-of-failure ( $M = 52$ ,  $SD = 8.9$ ) daydreaming styles, however, scored well above average (at 68 and 63, respectively). On the poor attentional control dimension, she was significantly below the average of 47.1 ( $SD = 11.6$ ) with a score of 21.

This was a case in which the full range of weight- and shape-related scores, considered in the context of the very high scores on the eating behaviour questionnaires, would need to be taken into account in understanding the relevant issues. Taken in isolation, the Body Mass Index, which was in the normal range, does not provide insight into the possible body image and eating problems experienced by this young woman, although those afflicted with bulimia are usually in the normal weight range. Her profile of scores on the eating behaviour questionnaires suggested that both dietary restraint and bingeing behaviours were at a relatively high level, which could indicate that she had bulimic tendencies. High dissociative and fantasy abilities may play some part in this symptomatology. Once again, this participant scored above average on the GFF (SIPI) scale.

### **Case 6: Barb — Normal Weight Range, High Scores on Eating Behaviour Inventories**

Aged 35 years, and with a Body Mass Index of 21.1, this participant also had high scores on the PASTAS-Weight (22), the Eating Attitude Test (23), and the Three-Factor Eating Questionnaire (23). Scores on dietary restraint were quite elevated in both questionnaires. She actually rated her current size as a 3, her felt size as a 4, and her desired or ideal size as a 4. During her adult life, differences of only about 2.5 kilograms were reported in her weight.

Scores on the hypnotic susceptibility and fantasy questionnaires ranged from moderate to high, with a very high score on the HGSHS:A (11) and a correspondingly high score on the CIS (36), and high scores on PCD and GFF (SIPI), as well as on the ICMI. Barb was placed in the fantasy group of responders on the PCI, and had exceptionally high intensity scores on imagery, amount of imagery, imagery vividness, altered experience, body image, time sense, and absorption states. Her low score on voluntary control suggested that she felt very much as though she was responding to suggestions involuntarily. Her dissociation scores were in the average range for identity confusion and

amnesia, but well above normal for loss of control and absorption.

Overall, Barb appeared to have issues around size and shape, as well as a tendency to dietary restraint, combined with extremely high hypnotisability scores, higher than average fantasy scores, and some high dissociation scores. This was the kind of profile that would be predicted by the Hypno-Social-Cultural Model (see Hutchinson-Phillips, 2004).

### **Case 7: Zoe — Normal Body Weight, High Scores on Eating Behaviour Inventories**

Zoe's very normal body weight (BMI, 23.4) did not in any way predict the high scores she obtained on all the size, shape, and eating behaviour measures. Her PASTAS-Weight score (29) was in the range for eating disordered individuals. Despite her average body size, she rated her actual size as 7 on the Contour Drawing Rating Scale, while her felt size was 8, and her ideal size was a 3. Such ratings may be explained by the fact that, over her adult years, she had varied by some six kilograms in weight, with her highest weight placing her in the decidedly overweight category. Scores on both the eating inventories were also very high (EAT, 34; 3-FEQ, 33). Those factors on which she obtained highest ratings included dietary restraint (EAT) and all factors of the 3-FEQ (dietary restraint, disinhibition of eating, and susceptibility to hunger).

In relation to scores on the other measures, those related to imagery and fantasy were only average, although her GFF (SIPI) score was relatively high, while her score on the HGSHS:A (8) placed Zoe in the high average range. However, her scores on the intensity ratings of the PCI were high and she was identified as a fantasy hypnotic responder. Higher than average intensity scores were achieved on altered state, imagery, imagery amount and imagery vividness, body image changes, and altered state. Her dissociation scores were average, with a slightly elevated score on the loss of control factor.

Once again, these kinds of scores are generally supportive of the kinds of connections hypothesised in the Hypno-Socio-Cultural Model (see Hutchinson-Phillips, 2004), although the subject does not, strictly speaking, fall within one particular self-defeating eating category.

**Case 8: Myrna — Normal Weight, High Scores on Eating Behaviour Inventories**

One further case from this range of weights which would not, by itself, attract interest in terms of eating pathology will further reinforce the idea that measurement of eating pathology is not a straightforward matter. Myrna, aged 45 years, registered a BMI just outside the range classified as average (25.9). Her scores on all the weight, shape, size, and eating inventories were above average. Her PASTAS-Weight score of 31 was above the range considered eating disordered by the authors of the instrument, although her non-weight score was only 3. Although her score on the EAT (21) was only just above the cutoff advised by the author, her 3-FEQ score was high at 32. She scored high on both measures of dietary restraint, as well as on disinhibition of eating and susceptibility to hunger. She judged her actual weight as a 7, but felt more like a 9, and would have preferred to be the size represented by a 3 on the Contour Drawing Rating Scale. An adult range of 11 kilograms in weight perhaps helps to explain these choices.

Once again, this participant was rated a fantasy responder on the PCI, and registered moderate to high scores on most of the imagination scales, with the notable exception of her low scores on the SIPI. Dissociation scores were generally very high. Hypnotisability, while rated as only medium on the HGS:HS:A, was perceived by the respondent as phenomenologically somewhat higher on her pHGS score. Intensity ratings which were higher than average included altered state, imagery, imagery amount and imagery vividness, as well as time sense and absorption. Her perception of voluntary control was rated as extremely low.

Once more, the kinds of scores which would be expected if the Hypno-Socio-Cultural Model had some validity in reflecting reality were found with this participant.

**Case 9: Susan — Obese, Middle-Aged, Female**

Susan was 48 years old at the time of this research. With a BMI of 33.2, she would be classified as obese. Variations in weight of around 10 kilograms had involved weight concerns for much of her life. She classified herself as an 8 out of the possible 9 silhouettes, and maintained that she felt like she was a 9, while her ideal body shape she pinpointed as a 4. Concerns with weight-related body parts scored 26, compared with the group mean of 14.19 ( $SD = 7.7$ ). Because only two people were participants in this age group, only the

means for the total group are used as comparisons in this case. Non-weight-related concerns scored 7, compared with the group mean of 2.51 ( $SD = 5$ ). Again, this was a person who appears to have internalised the thin ideal and who seemed to objectify her own body.

Scores on both the EAT (41) and the 3-FEQ (34) were much higher than the group norms of 7.54 ( $SD = 9$ ) and 18.34 ( $SD = 9.4$ ). Particularly high scores were obtained on the first factor of the EAT (dieting), and on the dietary restriction and disinhibition of eating factors of the 3-FEQ. Comparison of the group means with Susan's scores are set out in Table 8.

**Table 8:** Comparison of Susan's Scores on EAT and 3-FEQ With Group Means and Standard Deviations

	Diet	Foodpre	Orcon	EAT	Dietrest	Diseat	Suscepthun	3-FEQ
Group	4.6 (6.3)	1.24 (2.4)	1.68 (2.3)	7.5 (9)	6.7 (4.7)	5.9 (3.7)	5.4 (3.2)	18.3 (9.4)
Susan	28	6	7	41	16	10	8	34

Dissociation scores for this participant were well within the average range, while her scores on the imagination scales ranged from medium on the ICMI, to slightly higher than average on the SIPI, and medium-low on the CIS. In particular, her score on the guilt-fear-of-failure factor was quite high (60) compared with the group mean of 52.32 ( $SD = 8.8$ ). However, her scores on the hypnotisability measures were comparatively high, as depicted in Table 9.

**Table 9:** Comparison of Susan's Scores on HGSHS:A and PCI With Group Means and Standard Deviations

	Hgshsa	Phgs	Alsta	Imam	Imviv	Imag	Altex	Bodim	Timsen	Absorp	Volcon
Group	6.6 (2.9)	5 (1.6)	3 (1.6)	2.2 (1.7)	2.3 (1.5)	2.3 (1.5)	1.8 (1.8)	2 (1.5)	2.8 (1.7)	3.8 (1.3)	3.5 (1.3)
Susan	12	6.48	3.33	5	2	4.5	2.23	1.33	4.67	5.5	2.33

Susan, like Zach, was in the virtuoso range of hypnotic susceptibility; however, her phenomenological profile was quite different from his, and her dissociative capacity was obviously less than his. However, she demonstrated a markedly higher concern with weight, shape and size, as well as eating behaviour, than did Zach. Again, after debriefing at the end of the study, this participant chose to converse about her reflections on the experience. She maintained that she had always had a very active imagination, and described episodes of binge-eating, and failed dieting attempts, and constant concerns with weight, shape, size, and appearance.

**Case 10: Kan — Obese, Middle-Aged, Female**

Kan was 41 years old, had a BMI of 33.3, and had had a wide variation in adult weight of 12 kilograms. She was well above the group average in weight and shape concerns, reaching a 23 on the Physical Appearance scale, and a 6 on the non-weight scale. Her actual size silhouette choice was 8, her felt size was 9, and her ideal size was 4. Once again, this indicated a probable internalisation of the thin ideal.

This assumption was confirmed when considering her scores on the eating behaviours scales, on which she had a majority of scores above average, the exceptions being oral control and dietary restraint. Kan's DIS-Q scores were in the average range. Scores on the fantasy inventories were generally elevated. Her ICMI score was 23, her CIS rated 24, and the pleasant constructive daydreaming style was 63. Her hypnotisability scores were in the high medium range, and of the PCI intensities, her scores for imagery, vividness of imagery, and amount of imagery were all considerably elevated.

**Case 11: Cora — Young, Overweight, Female**

As a contrast to these two somewhat older women, Cora was a 19-year-old whose BMI of 28.5 placed her in the overweight category. As well, she chose silhouette 7 to signify her actual size, a 9 to indicate the size she felt, and selected silhouette 3 as her ideal. In her adult life, variations of three kilograms in weight had been experienced. Her score on the Physical Appearance Scale was 29, and for non-weight-related concerns she rated herself 4. Both of these scores were above average. This young woman appeared to have the requisite objectification of her body that suggested efficient thin-ideal internalisation.

Scores on the eating behaviour scales were generally elevated, but the EAT score was particularly high because of the dieting score. Disinhibition of eating was also markedly high on the 3-FEQ. Dissociation scores were in the average range. However, many of the fantasy scores were considerably elevated, with an ICMI score of 23, pleasant constructive daydreaming style totaled 60, while her GFF score was mildly elevated, with high intensities for imagery, imagery amount, and vividness on the Phenomenology of Consciousness Inventory. Her HGSHS:A score was 12, again in the virtuoso range, although her pHGS score was only in the medium range. Her altered state intensity on the PCI was likewise high.



**Case 12: Anton — Younger, Overweight, Male**

Anton, the code name for an older male participant (32 years) was another person whose BMI (28.44) placed him outside the optimally healthy weight range, as this BMI would be classified as overweight. While his weight had only fluctuated about three kilograms during his adult life, he fairly accurately classified his shape as a number 7 silhouette, and claimed that he also felt this same size. However, he nominated his ideal silhouette as number 5, which was exactly average, and probably a reasonably healthy choice. His weight-related concerns scored 19 (compared with a group mean of 14, *SD* = 5.7) and were also probably realistic. As there were only two other participants in the same age bracket, these means will not be cited. Non-related weight concerns rated zero, which put him well below the group mean of 2.5 (*SD* = 3.5).

Scores on the two eating behaviour questionnaires were likewise elevated compared with the group means, as is evident in Table 10. Anton's dissociation scores were average, apart from his score on absorption, which was 3.33 (compared with the group mean of 2.4, *SD* = .7).

**Table 10:** Comparison of Anton's Scores on EAT and 3-FEQ With Group Means and Standard Deviations

	DiETING	Foodpreocc	Oralcontrol	EAT	Dietrest	Disofeat	Sustounger	3-FEQ
Group	4.6 (6.3)	1.24 (2.4)	1.68 (2.3)	7.5 (9)	6.7 (4.7)	5.9 (3.7)	5.4 (3.2)	18.3 (9.4)
Anton	24	10	4	38	10	11	10	31

His fantasy scores, on the whole, were within the average range, apart from the ICMI score which was in the high range and his GFF (SIPI) score which was elevated. Scores on the hypnotic susceptibility measures demonstrated an unusual profile, and are shown in Table 11, in comparison with group means.

**Table 11:** Comparison of Anton's Scores on HGSHS:A and PCI with Group Means and Standard Deviations

	Hgshsa	Phgs	Alsta	Imam	Imviv	Imag	Altex	Bodim	Timsen	Absorp	Volcon
Group	6.6 (2.9)	5 (1.6)	3 (1.6)	2.2 (1.7)	2.3 (1.5)	2.3 (1.5)	1.8 (1.8)	2 (1.5)	2.8 (1.7)	3.8 (1.3)	3.5 (1.3)
Anton	1	4.5	2	5	3	2.5	2.15	1	2.3	3.5	3.7

While his overall hypnotic susceptibility score was so low as to lead one to expect that Anton was virtually unhypnotisable, his phenomenological report of the experience suggested that he was moderately so. The amount of imagery he experienced was considerably above the group norm, while both imagery vividness and amount were relatively high. In combination with his higher ICMI score, this suggests that perhaps he was quite well endowed with imaginative capacity, but for reasons unknown at this stage his behavioural responses to hypnosis did not indicate accurately his level of susceptibility.

## **CASE STUDIES: SUMMARY**

Each of these participants demonstrated a quite different profile of scores, which are tabulated for comparison in Table 12. Included in the table are the norms and standard deviations for the group, as well as the number of subjects who completed each assessment. As explained in the individual case studies, four of the participants (Effie, Zach, Molly, and Kat) were underweight; four were in the normal range of weight (Ally, Barb, Zoe, and Myrna); while the remaining four participants (Susan, Kan, Cora, and Anton) were in the overweight or obese range.

Further analysis of the results set out in Table 12 suggested that a combination of measures might be needed to obtain an accurate impression of any individual's weight, size, and shape concerns, as well as to understand how these might relate to dysfunctional eating behaviours. Only in this way would it be possible to begin to find any pattern of significant relationships with the other variables of interest, those pertaining to hypnotic susceptibility, fantasy proneness, and dissociative capacity.

Ideal weights (CDRS) ranged from choices of third smallest silhouette to the sixth silhouette; however, nine of these participants wanted a body size (silhouette 3 or 4) of below an average weight (which was represented by silhouette 5 on the CDRS). For Zoe, Myrna, Susan, and Cora, differences between ideal and felt body sizes were very high (differences of 5 or 6 silhouettes).

## **Implications of the Case Studies**

There are several facets of these results that seem to be outstanding, and which have implications for further study of the Hypno-Socio-Cultural Model as outlined by Hutchinson-Phillips (2004), as well as for the results of the study under discussion. Hutchinson-Phillips indicated that from these results and those of the larger study, and "it seemed feasible to interpret these results as

**Table 12:** Comparison of Scores of Each of Cases Cited With Group Means and Standard Deviations, and Total Number of Cases

	Group norm, SD & no. of cases	Effie	Zach	Molly	Kat	Ally	Barb	Zoe	Myrna	Susan	Kan	Cora	Anton
PASTASW	14.3 (7.7) 69	14	5	8	14	25	22	29	31	26	23	29	19
PASTASN	2.5 (3.5) 69	7	2	0	5	0	0	4	3	7	6	4	0
Diet	4.6 (6.3) 68	5	0	0	2	16	15	21	16	28	11	9	24
Foodpreoc	1.2 (2.4) 68	0	1	0	2	7	1	3	5	6	7	3	10
Oralcon	1.7 (2.3) 68	1	10	1	0	0	7	10	0	7	0	1	4
EAT	7.5 (9) 68	3	11	1	4	23	23	34	21	41	18	13	38
Dietrest	6.7 (4.7) 68	1	1	5	9	17	16	9	12	16	7	8	10
Disofeating	5.9 (3.7) 68	6	2	5	7	16	4	13	10	10	11	10	11
Sustohung	5.5 (2.5) 68	10	6	9	11	10	3	11	10	8	6	6	10
3-FEQ	28.5 (7.8) 68	17	9	19	27	43	23	33	32	34	24	24	31
IDC	1.8 (.6) 74	1.5	3.5	1.9	1.3	3	1.6	1.6	3.3	1.9	1.6	2.4	2
LOC	2.5 (.6) 74	3.1	3.8	2.4	1.9	3.7	3.1	2.1	3.3	1.8	2.6	1.5	2.6
Amn	1.8 (.6) 74	2.7	3.4	1.8	1.2	2.2	1.2	1.5	2.9	1.9	1.7	2.7	1.4
Abs	2.3 (.7) 74	2.7	3.5	3.1	2.3	3.4	3.5	1	2.5	2.3	2	1.7	3.3
Dis-q	2 (.5) 74	2.3	3.5	2.1	1.5	3	2.2	1.8	3.1	1.9	2.3	1.8	2.2
ICMI	22.6 (7.6) 74	20	29	24	16	21	28	22	23	19	23	23	25
CIS	18.5 (7.5) 59	30	26		30	22	36	13	15	12	24		
PCD	52.5 (8.8) 73	50	63	59	50	68	60	46	40	59	63	60	50
GFF	52.3 (8.5) 73	62	67	65	62	63	60	58	43	60	47	55	47
PAC	47 (11.6) 73	58	53	45	58	21	37	43	46	62	37	40	49
HGSHSA	6.6 (2.9) 63	9	12	10	8	6	11	8	5	12	8	12	1
pHGS	4.9 (1.6) 61	5.8	8.1	5.98	5.9	5.2	5.6	4.9	5.7	6.48	4.3	5	4.5
Imam	2.2 (1.7) 61	3.5	5	4	2.5	3	5.5	5	4	3	5	4	2
Imviv	2.3 (1.5) 61	3	6	5	1.5	0	5.5	4.5	4.5	2	4	3.5	3
Imag	2.3 (1.5) 61	3.2	5.5	4.5	2	0	5.5	4	4.3	2.5	4.5	3.7	2.5
Alsta	3 (1.5) 61	4.7	6	4.7	2.67	4.3	2.7	3	3.3	3.3	2.6	3.6	1
Altex	1.8 (1.2) 61	2.5	3.7	3.4	1.4	1.8	3.9	2.7	1.6	2.2	1.1	2.4	2.1
Bodyim	2 (1.5) 61	2.3	4	3.3	1.6	1	5.3	3.3	1.3	1.3	.3	4	1
Timesense	2.8 (1.7) 61	4.3	6	5	4.3	3.7	5	3	5	4.6	3.3	1.3	2.3
Absorption	3.8 (1.3) 61	3.5	6	4.5	1	3.5	3.5	2.5	3	5.5	3.5	3	3.5
Volcon	3.5 (1.3) 61	3.3	4	4	3	4	2	3	1	2.3	2.3	3.3	3.7

Notes: PASTASW = Score on Physical Appearance State and Trait Anxiety Scale — trait, weight-related; PASTASN = Score on same scale for non-weight-related issues; Diet = Dietary restriction; Foodpreoc = Food preoccupation and bulimia; Oralcont = Third factor on Eating Attitude Test; EAT = Total score for Eating Attitude Test; Dietrest = Dietary restraint; Disofeat = Disinhibitor of eating; Sustohung = Susceptibility to hunger; 3-FEQ = Total score on Three-Factor Eating Questionnaire; IDC = Identity confusion; LOC = Loss of control; Amn = Amnesia; Abs = Absorption; Dis-Q = Total score on Dissociation Questionnaire; ICMI = Inventory of Childhood Memories and Imaginings; CIS = Creative Imagination Scale; PCD, GFF, PAC = pleasant constructive, guilt-fear-of-failure and poor attentional control daydreaming styles of Short Imaginal Processes Inventory; HGSHS = Harvard Group Scale of Hypnotic Susceptibility = Form A; pHGS = Predicted Harvard Group Score of Phenomenology of Consciousness Inventory; intensity of dimensions on Phenomenology of Consciousness Inventory including Imam (amount of imagery), Imviv (vividness of imagery), Imag (imagery), Alsta (altered state), Altex (altered experience), Bodyim (body image), Timesense (sense of time passing), and Volcon (impression of voluntary control).

suggesting that higher reliance on self-protective and defensive modes of using imaginative and dissociative capacities may mark the self-defeating eater. A modified Hypno-Socio-Cultural model, incorporating such a possibility, has been proposed as the basis for further study” (p. v).

Assessment of the amount of internalisation of the thin ideal cannot be inferred from any of the scores relating to weight and shape, if they are taken in isolation. It seems that one needs to understand the interplay of factors such as Body Mass Index, range of adult weight change, and the expressed concerns regarding shape and size in relation to these measures, as assessed by both the silhouette drawings (CDRS) and the Physical Appearance State and Trait Anxiety Scale (PASTAS). In relation to this internalisation of the thin body ideal, neither Zach nor Anton appeared to have objectified their bodies in the same manner as the female participants, although they did have concerns regarding being overweight. Those who had suffered from excess weight, as measured by the BMI, expressed greater concerns with such issues which cannot always be directly inferred from any one of the reported factors.

Nor was it possible to assess dietary restraint from either of the eating questionnaires in a straightforward fashion. For those for whom dieting was a way of life, and regarded as normal eating, there was little reflection in the scores of this fact; however, it can be inferred from the overall profile, if we use both the EAT and the 3-FEQ measures, and pay particular attention to susceptibility to hunger and the tendency to disinhibited eating. This would seem to indicate that the use of both questionnaires is necessary to obtain a realistic picture of individual eating attitudes and behaviours.

Generally, there was some evidence of a fairly strong link between fantasy scores in particular, and these concerns with weight and size. Daydreaming styles, particularly guilt-fear-of-failure, and higher scores on the ICMI, were especially implicated. As well, higher intensities in the imagery areas of the PCI seemed to be involved. Dissociative capacity appeared to play some role in the disinhibition of eating, but perhaps was not as important in the ability to restrain dietary intake. Nor did high hypnotisability appear to be correlated strongly with either dietary restraint, oral control, food preoccupation, or disinhibition of eating. Nevertheless, it was possible that it did have some relation to susceptibility to hunger.

Of the 12 cases discussed here, 10 individuals scored above average on the GFF daydreaming style of the Short Imaginal Processes Inventory. Eight individuals also obtained high scores on the DIS-Q, perhaps reflecting a tendency to overuse dissociative capacities as coping mechanisms.

There did not seem to be a great deal of difference between females, whether younger or older, but the same generalisation was not applicable to the males discussed. The commonality with both these males was in the elevated dissociation scores, as Anton had quite low hypnotisability scores, as well as lower scores on the ICMI. Perhaps dissociative capacity was more influential in the male approach to eating behaviour, weight, and shape concerns than it was with females.

However, again there is some anecdotal evidence that while these may be influential contributors in determining the nature of an individual's approach to his or her own size, shape, and weight, they are uninterpretable without some understanding of the many-faceted nature of the spectrum of factors which influence people to adopt eating behaviours which are not optimally healthy.

One further comment regarding the measures used is warranted by the information revealed by these case studies. As concluded from the available statistical evidence, the ICMI and the PCI appear to be very useful as instruments to assess fantasy and hypnotisability capacities respectively. The authors have discussed those issues in a related article in the *International Journal of Clinical and Experimental Hypnosis* (Hutchinson-Phillips et al., 2007).

## **Postscript**

Of all the participants in this study, the scores of Anton and Susan in the Eating Attitude Test were the only data which suggested the possibility of eating pathology. Garner and Garfinkel (1979) recommended a cutoff point of 20, as the level over which further diagnostic assessment should be pursued. The fact that the other 78 subjects were all in the normal range of eating behaviour, as classified by these two questionnaires, was an acknowledged limitation, as these scores can only be indicative of possible tendencies in those with diagnosed eating pathology. However, both the statistical results (published in *Contemporary Hypnosis*; Hutchinson-Phillips et al., 2005) and the case studies discussed here, appear to highlight the implications of imaginative, dissociative, and hypnotic elements in perceptions of the self as having major weight, shape, and size concerns leading to some kind of self-defeating eating behaviour. In particular, it would appear that those whose imaginings are avoidant and escapist (dissociative) or who fail to adaptively rehearse successful future actions (because fear of failure intrudes on imaginings of outcomes) are also those whose concerns with weight, shape and size lead to eating behaviours which are not optimal for healthy living.

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## CHRISTIANITY AND HYPNOSIS: PERSONAL REFLECTIONS

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*Hypnosis and meditation are trance-related practices widely used in the community at large and increasingly amongst church members. Many religious behaviours and church practices also have a trance dimension. Yet apart from the Roman Catholic Church, the churches in Australia have maintained silence on the subject, seemingly implying disapproval. In some church quarters, both hypnosis and meditation (other than the rational study of, and reflection upon, the words of the Bible) are condemned as evil, even demonic, and as a threat to religious faith, moral integrity, mental soundness, and spiritual health. In this article, a call is made to the churches to acknowledge frankly the hypnotic implications of much religious behaviour and practice, and to encourage their members and ministers to undertake appropriate training and put safeguards in place to prevent injury and abuse.*

### HYPNOSIS BY ANOTHER NAME?

Rugby union, though played in heaven according to its publicists, is not *per se* religion. It has a religious dimension, and given the right blend of needs, inducements and influences, it can, like any form of football, transmute into religion, generating religious behaviours. Meditation, likewise, is not hypnosis. It has a hypnotic dimension and, in the right circumstances, can transmute into a form of hypnosis, generating hypnotic phenomena.

On one occasion in my early days as a leader of guided meditation for healing, I was about to conduct a group meditation for 60 people as part of a seminar on the subject. The people present were Christians and I knew some would be suspicious of meditation and some would be opposed to it. I did not want anyone frightened off or given ammunition by the occurrence



of spontaneous hypnotic phenomena, so I explained that meditation is *not* hypnosis and that it was not my purpose to induce hypnosis or precipitate these phenomena. When asked to explain, I instanced catalepsy.

At the end of the meditation, I prompted people to come back to ordinary waking awareness of the world around them, but one participant said, "I can't move." The look on his face said he was both surprised and nervously pleased. It would seem that, for him, the passing mention of catalepsy was suggestion enough for it to occur. This may have been so because he wanted to experience hypnosis and expected to experience catalepsy as well. Alternatively, he may have undergone hypnosis as part of which catalepsy had been induced, and he was open to experiencing hypnosis and catalepsy again. Happily, I had sufficient knowledge of, and training in, hypnosis to deal with this situation. But what if I had not?

Through my involvement in Christian healing ministry, I have often observed the use of techniques and the occurrence of phenomena in group healing prayer and guided healing meditation that are to my mind trance-related and perhaps hypnosis-related. For example, I recall a conference for Christians who were lay or ordained ministers of healing. Many also had serious health issues and a need for healing. A guided reflection was conducted by the teaching ministry team as a workshop exercise. The members of the healing ministry team were all presenters in the conference, offering their approaches and practices as useful models for others to adopt or adapt, so they enjoyed high status and authority with the participants. The leader of the reflection was an Anglican priest. His leadership of the whole conference, the teaching team and this exercise, and his status as an ordained minister with many years of success in pastoral and healing ministry, also gave him immediate rapport and great authority with them.

The chairs in the room were arranged so as to allow the members of the team, other than the leader, to move along the rows. The leader asked the participants to sit down, be silent, make themselves comfortable, rest their hands in their laps, relax and close their eyes. To give these directions, he used a public address system, which greatly magnified his deep, soothing, masculine voice so that it filled the room. Once a person's eyes were closed, the voice became disembodied and all-enveloping. Soft, mellifluous music was played continuously.

The leader did not use any confusional linguistic techniques. He simply spoke in an intimate manner, slowly and gently, relying upon the participants to be trusting and cooperative. At the same time, in giving instructions and

suggesting what the participant might be picturing, thinking and feeling, his manner was very directive. He led the participants through a breathing exercise into a deepening state of relaxation and a quiet that was “felt,” focused, wordless but prayerful, and a calm but expectant openness to God. This of course would have fostered openness to him as the conductor as well.

The participants were invited to be aware of, and to allow themselves to feel, their desire for healing, either for themselves or for someone else. I might explain that some Christians have difficulty allowing themselves to openly desire anything for themselves from God. Desiring a healing for someone else will include the thought of receiving a blessing oneself. It will be discreetly hidden from oneself but nonetheless active. In fact, it may be even more active when not attended to.

After some time, when the room was very quiet and very still, the leader began to explain that the team members would move slowly and silently around the room. They would stop behind people, without drawing attention to their presence, which information would have immediately given the participants a confused focus of attention. Without speaking, they would lay a hand gently on the person behind whom they were standing, in a gesture of prayer for that person. Then they would silently move on. Once this began to happen, I observed that there was a quality of dance or ceremony about: the slow, silent, movement; the stopping; the placing of hands; and the moving on again, as the team members worked the rows, back and forth, like fruit pickers in a vineyard.

When individuals were touched by team members, there were physical reactions, with the participants most often “melting” into a more relaxed posture, and often breathing out deeply in a release of tension. I was reminded of the hypnotic prompt: “When I put my hand on your shoulder, you will go immediately into a deep state of hypnosis.” It seemed to me that, on being touched, those meditating relaxed even further, intensified their inward focus, and heightened their affective and cognitive activity.

In one respect, I was pleased that people were in a meditative mode. Many people later reported real good coming for them from the exercise. However, I also felt some concerns. Many of the members of the group were well-known to me. I had personal experience of the deeply suspicious attitude of some toward any form of “meditation” other than studious, rational examination and life-application of the words of the Bible. I also knew their complete abhorrence of hypnosis. Given this, I was perhaps disappointed that only the

word “reflection” was used, and no reference, direct or indirect, was made to meditation. However, I was not at all surprised that no reference whatever was made to hypnosis!

My greater concerns were other than these. For example, nothing was said in the course of the conference to indicate that the leader and his team were trained in hypnosis. Yet discussion with participants after the session confirmed for me that hypnotic phenomena such as anaesthesia were common in the group, and that most people were in some measure of trance. Some took up to 20 minutes to come out of the meditation after it was finished, and a long time to attend to the presentation that followed on from the exercise. Some, then, may even have been in quite a deep hypnotic state. Two participants who spoke with me after the entire session, when everyone else had moved off to a tea break, still seemed to me to be in a dissociated state. I was not surprised, because no directions were given, and no suggestions were implanted, to guide and assist participants in the process of terminating the trance. Things just gently came to a stop and people were asked if they wished to share anything of their experience. This could have had the effect of maintaining the trance state or even deepening it further.

I am an enthusiast for guided meditation, but on this and other occasions I have come away uneasy. A potentially hypnotic exercise can be undertaken without the team acknowledging, being aware of, or trained in hypnosis. On this occasion, the team was certainly not upfront about the process, and proceeded without what I would judge to be appropriate safeguards for the participants, and for those who were in charge of it. Furthermore, while the Church denies that hypnosis-related or hypnotic practices are taking place, it will continue to create an environment in which this will be the case.

## **THE CASE FOR HYPNOSIS STILL NEEDS TO BE PUT**

Hypnosis is widely accepted and used in Australia for therapeutic purposes. Some Christians still oppose its use and thus impede a greater acceptance of it in Australia, but hypnosis will become more understood and acceptable as a treatment modality. As general public knowledge and trust in it increases, more and more Christians will also experience and endorse it. Moreover, church members are increasingly coming to believe that they have the right to make their own decisions about what is and is not permissible, and more are refusing to be ruled by an ecclesiastical decree or an official interpretation of the Bible.

Nevertheless, while this process is steadily unfolding, there are many people who are being denied this avenue of help quite unnecessarily. These are the people who do not access the services of trained health professionals on the basis of a religious belief that hypnosis is dangerous, evil, or even a tool of the devil. This belief is most often grounded in ignorance and prejudice and is not informed by experience. It may be held personally or as a requirement of membership of a particular church, to give the believer entree to fellowship with the members of that church and of churches of like beliefs.

People of Christian convictions might also greatly benefit by being able to access the services of registered health professionals, trained in clinical hypnosis, who share their beliefs and world-view. Rapport, for example, may be easier to establish. A Christian professional in this field also arguably has the opportunity to introduce commonly-held faith elements (the presence and loving purpose of God, for example; see Dowd & Nielsen, 2006) into the hypnotic and therapeutic processes. There are also opportunities to counteract unhelpful transference when the hypnotist and client share a belief in God as the source of healing.

Additionally, there are lay and ordained ministers and church members who may wish to, but are now unable to, make use of hypnosis as part of their pastoral ministry, healing ministry, meditation and meditation for healing, or simply to utilise the hypnotic dimension of religious behaviours. They might hope to see the hypnotic dimensions of prayer and worship recognised, understood, and explored, to their enhancement. Yet, from my observation, there is more than a little risk, very little incentive, and no official encouragement within the churches to do any of these things. As a result, there may be those who know what it is that they are doing, but they have to keep it a secret, which is problematic.

I am also persuaded and troubled by the thought that there are many Christians working in these areas who are employing hypnotic techniques, but without recognising or understanding them, and without setting safeguards in place around them. The veritable explosion in guided meditation in recent years, for example, is a case in point, as is the fashion for “healing of memories.” Again, there is the popularity in some Christian circles for the practice known as “prayer counselling” which, in some forms, is profoundly hypnotic. There is also a fashion in exploring spirituality through ritualised behaviours and evocative symbolism, well outside the boundaries of official religion, and using methods that entail trance and possibly hypnosis.

For so many reasons, then, there is still need to argue the case for hypnosis and for identifying hypnotic practice where it occurs. There is a need to ensure the right use and the careful avoidance of the abuse of hypnosis in the religious context.

## Trance

In the field of hypnosis and related practices, “trance” seems to be a useful, soft alternative to the more technical and controversial term “hypnosis.” The term can have as broad or as narrow a meaning as one cares to give it. But while others might use “trance” to mean hypnosis, I find it useful to use the term “trance” to maintain a working distinction between meditation and hypnosis. At the same time, the term allows me to acknowledge, not deny, the parallels and connections between them. For my present purposes in guided meditation, I treat meditation and hypnosis as two forms of trance, or two utilisations of the trance faculty.

According to Michael Yapko, trance is a state that people routinely and spontaneously enter and that can also be induced (Yapko, 1990, p. 209). Yapko quotes William Kroger’s dismissal of trance: “Most people refer to [hypnosis] as a ‘trance.’ It’s not a ‘trance’ ... That’s the most ridiculous term for it. [Hypnosis] is a state of increased awareness” (Yapko, 1990, p. 76). Nonetheless, Yapko invents the term “trancework” for the title of his book and uses “trancework” throughout to refer to strategic therapy employing hypnosis. Not surprisingly, “trancework” invites comparison with words such as “roadwork,” “artwork,” “basketwork” and is a play on words (“trance works” and “working with trance”). It suggests the inducing and employing of trance and therapeutic work that happens in the context of trance. Yet in using the term, Yapko offers no definition of “trance,” nor is one easy to come by.

The term certainly implies a shifting or movement, in transition from a normal state of awareness towards another, in which transitioning (not arriving) other ways of perceiving and responding become possible. Hence the American Christian Medical Association’s *Alternative Medicine: The Christian Handbook* comments that “The hypnotic trance is viewed by ... Christian hypnotherapists as a legitimate and natural way to achieve a greater sense of the transcendent and to become more open to spiritual encounter” (O’Mathúna & Larimore, 2001, p. 230). So why is it that there is still a lot of resistance to hypnosis in some quarters of the Christian Church?

## THE GROUND OF OPPOSITION

The opposition to hypnosis by Christians is commonly raised on the basis that it poses a threat to the mental and spiritual health, the moral integrity and responsibility of human beings. Hypnosis is also regularly represented by its Christian detractors as exposing Christians to demonic attack, and to the undermining of their faith and their adherence to Christian moral principles. The declared faith of a Christian hypnotherapist might mollify the concerns of some critics, but such is the opposition in some quarters that the religious faith of the hypnotherapist is more likely to be judged to be compromised, and discounted as a safeguard against harmful influence.

Yet, one cannot but wonder whether Christians who condemn therapeutic hypnosis and those who practise it, or anything like it such as meditation for healing, are imagining threats to human spiritual health and the truth and authority of the Christian religion, which these things, in themselves, simply do not pose. It is my view that some Christians perceive in any form of hypnosis, and in meditation other than study and reflection upon the words of Scripture, a threat to faith in God as the source of all healing and salvation. It seems to them to contradict the Christian principle that there is no other name given to humanity through whom humankind may receive health and salvation except the name of the Lord Jesus Christ (Acts 4:12).

In the 1980s, in “The Church and Hypnotism,” the Reverend Walter A. Debboli summed up the threat some Christians discern in hypnosis in this way:

Everyone who is able to think and reason as a normal, human being is able to learn the laws that govern his personality and thereby can be either an operator or a subject; or with this understanding can be both operator and subject at the same time, thereby practicing self-hypnosis. These principles should be taught to the masses so that everyone can know that he is capable of giving and receiving a hypnotic suggestion (concept) at will and thereby becomes his own master. It is high time that we were realizing that man is a complete entity within himself — a triune entity, who does not need to be enslaved by anyone. The sooner we teach people this, the quicker we will have a race of people who know how to be real selves and not puppets in the hands of anyone who happens to have authority or power over them ... The biggest battle in the religions of the world has been whether a man has a right to go direct to the Source of Omnipotent Power himself, or whether he has to channel his request through some authorized and accepted agent or agencies which claim to have a monopoly on the use of that Power.

In the U.S.A., hypnotherapy is freely promoted and apparently widely accessed as a tool for chaplains and for clergy working in pastoral care. A strong and apparently strengthening alliance has developed between religion and hypnosis in spite of vigorous opposition. We might witness the fact that the website of the Christian Center of Hypnotherapy in Montello, Nevada, advertises the fact that the CCH uses web tools and hosting “powered by ForMinistry, a service of the American Bible Society” (hence the CCH website <http://www.forministry.com/USNVINTERCOLMI>). Even if there is a disclaimer that “The content of this website ... does not necessarily reflect the views of the American Bible Society,” this preparedness of the ABS simply to be associated with hypnotherapy would, I am sure, be unthinkable for the Bible Society in Australia.

The widespread acceptance of hypnosis in Christian circles in the United States does not mean that church members and authorities were quick to see or admit that a portion of Christian religious and pastoral practice, including worship, preaching, meditation, prayer and counselling, has a hypnotic basis or dimension. The Roman Catholic Church, early on, gave official endorsement to therapeutic hypnosis and set down guiding principles. However, the inclusion of hypnosis in Christian ministry and the recognition of the hypnotic implications of many religious practices did not readily commend themselves to other Christian churches. On the contrary, churches are by nature slow to change, and novelty itself is often reason to hold back from making changes. When the matter is also controversial, one may expect opposition, deliberate delay, and the maintaining of pointed silence. So it was before and is so today.

Over the past few decades, Christians have gone on visiting hypnotists in secret and Christian practitioners have practised in secret. Thinking of those days, Debboli writes, in the same place, that “Being an Episcopal Priest and a hypnotist is a difficult position to maintain without adverse criticism. Recently, I have come out of the closet and openly admitted that I employ hypnotherapy.” Church members are usually able to conceal their visits to a hypnotherapist or hypnotist and continue in their home churches. Ministers of churches wishing to practise hypnosis, or openly exploit the hypnotic dimensions of, say, worship or prayer, are in a more difficult position. The existence of independent churches in the United States advertising hypnotherapy today suggests that, for some ministers, the freedom of an independent church allowed them to bypass institutional opposition. Yet, it cannot have been all easy, given that, in

an independent Evangelical or “Protestant” church, these ministers would have been even more exposed to the censure of their Evangelical neighbours.

In Australia, the situation would appear to be running about 20 years behind that which applies in the U.S.A. Christian counsellors using hypnosis have hung up their shingles and found a measure of acceptance, but my impression is that this is not the case for pastors and priests. Moreover, there is still nothing comparable to the promotion, that there is in the United States, of hypnotherapy as a part of, or adjunct to, the ministry of the church, and as a therapeutic technique which Christians might rightly and safely use.

As far back as 1984, when Debboli in the U.S.A. had already “come out of the closet,” David L. Walker of the Education Centre for Christian Spirituality, Randwick, New South Wales, also addressed these issues. He wrote that:

It hardly needs saying that official church bodies have not always looked favourably on the use of hypnosis. This could well be that those who use hypnosis have not themselves given it a very acceptable image. If official religious bodies are to take hypnosis more seriously, it is necessary to present it more positively, and especially to show in an enlightened way its application to religious matters.

I daresay many practitioners of hypnosis are content to ignore the churches opposed to hypnosis and to wait for them to exit the scene. It is reasonable to believe, however, that there are others who persist in the hope that the Christian churches will come to a more enlightened, more open and less fearful mind on the subject of hypnosis than that which prevails. It is their aspiration to see the Church, which preaches and promotes love of neighbour, to act in this area for the sake of those in need. There are those who look for signs that the Church will also adopt a more consistent understanding of meditation and other religious practices, especially as they relate to trance and have hypnotic implications.

It is only reasonable, in these days when churches are so mindful of the prevention of neglect and abuse, to want to see more safeguards put in to place when activities with hypnotic potential are undertaken. Christians have a positive contribution to make in the therapeutic application of hypnosis and they need to be reminded that they stand to gain much from the frank recognition and thoughtful utilisation of the hypnotic dimensions of its worship and ministries. So on what basis can conversation with the churches take place?



## **THE CASE OF ST PETER IS THE KEY**

It is customary for the advocates of hypnosis to argue the case on the basis of biblical passages such as Genesis 2:21–22, Matthew 1:20–25, and Acts 22:17. These suggest, or are said to imply, an experience of hypnosis or at least trance. Of these, the passage of paramount importance is Acts 10:19–11:18. This scripture contains two reports of trance episodes concerning Peter, the apostle appointed by Jesus to pastor the flock of his disciples and to be the leader of the Church.

The story is that Peter, waiting for lunch, goes up onto a roof to pray. He falls into a trance, and three times he sees a vision of a sheet lowered down from above, full of animals judged unclean by the Law of Moses. A voice commands him to get up, kill and eat. When he refuses, the voice tells him not to call “unclean” anything God has called clean. While he is wondering about the meaning of the vision, three Gentiles arrive, looking for him, to ask him to come to their master’s house to share with them the good news of Jesus. Peter senses the Spirit of God telling him to go with them and so he does. When he arrives, he tells them about the vision, and says God’s salvation is for everyone, not just Jews and Jewish converts. Immediately, the Holy Spirit falls upon the Gentiles (that is, they manifest signs of spiritual rebirth). So Peter baptises them, uncircumcised, making them Christians.

This passage is more important than any other in the discussion of Christian attitudes to trance and hypnosis. First, it makes a repeated and explicit reference to trance. It is also important because Peter was the leader of the disciples and the Apostolic Head of the Church. As a result of his trance experience, Peter abandoned the position that a person had to become an adherent of Judaism, and the men had to be circumcised, before becoming Christian. Instead, he threw his weight behind those who held that the “good news” of salvation was for non-Jews, and he, perhaps more than any other person, turned the Church around, to abandon circumcision plus baptism, in favour of baptism alone as the rite of initiation and sign of salvation. Peter opened the door to a Gentile Christian Church.

The episode is also highly significant, because it entails a personal healing for Peter himself. We can trace the process, of which the trance experience is critical, through the Gospels, the Acts of the Apostles, and Peter’s letters. The trance experience is the keystone to the process which begins with Peter’s three denials of Jesus on the night before Jesus was crucified (John 18:15–18). This is followed by the risen Jesus asking Peter three times whether he loves

him more than the other disciples do (John 21:15–23). On the basis of Peter’s indignantly positive answer, Jesus bestows the leadership of the disciples upon him. The process, however, is still not complete. It moves to a new stage with Peter, the leader of the Church, falling in with the “Circumcision Party” and their insistence that Gentiles must join the Jewish religion first, the men being circumcised before becoming Christians. This is perhaps reflected in St Paul’s references to Peter as having a commission to evangelise the Jews, while his was to evangelise the Gentiles (e.g., Galatians 2:7).

This brings us to the day when Peter, on the rooftop waiting for lunch, falls into a trance and sees a vision of unclean animals, offered to him three times, and he hears the command to eat. While he is trying to understand what the vision means, three Gentiles arrive at the street door below. When Peter goes with them to the Gentiles’ house, he is compelled to face the fact that the God of the Jews is already breaking the rules and giving his Holy Spirit to Gentiles. So Peter breaks with his own conservative and dogmatic convictions and baptises the Gentiles. In that moment, he is set free to lead the church into the radically different future that God intends for it.

Peter, it must be said, is not healed by trance, or hypnosis. Yet trance is clearly instrumental in the process. In the trance state, Peter was able to conceive of, and do, something unconscionable and impossible for so conservative a personality. His mind was freed from its moorings of prejudice, to search for a resolution of the conflicts and contradictions, that were growing in the Church and its leader, as more Gentiles pressed to join without becoming Jewish converts. It was through the non-judgmental creativity conferred by trance that Peter’s mind found the obvious answer that his waking, rational consciousness had done its utmost not to see.

Yet, we are left with a question. “For freedom, Christ has set us free,” the Christians say (Galatians 5:1). How, then, is it that the undeclared but real Christian experience of trance in worship, preaching, meditation, prayer, and counselling do not confer the same freedom to see a vision of trance, meditation and hypnosis, not as unclean, but as gifts that God intends his people to use?

## **SUMMARY AND CONCLUSION**

I have highlighted the fact that guided meditation, which is currently popular in Christian circles, is not hypnosis, but has a hypnotic dimension and can transmute into hypnosis and generate hypnotic phenomena. I have suggested

that a great deal of other religious activity, and not least healing prayer, are trance- and perhaps hypnosis-related. Yet by silence, the Church, so vigilant these days in maintaining professional standards and preventing abuse and accidental injury, denies the hypnotic implications of its practices and neglects the provision of safeguards and appropriate training.

Hypnosis is regularly represented by its Christian critics as exposing people to demonic attack and to the undermining of their spiritual integrity, adherence to Christian faith, and values. Perhaps the critics suspect the development of a coalition of spirituality, religion, hypnosis, therapy, and medicine that threatens to lead human beings into believing that they can be the origin, agents, and masters of their own healing, temporal and eternal, by dint of the power of the mind and invocation of alternative spiritual powers.

I have pointed out that, while this assault continues, people of Christian conviction are hindered from accessing the service of approved clinical hypnotherapists, even those who share their Christian beliefs. Church ministers and members are often unable to train in and make use of hypnosis openly, as part of pastoral ministry, healing ministry, meditation, and meditation for healing. Furthermore, they cannot openly acknowledge and utilise the hypnotic dimension of worship.

In Australia, then, there is still need to argue the case for hypnosis and for meditation, and for the Church frankly to acknowledge the hypnotic implications of standard religious behaviour and practices. Out of this can come the provision of appropriate training and the establishment of safeguards for the benefit of practitioner and client, pastor and church member alike.

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## JUST IN CASE: GAINING A SENSE OF CONTROL OVER DETRUSOR INSTABILITY THROUGH HYPNOTHERAPY

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*The aim of this study was to investigate whether hypnotherapy could be used successfully in the treatment of detrusor instability (DI) in which, as far as possible, organic, infective or structural causes had been excluded. Five incontinent women with detrusor instability completed 10 to 12 sessions of hypnotherapy over six months. Direct suggestion for symptom removal and indirect suggestion for ego-strengthening and improved coping strategies were both employed. Two or three of the sessions were recorded to provide audiocassettes which the patients could use to continue their treatment at home. At the end of the treatment, all five patients reported improved overall wellbeing. Three patients were free of DI symptoms, one had periods of improvement in her urinary frequency, and one remained very much the same as originally. The results of this study contribute to the hypothesis that hypnotherapy can be an effective treatment when the unstable bladder is of psychosomatic origin and the patient's symptoms have evolved as a result of an emotive or psychological disturbance.*

Female urinary incontinence can be defined as occurring when leakage of urine is frequent or severe enough to become a social or hygienic problem. It has been estimated that it affects at least 14% of women over the age of 30 (Cardozo & Bidmead, 1999). Its causes include urinary tract infections, hormone deficiencies, pelvic muscle weakness, organ or urinary tract tissue abnormalities, and neuromuscular disorders. Treatments currently available include antibiotics, hormone replacement therapy, medication to control abnormal bladder contractions, pelvic floor exercises to improve the support of the pelvic organs, behavioural techniques to reduce frequency and urgency, electrical stimulation of the muscles around the bladder and the

urethra, devices to support prolapsed organs, and surgical intervention of organs. Garley and Unwin (2006) note that there is limited research available regarding psychological interventions for urinary incontinence.

Detrusor instability (unstable bladder) is the second most common cause of female incontinence. It is present in around half of all women presenting with urinary incontinence (Freeman & Baxby, 1982). The normal bladder takes three to four hours to fill to a consistent volume of about 400 ml. The bladder muscle contracts under voluntary control acquired in infancy when the subject becomes aware of the need to urinate. With detrusor instability, however, the bladder (detrusor) muscle contracts involuntarily, and sometimes without warning, before the bladder is full. When the bladder becomes unstable, the commonest symptoms it exhibits are urgency of micturition and frequency (voiding more than once every two hours, or more than seven times a day).

The pathogenesis of detrusor instability is poorly understood. It is considered to be among possible neuromuscular disorders — a problem with the nerves that control the function and contractions of the bladder. Somewhere, somehow, the brain–bladder connection has become faulty, and as yet the reasons for this are not known. Psychosomatic origins (Frewen, 1978), psychological factors (Freeman & Baxby, 1982), and hysterical personality traits (Stone & Judd, 1978) have all been investigated as possible contributory factors. Stone and Judd (1978) also identified an association between the relief of emotional distress and the relief of incontinence symptoms.

Distress does affect the bladder. The wilful control of the smooth muscle is a function of evolution, and the detrusor has conditioned itself to the demands of social development (Hodgkinson, Ayers, & Drukker, 1963). As a remnant of the flight response, humans going into stressful situations often feel the need to void or defecate (before a performance, for example). The bladder is an organ of habit, and when it learns a response it continues with it. Similarly, early toilet training can reinforce the “just in case” scenario. A mother cautions her child to go to the toilet before leaving the house, just in case there is no toilet available wherever they are going. This habit can become fixed and an adult woman may find herself going to the toilet every hour “just in case.” DI can become a chronic condition.

The development of urodynamic investigations makes it easier to confirm a diagnosis of DI. Initial investigations must first be made to eliminate, as much as possible, organic, infective, or structural causes for the unstable bladder. Three channel cystometry can then be used to measure the pressure

inside the bladder, the pressure in the abdomen, and the rate at which the urine is emptied from the bladder. From these tests, DI can be recognised and treated as a clinical entity in its own right. Not knowing the aetiology of the condition, however, makes it difficult to find a successful treatment. In some cases, a simple and clear explanation of the problem and how the bladder works is enough to rectify the situation (especially in the “just in case” scenario). Behavioural therapy and “bladder drills” accompanied by voiding charts are used to mimic the conscious infant inhibition of the voiding reflex (Jarvis & Miller, 1980).

Anticholinergic drugs (oxybutynin and tolterodine) have been developed to block transmission at the neuromuscular junction of the parasympathetic nerves activating the detrusor. These are often very successful, but their use is limited by their side effects such as dry mouth, blurred vision, constipation, tachycardia, drowsiness, and urinary retention. Intravaginal electrical stimulation (IVS) of the pudendal nerve has been used to relax the bladder (Lindstrom, Fall, Carlsson, & Erlandsen, 1983), as has the implanting of an electrode to stimulate the sacral S3 nerve (Mundy, Stephenson, & Wein, 1994). Surgical treatment for DI is no longer the treatment of choice as the long-term results are poor and the complication rate is high. In the fields of complementary medicine, acupuncture has achieved some results with DI (Philp, Shah, & Worth, 1988), as have biofeedback (Cardozo, Abrams, Stanton, & Feneley, 1978) and hypnotherapy (Freeman & Baxby, 1982).

Somatisation has been described as medicine’s “unsolved problem” (Lipowski, 1987). It may involve up to 50% of all patients seen in primary care (DeGruy, 1996). Over the past 20 years, hypnosis has gained credibility as a therapeutic tool in the treatment of psychophysiological disorders. It has successfully been used for complaints such as irritable bowel syndrome (IBS; for an update on research on IBS, see Jones, Latinovic, Charlton, & Gulliford, 2006), migraine, asthma, nocturnal enuresis in children, and temperomandibular disorder (all of which are often stressed induced). It is also useful in identifying and uncovering unconscious, threatening perceptions and memories that drive somatisation and autonomic nervous system dysregulation (Jones & Levin, 1999).

## **AIM OF STUDY**

The aim of this clinical case report was to investigate whether hypnotherapy could be successfully used in the treatment of detrusor instability and resultant urinary incontinence in cases where psychological factors are connected to its

occurrence. The very nature of the practice of hypnotherapy produces some variables that are difficult to control. The success of hypnotic intervention, for example, attributes much of its effectiveness to the relationship between the therapist and the subject. Engagement, communication and rapport are crucial. The question also arises whether it could simply be the time spent listening to, and talking with, the patients that effected change. Feeling comfortable with, and speaking openly and honestly to a concerned and interested person has always been therapeutic. In the past this may have been possible with priests, family members, or friends. Today the structure of society and social relationships has made this less available. The nuclear family and the community are not as cohesive as in the past. Lifestyles have become stressful and the pace of living is often too fast; some people have thus become more isolated.

In order to shed light on the benefits of simple “talking therapy,” and to remedy the ethically instigated elimination of an untreated control group in this convenience sample, it is suggested that a “non-hypnotic” (perhaps cognitive-behavioural) therapy control group could, in future research, be conducted alongside the hypnotherapy subject group. In this way, both variables could be dealt with and the ethical considerations would be improved. The fact that both direct suggestion for symptom removal and indirect suggestion for general coping skills were included during trance work makes it difficult to determine which approach was the more effective. Some people respond more to an authoritarian approach, while others prefer open-ended suggestion. The question also remains whether hypnosis reinforces inhibitory stimuli from the cerebral cortex, as suggested by Godec (1979), or is more effective in reducing the stresses which may be causing the bladder instability. Again, in a future study, these two approaches could be separated out.

The dynamics of anticipation and the placebo effect should also be considered. Often patients who feel that it is the practitioner’s responsibility to make them feel better do worse. Furthermore, the desire to be a “good subject” can play a role in the reporting of progress and in actual improvement. In this study, an attempt was made to set up a “no fail” situation in order to eliminate positive or negative expectation. Ego enhancement was used to hand control back to the patient. At the end of the study, each patient did in fact “win”; all the subjects reported quality of life enhancement, and one patient (whose progress within the study was very erratic) found that she no longer suffered from the IBS symptoms that had affected her over a 30 year period.

Placebo and “good subject” participants would be present in this as in any study. The advisability of showing the patients their progress graphs was debated. On the one hand, the visual record of even small steps toward improvement in a condition can reinforce further improvement. On the other hand, it can also make the subject apprehensive and/or discouraged, thereby reinforcing stress. It was decided to show each patient their weekly graph as the visual record helped them understand more about their progress (or lack of it).

Although the subjects were tested for absorption (Tellegen & Atkinson, 1974), there was no correlation between absorption scores and successful treatment in this study. The issue of hypnotisability and the role absorption plays within it is still under much debate, and best left to other researchers. This study also did not attempt to find underlying causes of somatisation by using age regression or hypnoanalysis. Nor were toilet training histories considered.

## **PROCEDURE**

This was a pilot study conducted with the permission, and under the auspices of the chief consultant of a urogynaecological clinic at a National Health Service hospital in the south of England. Between 10 January and 19 June 2000 nine women between the ages of 18 and 53 came forward to join the study. Each had been urodynamically diagnosed as having detrusor instability, and only one was currently on drugs which might have affected the detrusor. The length of time the women had suffered from this condition ranged from four months to six years. Each patient had already tried various other therapies — mainly bladder drill, drugs, and some intravaginal electrical stimulation. All the patients were exasperated by their condition, and two were depressed as indicated on their health questionnaires.

Each patient met with the researching hypnotherapist for an introductory meeting in which the mechanics of DI, the pilot study, and hypnotherapeutic techniques were explained. Questions were also answered and points of ethics discussed (including privacy, confidentiality, and the freedom to withdraw from treatment). Each patient verbally gave her informed consent and an hour long appointment was made for the following week. At the same time a King’s Health Questionnaire (Kelleher, Cardozo, Khullar, & Salvatore, 1997) was administered, thus providing a comprehensive picture of how detrusor instability affected the specific patient, and her life in general.



The treatment was to consist of 12 sessions of hypnotherapy. One patient chose not to continue after the first session. Three of the patients commenced treatment quite late in the study and had only between two and five sessions. For the purposes of this article, the discussion will be confined to the remaining five patients, who each had between 10 and 12 sessions. The longest interval between appointments for hypnotherapy was three weeks (for one patient).

A progress report scale was devised for each patient. The first scale monitored the preceding week's average interval between daily micturation. The second scale monitored the average amount of visits the patient made to the toilet at night; and the third recorded the patient's subjective assessment of her overall wellbeing. Objective voiding charts of frequency of micturation and incontinence were not kept, as all the patients had already done so in the past and objected to this procedure as an intrusion and a continual reminder of their problem. Each initial treatment session was used to gather and record further information about the client (including her lifestyle, interests, beliefs, attitudes, body language, predominant sensory systems, and general personality types). The hypnotherapy at the end of the first session was a simple relaxation and anchoring exercise — an introduction to trance work. Subsequent sessions began with a quick recording of figures for the progress scales, and then moved into a longer discussion of the patient's past week in general. The final 20 to 30 minutes of the session consisted of hypnotherapy using scripts for relaxation and ego-strengthening. Direct and indirect suggestion was used for unconscious bladder drill, rearrangement of neuromuscular connections, symptom removal, and improved coping mechanisms. Deepening was achieved through matching, mirroring, leading, and suggestion. Selected sessions were recorded on audiocassette tapes for the patient's own use at home and practising trance two to three times a day, either with use of the tapes or on her own, was assigned as "homework."

At the end of each patient's treatment she was asked to fill in another King's Health Questionnaire as a further measure of her progress. The subjects were also tested at this time for absorption (Tellegen & Atkinson, 1974). The value of the treatment was discussed from the patient's point of view, and any questions answered. Follow-ups were scheduled in six months time.

Of the nine women who entered the study, only five were able to complete 10 to 12 sessions of hypnotherapy. Of these, three patients reported they were symptom free by the end of the treatment. These patients' intervals between daytime micturations increased from as often as every 30 minutes to up to four hours. Their night-time patterns (previously waking three or four times

a night) settled down to almost consistently sleeping through the entire night. The objective results of the final King's Health Questionnaire indicated that the effect that DI had on four out of the five patients had significantly diminished. Subjective scorings of wellbeing rose in three patients to almost 100%, and in the remaining two, to 80%.

A six month follow-up study showed continuous improvement in four out of the five patients' KHQ scores. Three out of five patients maintained their daytime and night time urine retention intervals, and two reverted to their initial figures. Four of the five patients maintained their reported overall wellbeing (between 80% and 100%). It is interesting to note that the three women who attended for only two to five sessions also had quality of life increases of 10%–30%.

## **DISCUSSION AND CONCLUSION**

Despite the small size of this sample, the results support the hypothesis that hypnotherapeutic intervention can improve, and sometimes even eliminate, the emotional and physiological effects of DI. Identical findings were reported in the 1982 paper by Freeman and Baxby. Hypnosis hands control back to the patient and the effect is a compound one. The patient learns that there is no "just in case" scenario, because she is in control, rather than being controlled. During their initial interviews, four out of the five patients participating in this study initially reported that they were affected by life stresses originating from past or present family dynamics and problems. The King's Health Questionnaire gave a picture of the compounded stress that was actually caused by the unstable bladder condition. At the completion of the study, all five patients had noticeable improvements (ranging from 25% to 100%) in their overall wellbeing and ability to cope with life adjustments and stressors. It is interesting to note that the three women who attended for only two to six sessions also had quality of life increases of 10%–30%. And, as mentioned earlier, one patient learned to control the IBS that had plagued her for the past 30 years. Side effects, in other words, were only beneficial.

The interplay of conventional and complementary medicine is a valuable new direction in the treatment of debilitating conditions like DI. As in many conditions, where the psyche plays a contributory role, hypnotherapy can be favourably recommended as a treatment. It is non-invasive, does not require hospital admission, and is cost effective. Success does not depend on IQ, motivation, continuous monitoring, or self-awareness. Hypnotic relaxation

and ego-strengthening techniques reduce and often eliminate past and present life stresses which contribute to somatisation. The use of audiotapes and the practice of self-hypnosis help reorient patients to a position of control over stress and enhanced management of adverse life occurrences. Working on an unconscious level, hypnotherapy can also be used as an adjunct to bladder retraining and biofeedback which aim at improving bladder control consciously. It is hoped that further and more extensive research will be undertaken, so that not only the causes and symptoms of DI can be treated, but also that the patients' quality of life can be improved.

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## USING HYPNOSIS WITH A BATTERED WOMAN WITH POST-TRAUMATIC STRESS DISORDER

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*This report describes the successful hypnotic intervention with a battered woman who has post-traumatic stress disorder (PTSD). The treatment basically consists of three phases: The first is stabilisation by reducing stress and building up personal resources, the second is re-exposing the client to the trauma by graded approximation, and the last is consolidation of the therapeutic gains. Data obtained by the client's verbal reports, the therapist's observations, and objective measures at one month and three month post-treatment follow-ups provides evidence of maintenance and continued improvement in symptoms. This suggests that hypnosis may be an effective adjunct to therapy for battered women with PTSD.*

### OVERVIEW

According to *DSM-IV*, PTSD symptoms fall into three clusters: (a) intrusive symptoms, such as nightmares and flashbacks; (b) avoidant behaviours, such as emotional numbing, detachment, derealisation, and avoidance of triggering stimuli; and (c) hyperarousal symptoms, including hypervigilance, exaggerated startled response, and anger outburst (APA, 1994).

Interestingly, clinical findings suggest that there is a resemblance in phenomenology between PTSD symptoms and hypnotic experiences (Desland, 1997; Spiegel, 1996). In hypnosis, there is a narrowing of focus of attention with total absorption into the suggested experiences. This full absorption is also evidenced in people suffering from PTSD. Sufferers of PTSD demonstrate an absorption in the intrusive memories, as if the traumatic events have come to life again, therefore causing them to experience all sorts of physical and

emotional symptoms. Dissociation is another shared phenomenon in both hypnosis and PTSD. When reliving the traumatic events, PTSD sufferers may unconsciously dissociate the memory out of their conscious awareness. They may become numb in their responses, or they may not be able to recall the details of the events; whereas people in hypnosis also experience a separation between consciousness and unconsciousness (with the conscious mind focusing on the hypnotic process and the unconscious mind actively processing the suggestions) (Yapko, 2003, pp. 189–190). Apart from absorption and dissociation, there is a third shared phenomenon in PTSD and hypnosis. PTSD sufferers are hyper-sensitive to internal triggers or environmental cues that remind them of the traumatic experiences, whereas in hypnosis, people also show a heightened responsiveness and uncritical acceptance of any suggestions and social input.

Given this resemblance, Spiegel proposed that in treating PTSD, “it is logical that hypnosis should be an especially valuable tool in the treatment” (Spiegel, 1993, p. 496), and Evans (2003) also regarded hypnosis as useful in treating PTSD. Apart from this logical deduction, the clinical literature also confirms that hypnosis is an effective therapeutic intervention in PTSD. For example, there are reports of successfully using hypnosis in treating PTSD sufferers following combat (Degun-Mather, 2001; Gafner & Benson, 2001; Spiegel, 1993), post-abortion distress (Walters & Oakley, 2002), sexual abuse (Kozłowska, 2004; Smith, 1993; Spiegel, 1996;), and accidental injury (Carter, 2005). In these cases, hypnotic intervention has been used in a number of ways, including the management of heightened anxiety, as a means of providing a safe context for gaining access to the repressed or the dissociated traumatic memories, for reframing and restructuring the meaning of the trauma after the traumatic memories have been uncovered, and also as a means for reintegrating the new meaning into the sufferers’ belief system.

The following case illustrates the successful use of a hypnotic intervention in a PTSD sufferer called Angel. The therapeutic framework in this case followed Brown’s (1995) three-phase treatment in PTSD. The first phase focuses on stabilisation and resources building, the second concentrates on emotional processing by confronting the client with traumatic memories, and the third integrates the new meaning that has been constructed during the hypnotic process into the client’s belief system.

## **CLIENT BACKGROUND**

Angel was a 35-year-old Chinese woman, who was married with three sons aged 9, 7, and 5. She was referred for therapy in relation to her experience of having been abused by her spouse. At the time of referral, Angel had left her husband and was living with her youngest son in a shelter, while the other two sons remained with their father. Because the father needed to work shifts, he placed the two boys in his mother's home. It appeared that this old lady was very supportive and sympathetic to Angel. Now and then she would arrange for the two boys to meet with Angel without the knowledge of her son. She also kept Angel's whereabouts confidential.

Angel has been abused by her spouse for about eight years. According to Angel, it started off with his criticising her for being incompetent in child care and for her obesity after the delivery of the first baby, and gradually it escalated to acts of diminishing and degrading her (e.g., he teased her that she was like a pig: fat, useless, stupid, ignorant) and disapproving of everything that she did (e.g., cooking, child caring, house management, visiting friends and family). He also controlled the household expenditure, making her financially dependent on him. Whenever he was not satisfied with her household management or when he was frustrated, he threw things (e.g., eggs, television set, chairs, an electric fan) at her, causing bruises all over her body. Once he nearly strangled her to death. Angel had run away from home several times to obtain shelter with her friends, but she returned home shortly after his apology and threats to the children's safety. The battering became known to social workers in December 2003 when she was so severely injured that she had to seek medical treatment in a public hospital. From that point in time, she made up her mind to leave him.

At the beginning of therapy, Angel presented with recurrent intrusions and flashbacks of the abuse. She was particularly disturbed by three kinds of memories: He threw things at her; he overturned the dining table scattering all the dishes; and he attempted to strangle her with his bare hands. These scenes popped up in her mind whenever she watched television depicting scenes of violence, read similar news in the papers, or saw men who looked like her husband. As a result, she would become startled, shaky and restless, feeling unreal, even insomniac. She calmed herself by switching her attention to something else, like working busily at something, calling on friends, or going shopping. Her daily functioning was largely unaffected, but she tended to be worried and irritated over trivial things. She was worried that her husband might chase after her and harm her.

## PERSONAL HISTORY

Angel described her family of origin relationships as generally harmonious and she ranked as the first among four siblings. Angel studied up to Grade 7 before going to work in a factory. Her parents were apparently loving and nurturing; however, from time to time she had witnessed her father being violent with her mother. The violence was in the form of pushing, slapping, and scolding. Being submissive in personality and also because she wished to cover up the shame, Angel's mother put up with the abuse and stayed with the marriage. Seemingly, this belief in putting up with such behaviours affected Angel very much. Initially, she had tried hard to tolerate her husband's violence, hoping that he might change his behaviour as her father had done in recent years. This hope shattered when the violence escalated to the extent that she nearly lost her life.

Angel had met her husband in the workplace. At that time, he worked as the manager in the factory. She felt that she did not deserve his love as he was a high school graduate with good prospects, whereas she was a woman of humble origin with a poor education. She thought he loved her because she was submissive and obedient.

## THERAPY

### Preparatory and Assessment (Sessions 1–2)

Angel was firstly seen in June 2004. She was of small build, well-groomed with a smiling face and good eye contact; her speech was relevant and coherent. She explained that she used to be optimistic, enjoyed life and had lots of friends, but now she was gloomy and isolated. She would tremble and tense up whenever she spoke about the past battering. Before the start of treatment, she was assessed on the Beck Anxiety Scale (BAI; Beck & Steer, 1988) and the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979).

On the BAI she scored 21, which lay within the range of moderate anxiety (Beck & Steer, 1993). On the IES, she had a score of 64. According to Horowitz (Horowitz et al., 1979), this score is interpreted as evidence that the trauma has had a severe impact on the person. According to unpublished Chinese local data, this score exceeds the mean score of a clinical group by one standard deviation,<sup>1</sup> implying that the trauma had a severe impact on Angel,

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<sup>1</sup> Unpublished IES data on 27 Chinese adults (4 males and 23 females) who were referred to the Clinical Psychological Unit of the Social Welfare Department of Hong Kong for psychological treatment in relation to the trauma of having been physically assaulted ( $M = 46.26$ ,  $SD = 14.77$ ).



whether compared with local Chinese norms or across cultures.

The first two sessions with Angel were spent on history taking, assessment, and psycho-education. She was educated on how her past trauma had contributed to her current symptoms, which were normal reactions to chronic physical and mental abuse. She was briefed about hypnosis in the second session, during which hypnosis was described as a valuable therapeutic tool for relaxation and for processing her traumatic memories in a safe and controlled fashion. Her hypnotisability was assessed by using the Stanford Hypnotic Clinical Scale for Adults. She scored 3.5 out of 5, demonstrating good response in imagery and fantasy.

### **Stabilisation and Resources Building (Sessions 3–6)**

The third and fourth sessions were spent on relaxation training and ego-strengthening, as building up ego strength is a prerequisite for conducting deeper trauma work (Gafner & Benson, 2001). During this phase of treatment, hypnosis was typically induced in a formal and direct manner by suggesting to Angel firstly to relax her muscles progressively and secondly to deepen the trance state by counting each stair as she walked down an imagined staircase (Hammond, 1990, p. 254). Angel generated a happy childhood experience when she was nine years old in which she played with other children in a garden. She was instructed that if scary memories popped up in future hypnotic sessions, she could access this safe place. It was also suggested to her to store all of her traumatic memories in a box until the time that she felt safe to open it with me in therapy. These two hypnotic sessions showed that Angel was highly suggestible since she readily regressed to the 9-year-old garden scene and was totally absorbed into her own experience, while at the same time she was responsive to my suggestions and the questions asked of her.

In Session 5, after ego-strengthening and the hypnotic script on the serenity place, she told me that she had experienced different imagery. She saw herself walking in a barren mountainous area where there were three big rocks blocking her way. She tried very hard to find a path around or over these rocks and with repeated effort she finally wormed her way through them. As she continued her journey in this barren landscape, she saw a bright light at the far end. She was fearful and worried, wondering what would be there. She finally made up her mind to continue the trip and her imagery ended at this point.

This self-generated imagery was utilised in the hypnotic suggestion in the sixth session in which indirect suggestion and metaphors were used to encourage Angel's strengths and mastery. In this session, a journey metaphor (Hunter, 1994, pp.142–44; Yau, 2004) was suggested to Angel; she had successfully gone through a difficult journey and now she was in a safe place searching for her way ahead. There was a dumping ground somewhere in the present journey for her to dispose of her burdens if she wanted to. It was suggested to her to use her newly found courage to move on in the journey. Angel told me, after she was out of trance, that she wished to open the memory box in the next session.

### **Graded Exposure and Desensitisation (Sessions 7–12)**

The second phase of treatment lasted for a total of six sessions. In Session 7, Angel was reassured that the remembering of the trauma would be carried out in a graded manner according to her pace and wishes. She went into trance quickly and easily. It was suggested to her to have a handset at hand, so that she could control the display of images on a split screen in front of her (Spiegel & Spiegel, 1987, pp. 229–32). When she was ready to view the video, the lid of the memory box was opened firstly by an inch. From that tiny opening, one of her previous family scenes was released and was projected onto one side of the screen. The image of a little angel was to be imagined on the other side of the screen. This little angel was brave and strong and was ready to support Angel while she viewed the video. This angel metaphor was used to represent the stronger part of the self that would provide comfort and strength to her vulnerable self. On coming out of trance, Angel told me that she visualised herself playing happily with her three children on one side of the screen.

Similar split-screen suggestions were made in Session 8. Angel was noted to be absorbed, but was slightly frowning and evidenced rapid breathing for a brief period during hypnosis. On coming out of trance, she told me that she had encountered a special imagery this time. She had visualised herself making her way in the previous barren land and on her way she saw a little house by the roadside. She entered the house and there she saw her husband. All of a sudden she heard a loud noise, like something very heavy being thrown onto the ground. She was so frightened that she left the house immediately. The fear lasted for only a brief time since the little angel reassured her that she was safe by her side.

This self-generated imagery was utilised and elaborated upon in Sessions 9–11. Since Angel actively formed images, she was encouraged to communicate with me her visualisations while she was in trance. In this way, I could utilise her imagery in my suggestions in guiding her through the journey. The content of suggestions in these sessions was primarily focused on what Angel experienced in the little house, for example, playing with her children, doing household chores, witnessing her husband yelling, scolding or throwing things at her. Various safe exposure techniques had been used during the process. For example, if Angel found the images too distressing, the little angel would use her magic power to move them fast-forward, fast-backward, slow-motion forward, or slow-motion backward; or the little angel could make the scary images shrink in size, or alternatively change Angel to become bigger and stronger. She was told that any time when she found her anxiety rising up to 8 or above (using the subjective unit of distress scale ranging from 0 to 10), she should not leave the frightening scene right away, but instead she should signal me to pause and then relax herself. If she wanted to continue the exposure afterwards, she could signal me to continue.

In between the sessions of re-visiting the trauma, Angel reported experiences of increased flashbacks in daily life. However, these intrusions appeared to be less vivid and less frightening. She learned to relax herself by using the techniques that she learned in the sessions. In Session 12, she had an image of talking to her husband face to face in the little house. She was frightened, but she knew she had to assert herself by telling him her wishes. She told him that she was no longer afraid of him and that she had decided to leave him. She also reminded him not to disturb her again. She was so firm in her attitude that it made her husband stop yelling at her. He finally left the house and she stayed there with her children. When she was brought out of trance, she reported feeling astonished by her courage, something that she had never imagined before. This marked the end of the second phase of treatment.

Issues relating to changes in power and dangers to the self when in such a violent relationship were discussed, so that Angel would not suddenly change her behaviour in a way that might increase the violence of her husband to herself or her children.

### **Integration (Sessions 13–16)**

In phase three, the main theme was moving on with the journey. This comprised three components: finding meaning from the past, integrating this

new learning into the present, and reinforcing the strengths and resources for moving on in the journey. Four sessions were spent on this phase of integration. In Session 13, the technique of age progression was used to assist Angel to visualise herself when she became old. It was suggested to her that she have a family gathering to celebrate her success and that during this gathering she would share her story with others. In Sessions 14 and 15, an age progression technique was used (Hammond, 1990, pp. 509–519) in which it was suggested to her that she write an autobiography in which she described herself as a persistent, competent, tough, and confident woman who had successfully overcome various obstacles in life. In Session 16, a past-present-future analogy was explored in which she could leave the burdens (past) in the dumping ground and then locate a number of treasure boxes along the present path. These boxes would contain all of her new discoveries of strengths and abilities. With all these treasures at hand, she confidently moved on in her future journey. This marked the termination of the planned hypnotic intervention. It was agreed that Angel would be followed up for a few more sessions in order to consolidate her gains.

### **Additional Sessions for Tension Reduction (Sessions 17–19)**

In session 17, Angel appeared to be tense and edgy. She reported that her tension had risen again when it was getting near to November, at which time she would apply for a legal divorce against her husband's wishes. (In Hong Kong one party can apply for divorce without the other party's consent after two years' separation, and Angel would meet this requirement by the end of November.) She wanted to obtain a divorce certificate to formally certify the end of her miserable marriage. As she had little knowledge about the divorce procedure, she became worried and frightened. She was particularly worried about meeting her husband in the courtroom.

The Impact of Event scale was administered in this session and Angel scored 37. Compared to her score in the first session, this was actually a 27 point drop, implying the impact of the battering had lessened significantly. I believed that her present anxiety was related to her limited knowledge about the divorce procedure and I provided her with the necessary information on divorce (e.g., how she could file the application, and what would be the usual procedure, etc.). However, I explained that it was not my role to advise people to divorce or how to obtain a divorce; she needed to consult lawyers about that. Afterwards, she was put into a trance and the scene of her relaxing

garden was brought back. The therapy suggestion was focused partly on relaxation, and partly on reframing the meaning of the certificate of divorce. The suggestion was made that she could attend a surprise party held by her family and friends for her. At this party, she would be awarded a certificate to certify her courage and strengths in overcoming a difficult journey. She was proud of herself and felt that she was no longer a stupid or worthless person. The participants shared her joy and expressed their appreciation of her. When she was brought out of trance, she reported that her tension had reduced and she was looking forward to obtaining the certificate.

Angel was calm and composed in Sessions 18 and 19; the fear and worries had subsided. These two sessions focused on consolidating her use of self-hypnosis for tension reduction. She was hopeful and confident. The IES was administered again in Session 19. She scored 20, meaning that the battering had now only a mild impact on her. We agreed the therapy should be terminated gradually after two more follow-up sessions at one month and three month intervals.

### **One and Three Month Follow-Up**

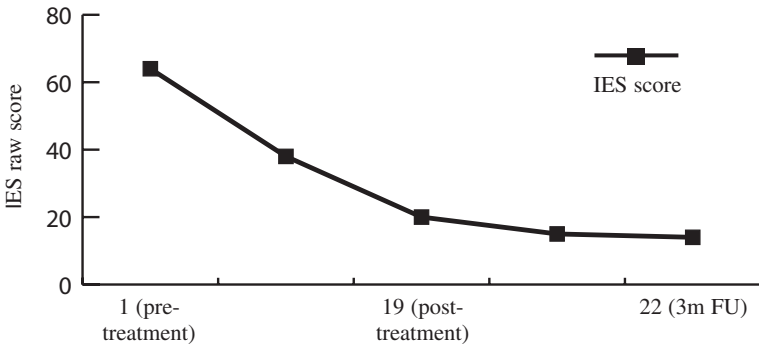
At the one month follow-up, Angel's IES score had further dropped to 15. She had formally divorced and she was satisfied and happy with her life. We undertook an evaluation of the therapy and her progress. She determined that the hypnosis had been most useful and acceptable to her, because it allowed her to work on her pain at her own pace. She felt that she had matured a lot, and had a sense that she had changed from a weak and shameful victim to a courageous, assertive, optimistic, and hopeful person. She wanted to share this new discovery with others and therefore she had joined a support group for women with similar experience.

At the three month follow-up session, Angel scored 14 on the IES, implying that she had maintained the therapeutic gain. She scored 14 on the BAI, which is within the range of mild levels of anxiety. This tension was due to the stress in supervising the school work of her youngest son with whom she was living. As for the impact of the previous battering, she believed she had largely overcome it. She was glad that she started to have access to the other two sons in school holidays, and her ex-spouse also had visitation rights to the third son who lived with her. Although she was not sure whether he had really let go of his anger, she felt she was less fearful of him. There were occasional anxiety flashbacks, but she was able to contain these without

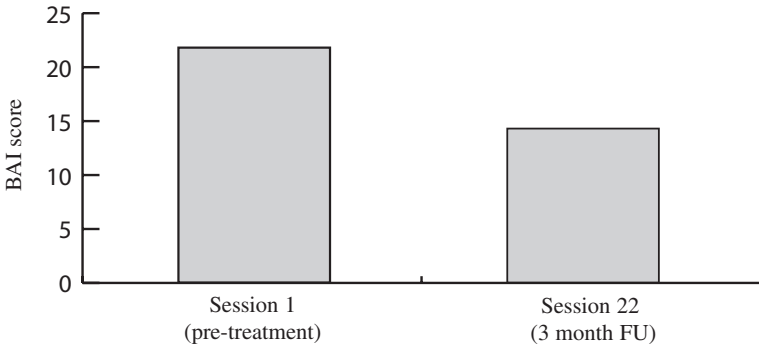
undue distress. She described her new life as having started and she planned to look for a job. I granted her a graduation certificate to signify her active participation in the treatment process. This certificate also served as a reminder of her effort in helping herself to stand up again.

Figures 1 and 2 show the pre-treatment, post-treatment, one month and three month follow-up data.

**Figure 1:** Treatment Progress as Function of IES Scores



**Figure 2:** Treatment Progress as Function of BAI Scores



## DISCUSSION

Results from this single case study indicate that hypnosis is an effective adjunct to therapy for a battered spouse suffering from PTSD. This case also illustrates the benefit of utilising a client's self-generated imagery to make the therapy more individualised and tailored-made.

To conclude, the following points are the important therapeutic elements of hypnosis as demonstrated by this case:

1. Hypnosis is an effective means of stabilisation and grounding.
2. Hypnosis allows access to traumatic memories in a safe and graded fashion.
3. Hypnosis enables a client to have control in the healing process. In this case, it is the client who finds her own way to heal and not the therapist.
4. Hypnosis provides a platform for consolidating and generalising the newly acquired strengths to a future life.

Given that this is only a single case study, conclusions regarding the efficacy of hypnosis in treating victims of domestic violence cannot be drawn at this stage. It is hoped that the continuation of applying hypnosis in similar cases will enable data to be accumulated over a period of time, and this will definitely help in further evaluating the effectiveness of hypnosis as an adjunct to the psychological treatment of PTSD amongst battered wives.

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## CASE NOTE

### USING VAK AS A RELAXATION STRATEGY

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*Rather than a traditional case study, an easily accessible relaxation technique, called VAK, is presented in this article. The VAK technique — based on visual (V), auditory (A), and kinaesthetic (K) imagery — might be used with different client groups, for a variety of problems. As a relaxation technique, VAK might be applied either alone, or in conjunction with other interventions including hypnosis.*

Relaxation techniques are increasingly used as a sole or complementary intervention (with other strategies such as hypnosis, medication, biofeedback, or cognitive behaviour therapy) in the treatment of various disorders including pain-related medical conditions (Astin, 2004), generalised and specific anxiety disorders (Seaward, 1997), stress and depression (Eller, 1999), as well as behaviour problems in children (Chang, 1991). Relaxation strategies have been defined as those that induce a wakened state of low physiological arousal (Everly & Rosenfeld, 1981) and tend to involve slow, deep respiration, decreased muscle tension, lowered blood pressure, and increased skin temperature in the extremities (Chang, 1991). The various relaxation strategies include meditation, autogenic training, biofeedback, progressive muscle relaxation, and guided imagery (Carroll & Seers, 1998). A description of one guided imagery technique, using visual, auditory and kinaesthetic cues, is showcased in this article.

Imagery has been described as a form of mental processing in which an individual creates internal sensory experiences in the absence of external or actual stimuli, and which involves any one or combination of the senses, including visual, auditory, olfactory and kinaesthetic (Fezler, 1989).

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Imagery might occur spontaneously in clients, either positively or negatively (Johnsen & Lutgendorf, 2001), or might be guided verbally by a therapist. However, in therapeutic situations, Overholser (1991) points out that it is best for the imagery to be devised collaboratively between client and therapist, and in the long term for clients to take increasing control over the content and the flow of the imagery that works best for them.

While guided imagery is a distinct psychological procedure, it has many similarities with hypnosis (Overholser, 1991). For instance, hypnotic imagery typically includes suggestions to change a client's perception or experience of certain stimuli (Hammond, 1990). Consequently, the guided imagery technique described here, VAK, might be used with, or without, the induction of a hypnotic-like trance.

When teaching someone to relax, guided imagery is useful as it has the potential to strengthen the depth of relaxation, provide a positive source of distraction, and alter a client's psychological and physiological processes (Zahourek, 1988). Guided imagery is particularly effective in inducing relaxation for clients who are experiencing severe levels of pain (Sloman, Brown, & Aldana, 1994; Syrala, Cummings, & Donaldson, 1992) or stress, anxiety, and/or depression (Eller, 1999).

The guided imagery outlined here uses visual, auditory, and kinaesthetic cues. Even though people might use all three modalities when responding and understanding stimuli, most prefer one modality over the other two (Bandler & Grinder, 1979). Chang (1991) suggests that clients may respond to stimuli in their dominant modality — that is, visual, auditory, or kinaesthetic. For instance, a kinaesthetically orientated client will respond better to an approach like progressive relaxation, in which the client is asked to respond to bodily sensations, while a visual client will find visual imagery more useful. While clients might have a dominant modality (usually visual), Norris (1992, as cited in Seaward, 1997) argues that imagery should include kinaesthetic suggestions, so that clients can have a sense of what they are seeing as happening inside their bodies, particularly for those in physical pain (though in these instances the emphasis should be on a positive, physical experience that includes relaxation and/or healing).

Utilising all three modalities and accessing open-ended images of visual, auditory, and kinaesthetic stimuli, as outlined in the VAK technique described below, ensures variety, thus maintaining clients' interest levels, and makes it easier for clients to develop their own VAK set, over time, and in different situations.

## VAK Script

Explain first to the client that this is a relaxation exercise that will help them with whatever problem they are presenting with. Explain that this exercise is simple, easy to use and something for them to use on their own. It is important that the facilitator speaks in a slow, steady, and calm voice throughout, with relevant pauses when appropriate.

*Pay attention to three things you can see around you for three seconds each ... [V]*

*Now attend to three things you can hear for three seconds each ... [A]*

*Now pay attention to three parts of your body you can feel (such as your feet on the floor, or your tongue on the roof of your mouth) ... [K]*

*[Pause for several minutes]*

*Now again, in this sequence, pay attention to two things you can see around you for three seconds each ... [V]*

*Now attend to two things you can hear for three seconds each ... [A]*

*Now pay attention to two things a part of your body can feel in your surroundings ... [K]*

The technique can then lead into other approaches such as: *Now close your eyes and pay attention to your breathing. As you do, become aware of how relaxing each out-breath can be. As you focus on your breathing begin counting these out breaths from ten until you reach one ...* Alternatively, clients can be invited to go to a relaxing, calm place.

While the VAK script employs three different modalities, an important extension of the technique is to prompt clients to choose their most “relaxing modality” from the three, and to encourage them to modify the above script to best accommodate this preferred modality. For example, if the client finds the kinaesthetic most relaxing, he or she may decide to focus only on this mode in the future use of the script.

As with all relaxation procedures, regular practice is the key to ease of entry into a relaxed state. Not coincidentally, this is a major strength of the VAK approach, as the technique is easy to learn and can be practised almost anywhere (e.g., riding on the bus, waiting in a queue, in the bathroom, watching television with family). The technique is particularly recommended for aiding sleep (the above script can be the precursor to breathing, body awareness, or safe place techniques), as well as managing panic and/or phobia reactions.

With guidance and planning from a therapist, and if the client has sufficiently practised the procedure, the VAK technique can be readily activated

in situations that in the past might have resulted in an agitated state (such as dealing with a phobic stimulus). Importantly, the technique provides clients with the tools (i.e., they can pay attention to their preferred visual, auditory or kinaesthetic environmental stimulation) to divert their attention away from bodily (e.g., hyperventilation) and/or environmental (e.g., the phobic object) components that might otherwise accompany their hyper vigilant responses.

The VAK script might be used on its own, or lead on to further guided imagery, relaxation, or hypnotic work. Therapists, nurses, occupational therapists, and other general counsellors might successfully integrate the VAK technique into their general repertoire of skills and strategies, for different client groups. Although this intervention should not be considered a panacea, such a strategy might form a useful supplement to other relaxation strategies when working with a range of different client groups.

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## SCRIPTS

### POWER BREAK™ SCRIPT

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The Power Break™ Program consists of a 10-minute hypnorelaxation script recorded on a compact disk that participants are required to listen to via headphones attached to a computer work station on two occasions each day. The script includes suggestions for relaxation and statements about being re-energised, and is recorded against a background of music composed specifically for this project. The Power Break™ Program is designed to allow people to take a short break in the workplace to facilitate relaxation, reduce stress, promote feelings of being re-energised and thus perform more efficiently upon returning to work. Power Break™ is specifically designed as a short break of only 10-minutes in order to minimise the chance of people falling asleep during the break. Power Break™ is not meant to be a Power Nap. With the short period of a Power Break™, it is unlikely that people will fall asleep, unless they are extremely efficient sleepers, sleep deprived or have a sleep disorder (e.g., obstructive sleep apnoea, or narcolepsy).

*Welcome to power break. You are taking a high quality, 10-minute break, a time out from what you have been doing until now, in order to revitalise yourself. Then, you can return to your day or night with renewed energy and effectiveness.*

*So ... for next little while, you can allow everything that has taken your time and energy until now, to fade into the background of your awareness ... you can return to all that soon in a whole new way.*

*There is nothing for you to do right now ... nothing to bother you ... nothing to disturb you ... this is your quality time ... just for you.*

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This script is the one referred to in the article on Power Break™ to appear in the November edition of *AJCEH*. Further details can be obtained from Dr Kennedy.  
Requests for reprints should be sent to Gerard Kennedy at Gerard.Kennedy@vu.edu.au.

*Be as comfortable as possible .... sitting or reclining just as you are ... arms and legs uncrossed. Gently close your eyes once you have found a comfortable position, so that even if there is activity going on around you, you are not disturbed or bothered. Whatever is happening around you ... sounds from near or far ... can simply fade into the background of your awareness.*

*Gently and effortlessly bring your attention to the way you breathe ... noticing the sensations associated with air entering your nose or mouth as you inhale ... the way the chest rises then falls ... the feel of the air as it is exhaled.*

*These are subtle sensations that are not usually observed, and yet when you begin to pay attention to the experience of breathing, it may be surprising to notice them or to find these indistinguishable. Continue to follow the in-breath and out-breath for a few cycles, perhaps observing the subtle sensations ... possibly becoming aware of the rhythm and depth of the breathing pattern, without trying to regulate or change anything.*

*Notice how breathing seems to happen all by itself ... naturally and effortlessly ... each in-breath bringing a fresh supply of oxygen to the lungs which is carried to every part of the body to replenish every cell. Each and every out-breath removes what the body no longer needs, making room for fresh nutrients and energy arriving with the next in-breath.*

*You may have already become aware of small changes in your body, as the muscles begin to release some of the tension they are so accustomed to holding during everyday business life. Perhaps this relaxation of tension is so subtle that it has not come to the forefront of your awareness yet.*

*You may wish to move the head and neck from side to side, roll the shoulders, wriggle the toes or shake the hands to release some more of the stored-up muscle tension. Perhaps you can shift into a new and even more comfortable position as you continue listening.*

*As you take the next breath, let it enter deeply into the body and exhale through the mouth with a sigh ...*

*Every out-breath bringing comfort and muscle relaxation ...*

*Every out-breath releasing some of the stored muscle tension and fatigue ...*

*Breathing in comfort and energy ...*

*Breathing out tension and fatigue ...*

*Becoming refreshed and energised moment by moment ... breath by breath ...*

*It may begin to feel like something is being replenished throughout your body, or it may seem like nothing is happening at all. You don't need to try to make anything happen or stop anything from happening. All there is for you to do is to notice whatever you are experiencing ... if there is anything to notice at all ... these changes are so subtle at first.*

*So continue to pay attention to the breathing and as you do that you may wish to imagine or think about a most wonderful place where you have been or would love to be ... in nature or in a beautiful room feeling safe ... comfortable ... happy ... perhaps relaxing in the sun or doing an activity you love ... you have poetic licence to transport yourself wherever you wish for a few precious moments ... doing so enhances the calming and replenishing of the body and mind. You can do this even without seeing pictures or having thoughts, you may simply tune into the sensations, the feelings and sounds of the memory or imagination ... whatever way you do this is fine.*

*Then in a moment or two ... when you are ready ... imagine becoming even more energised and refreshed as you return to your job. See yourself as you go through the next part of the day or night feeling great, performing tasks with ease and clarity.*

*Now you can feel more and more alert, refreshed and re-energised with every breath.*

*You may wish to stretch as you open your eyes ... take as long as you need to reorient to what is around you ... and when you are ready you can move on to what is next for you, feeling refreshed and empowered.*



## **HYPNOSIS ANTENATAL TRAINING FOR CHILDBIRTH (HATCh): INTERVENTION SCRIPTS 1 AND 4**

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Evidence suggests that hypnosis preparation for childbirth decreases maternal analgesia requirements and other interventions during labour, and increases the incidence of spontaneous vaginal birth (Cyna, McAuliffe, & Andrew, 2004). Since April 2002, we have been developing an antenatal hypnosis training program for women in late pregnancy (after 34 weeks gestation) to be utilised for anxiolysis and as an analgesia adjunct during childbirth (Cyna, Andrew, & McAuliffe, 2006a). Initially, we were seeing women on an individual basis. However, increasing demand for hypnosis preparation for childbirth from mothers, midwives, and obstetricians at our institution has led us to our current practice of training groups of 5–10 women / week in self-hypnosis techniques developed along the lines described by Waxman (1990), Bejenke (1996), and McCarthy (2001). The hypnosis training sessions have continued to evolve over the past three years. Each session lasts approximately one hour. They are held over three consecutive weeks after the 34th week of pregnancy.

Audio compact discs (CDs) on hypnosis were developed in our institution following increasing requests from patients for a supplement to what was learned in the live hypnosis sessions. An experienced physician (CW) who has practised full-time hypnotherapy for over 10 years and whose practice involves regular hypnotherapy preparation for childbirth observed our hypnosis group sessions for several weeks and took notes of the types of suggestions utilised.

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The HATCh trial has received support from the Women's and Children's Hospital Foundation, the Australian Society of Anaesthetists, and the NH&MRC (Project Grant No.:453446). Requests for reprints should be sent to Allan Cyna at [allan.cyna@cywhs.sa.gov.au](mailto:allan.cyna@cywhs.sa.gov.au).

A final written script for each session, based on our current clinical practice in training women using hypnosis in preparation for childbirth, was agreed to by the hypnotherapist members of our research team.

These scripts were used to produce three audio CDs that mirrored our current hypnosis preparation for childbirth training program. The audio CDs were produced at a local recording studio and each lasted between 21 and 32 minutes. A fourth audio CD, of 18 minutes duration, has also been developed for use during labour and childbirth. Multiple copies were made through our institution's digital media department. The CDs are labelled with a caution that they should not be used while operating machinery or driving. Two lead investigators' names (Allan Cyna and Marion Andrew) with the contact phone numbers of our institution are shown on each CD label.

The HATCh (Hypnosis Antenatal Training for Childbirth) trial (Cyna et al., 2006b) seeks to determine the efficacy or otherwise of antenatal group hypnosis preparation for childbirth in late pregnancy using a structured intervention. We also aim to compare two methods of delivering antenatal group hypnosis. One method uses a hypnotherapist to deliver the intervention followed by an audio CD on hypnosis for re-enforcement of the techniques learned. The other is to use an audio CD on hypnosis alone administered by a nurse with no hypnotherapy training. Participants were advised that the CDs are for their use only as part of the HATCh trial. The two scripts below are the transcripts of the suggestions used on the first audio CD and the fourth audio CD given to Groups 1 and 2 HATCh trial participants on the first of the three occasions prior to the expected date of delivery of the baby (Cyna, 2006b). The additional fourth audio CD is given to trial participants for use in labour if they wish. Scripts for the sessions 2 and 3 will be published in the next edition of this journal.

### **HATCh TRIAL SESSION 1**

*As you settle yourself down and feel the supportiveness of the chair or whatever, and as you listen closely to the sound of my voice, you can enjoy how easy it is to relax and to go into daydreaming type thinking. One part of your mind might be thinking about what I am saying and another part of your mind might be thinking about something else ... and you can still enjoy how easy it is to relax and to go into daydream type thinking.*

*There are lots of ways to settle down into this daydreaming state and some of you may already know how to do it and some of you may be curious to learn ... and so ... if you already know you can just let yourself settle down in your own time and your*

*own way ... drifting comfortably, relaxing comfortably ... just letting it happen the way it wants to, and for those of you who are curious to learn ... in a moment, but not yet, I'm going to count from 1 to 3. On the count of one, I'm going to ask you to do one thing, and on the count of two, I am going to ask you to do two things, and on the count of three, I'm going to ask you to do three things. So in a moment, but not yet, on the count of one, I'm going to ask you to roll up your eyeballs as high as they will go, as if you're looking through to your hairline.*

*In a moment, but not yet, on the count of two, I'm going to ask you to slowly close your eyelids keeping the eyeballs rolled up, and take a deep breath and hold it. In a moment, but not yet, on the count of three, I'm going to ask you to relax the eyes, breathe out and float down, down into the daydream. So ... here we go: One, roll your eyeballs up as if you are looking through to your hairline. Two, slowly close your eyelids keeping the eyeballs rolled up ... and ... take a deep breath and hold it. And three, relax the eyes, breathe out ... float down, float down, down into hypnosis. And you can welcome on this pleasant floaty feeling ... drifting and floating ... and as you continue, continue to breathe ... many people find that as they breath in, they feel stronger and, as they breathe out, they relax ... and feel more comfortable.*

*As you breathe in, you feel stronger, as if you can cope, like you're in control, and as you breathe out, you relax. Breathe in and feel your strength, and breathe out, and relax, comfortably. And as you breathe, you may at first be quite aware of outside noises, but after a while, they just fade into the background, as you become more focused on the sound of my voice and, on your own inner experience. More and more comfortable, with every breath, and as you breathe out, the shoulders sag a little, quite easily, quite naturally, and that shoulder saggy feeling is relaxation. And as you breathe, you can send that shoulder saggy feeling all through your body, so you can relax ... deeper and deeper with every breath. So breathing is relaxing, and you can let that comfort, let that relaxation happen any way it wants too, just letting it happen.*

*Sometimes, when we think about comfort, we can be aware of discomfort, and that's okay. Watch the discomfort, just as you watch the comfort ... and as you feel the comfort, you can feel it even more.*

*Any time you need to move and adjust your posture, you can allow that comfort to spread all through the body. Letting your forehead muscles become smooth, and the muscles beside the eyes become flat, eyelids heavier and heavier and, letting the muscles all around the jaw relax so that maybe the mouth wants to open a bit, and maybe ... it doesn't. Letting the face become smooth and quiet, down into the neck muscles, maybe imaging the neck muscles like a little tower of rubber bands one on top of the other pulled tight, and that one by one you let them go, just letting them go, down into the shoulders ... letting the shoulders sag ... and with every breath it's as if you breathe*

out a little more tension, out into the air, a little bit more, and a little bit more, with every breath deeper, and deeper relaxed, and you can let that relaxation and comfort ripple all the way down the body.

Now, maybe like a gentle wave of relaxation ... down through the arms, upper arms relaxing letting go, elbows relaxing ... letting go, forearms relaxing, letting go, wrists relaxing — letting go, hands relaxing letting go, all the way down to the fingertips. So the arms feel all loose and limp and floppy, just kind of sinking down, letting that comfort spread down through the trunk of the body. Breathing away any tension out into the air, letting that comfort spread down to the chest and abdomen, down the back, letting the spine go like a tightly coiled spring that you just let go loose and floppy ... letting go, letting that gentle wave of relaxation spread down the legs, thigh muscles loose and floppy, knees loose and floppy, calf muscles loose and floppy, ankles, loose and floppy, down into the feet ... down into the toes all the way down ... deeper and deeper relaxed, more and more relaxed with every breath. And one part of your mind might be curious about just how deeply relaxed the body can go, while the other part of the mind may like to daydream about something else.

How about imagining that you and I are standing at the top of a staircase, and the staircase might be covered with a thick soft carpet with a beautiful colour of your own choosing. You can feel your feet sinking down into the softness of the carpet. On one side, there might be a railing and you can glide your hand along if you wish, because in a moment but not just yet, you and I are going to go down the staircase together. The deeper down we go, the more comfortable we become. We have 10 steps to walk down and you will stay safe and secure all the way. Maybe the steps are numbered from nought to 10, or maybe there is a measuring pole that is measuring from nought to 10 down the staircase, and as you look at the numbers you can start thinking of relaxing on a scale of nought to 10 where 10 is relaxed as you can be. You can go closer and closer to the number 10 and, as you go closer and closer down the steps, you go deeper and deeper relaxed. So down the 10 steps now, going down ... 1, 2, 3, soft plush stairs, sinking down 4, 5, 6 ... the carpet becoming an even deeper and richer colour, the deeper down we go. Deeper, deeper relaxed 7, 8, 9 ... almost there, almost ready to go all the way down to be relaxed as you can be. Ten ... way down deep, deep, deep ...

Now we are at the bottom of the stairs, and in front of us there are several paths. Each path leads to a special safe place for you, a place where you can feel safe and comfortable. It may be somewhere you have been before, or it may be somewhere you see in your mind's eye, or it may be somewhere beautiful in nature. But the point is, it is a safe place where you can shut the door on the outside world, and where you can retreat to, to relax and refresh yourself, a safe place where you can feel contented and confident. So follow a path to a special, safe place for you and, wherever you find yourself right

*now, stay here and enjoy it with all of your senses; and I wonder which sense will be the most vivid for you? I wonder if it will be what you can see; the colours around you or down low, and the patterns of light and shade, the colours up high, or perhaps what will be the most vivid for you is what you can hear; louder and closer sounds, or maybe far away distant sounds that you really have to concentrate to hear. But once you do hear those quiet sounds, it's like they fill your awareness. Perhaps what will be the most vivid for you would be the smells. Here in your special place, as you breathe deeply, you can inhale that wonderful aroma and get a sense of it spreading all through the body, relaxing, and refreshing you. Maybe there is a nice taste for you to enjoy, something nice to eat and drink coming into your awareness right now if you wish.*

*And I don't know what you're doing, I don't know if you're sitting down or looking around, or if you are walking around exploring, or if you are enjoying a favourite activity ... but whatever you're doing, maybe what is most vivid for you is what you feel with your body. Like the feeling under your feet, like the temperature of the air ... and I wonder if you have begun to notice the way that the more time you spend here, the more the feelings of comfort and relaxation become more a part of you and flow all through you to all parts of you. A sense of comfort and safety just taking you over, filling you inside out, outside in, and you go deeper, deeper relaxed right now.*

*Right here, right now, you have no need of your cares or worries, that's right — you can let yourself feel the relief of off-loading them into a container like a box or a basket. Any cares or worries that you may have about the rest of the pregnancy, or your health, or the baby's health. You can off-load them into the container, or any cares or worries you might have about labour, and how you will cope, or how your partner will cope, off-load them into the container, the box, the basket. Any cares or worries you might have after the baby is born and how you will cope with establishing your routine — put them in the container and when you have off-loaded any cares or worries that you don't need or want right now, then you can send that container off and away into the horizon. Maybe you will put it on a cloud or maybe you will put it in a boat, or maybe you will attach it to some bright coloured helium filled balloons and just let it drift off smaller and further, further and smaller, until it is just a little dot resting on the horizon.*

*So you know where the cares and worries are and you can get them back any time you want to look at them, but for now you can let yourself feel the pleasure and release of sending them off and far away; they are just a little dot on the horizon; you can really experience a sense of release and relief, and go even deeper relaxed, drifting deeper and deeper and deeper. And you can feel confident in knowing that you have the ability to re-experience this comfort and relaxation whenever you choose, and when it is safe for you to do so.*

*In a moment, but not just yet, you are going to enjoy discovering just how easy it is to take yourself into, and out of, hypnosis. In a moment, but not just yet, I'm going to ask you to drift and float safely back up to the top of the stairs, and then I'll count you back down to your special safe place. You can go even deeper relaxed than before, so drift and float back up to the top of the stairs. You can open your eyes leaving the body relaxed, deeply relaxed from the neck down — that's right — floating back up to the top of the stairs now, and when you reach the top of the stairs, you can open your eyes leaving the body deeply relaxed from the neck down. That's right — eyes open, that's right — eyes open. And now, one, roll up the eyeballs as if you're looking at the hairline; two, slowly close the eyelids keeping the eyeballs rolled up, and taking a deep breath in, hold it, and feel your strength ... and three, relax the eyes, breathe out and float down, down the steps, back to your special place, feeling even more deeply relaxed and more comfortable than before, and you can enjoy re-experiencing all the comfort of this special place of yours ... with all of your senses, and you can let the comfort and relaxation flow all through you, to all parts of you ... comfort and relaxation just taking you over and feeling deeper and deeper relaxed with every breath ... and you can go even deeper than before, and you can feel confident in knowing that you have the ability to put yourself into this relaxed state that we call hypnosis — whenever you choose and feel safe to do so.*

*Let's practise another time. In a moment, but not just yet, I'm going to ask you to float back up to the top of the stairs and open your eyes, and then I'll help you to silently count yourself back into hypnosis back to your special place ... and you can go even deeper relaxed than before. So, float back up to the top of the stairs now, and open your eyes, leaving your body relaxed from the neck down. That's right — eyes open, that's right, eyes open; and now, roll up the eyes, close the eyes, and take a deep breath, and feel your strength, relax the eyes, breathe out, float back down, down the steps, and down to your special place, deeper and deeper relaxed with every breath, more and more comfortable with every breath, ready to enjoy all the comfort of your special place with all your senses, comfort and relaxation just taking you over, even deeper relaxed than before — that's right, that's right — and, as you continue to enjoy this growing sense of comfort, it might be nice to spend some time thinking about your baby.*

*A baby is growing inside you. Every day your baby grows bigger and stronger, nurtured by your body. Your body is nurturing your baby, and your body knows what to do. Trust in your body, every time you feel your baby kick or move, it's a reminder to you that your baby is growing bigger and stronger, because it is being nurtured by your body. Every kick or movement is a reminder to you that your body knows what to do, and your body knows how to deliver your baby safely and comfortably. That's right, the whole time you have been pregnant, your body physiology has been changing*

*and preparing for the safe and comfortable arrival of your baby. It's as if you have spent the last nine months like an athlete preparing for birth, and your body is very well prepared to give birth to your baby safely and comfortably. Your body knows what to do, so trust in the body. All you need to do is relax, and leave the uterus to do what is has to do, because we do everything better when we are relaxed. We do everything better, whether it be physical, mental, emotional or spiritual, and you know you can relax, and you can relax and give birth to your baby safely and comfortably. You can relax and let your body flow, relax into the flow, go with the flow and deliver your baby safely and comfortably.*

*During the first stage of labour the uterus contracts, and the cervix dilates from nought to 10 cm, and you can relax and just let it happen. The uterus knows what to do, the cervix will dilate from nought to 10 cm. Many women know that during the first stage there are three times to particularly look forward to, times when they get surges of energy and strength, surges of confidence where they go even deeper relaxed.*

*The first time is when your cervix is 2–3 cm dilated, and when the cervix is 2–3 cm dilated then you know you are in an established labour, and you are getting closer to the joy of meeting your baby ... and at 2–3 cm dilation, you can feel excited and get a surge of strength and confidence and relaxation and you don't even need to remember this; it will just happen.*

*The second time to look forward to is when the cervix is around 4–5 cm dilated, because you know that you are entering the accelerated phase of labour and for most women it means that you are more than halfway there and you are even closer to meeting your baby and, without even remembering, you will get a surge of confidence and strength and go even deeper relaxed. The third time to look forward to is when the cervix is fully dilated at 10 cm, and you will feel excited — completely re-energised. So during the first stage of labour, there are these three times to particularly look forward to, and you know you can relax, and during a contraction, every time you breathe in you are going to feel stronger and as you breathe out feel more and more relaxed and comfortable. When the contraction is over you can forget about it, that's right, you can forget about it, and know that you are coming even closer to meeting your baby for the very first time. That's right you will never have that particular contraction again, and you can forget about it, and enjoy your nice long rest. As the contractions get stronger, you'll take an even deeper breath and you will feel even stronger and you will breathe out even more and feel even more relaxed and comfortable. That's right, as the contractions get stronger, you'll feel stronger and as you breathe out, even more relaxed and comfortable ... and as you feel even stronger, you will feel even more confident; and as the contractions get stronger, you will be confident in knowing that they are even more effective, and because they are even more effective you'll know that you are getting closer to meeting your baby for the first time.*

*As you relax deeper and deeper, you know that you will allow your labour to progress at just the right rate for you and your baby, and I don't know why, but as the contractions get stronger, they feel shorter and the rest in between the contractions will feel even longer, that's right as the contractions get stronger, they'll seem shorter, and as the contractions get stronger the rest in between will seem even longer, and all those nice long rests will give you more energy than you could possibly need to deliver your baby safely and comfortably.*

*When the cervix is fully dilated at 10 cm, you can look forward to a surge of energy for the second stage of labour and know that all those nice long rests will give you all the energy you could possibly need. During the second stage, you feel pressure in the bottom. The ligaments will just stretch and stretch and expand and stretch, and it will happen without you even trying to notice ... and you can relax and you will feel as if you have so much room so you can deliver your baby safely and comfortably. That's right, your body knows what to do. Your body has been preparing for nine months and the ligaments are so elastic — thanks to the pregnancy hormones — thanks to the body. When you feel pressure in the bottom, the ligaments will stretch and stretch and expand and stretch and you will have so much room to give birth to your baby and meet your baby for the very first time. Many people don't know this, but when skin stretches, it becomes numb and as the perineum stretches, it will become numb and many people don't know this, and you can deliver your baby safely and comfortably. And you know that you are relaxed and you can use your relaxation all through your labour to feel comfortable and in control. During your labour, you will pay attention to only what is helpful for you and your baby. That's right, any unhelpful words or comments ... you can tune out to, as if they are in a foreign language, or as if they are the white noise on an untuned TV channel. That's right, noises around you that have nothing to do with you and your labour, you can tune out to, like white noise or a foreign language. Unhelpful words and unhelpful comments, will seem like white noise or foreign language. You will tune into your own choice of channel. You will tune into only what is helpful for you and your baby. Sounds, words, comments, images that are helpful to you and your baby — that's what you will tune into, only what is helpful. And now, you can allow everything helpful that I have just said, to go deeply into the unconscious mind, deeply into the unconscious mind, everything helpful — so that it is there for you, ready whenever you need it, and only when everything helpful, that I have said, is there in the unconscious mind, ready for you when you need it. Only then, will you be ready to drift back to the here and now, in your own time and, in your own way, so that when you open your eyes your senses will be back to normal. You will be relaxed and refreshed and looking forward to this wonderful event that soon is happening in your life — the safe and comfortable arrival of your baby.*



## HATCH TRIAL AUDIO CD 4 — THE LABOUR CD

*It's time, time to settle, and you can relax, and settle down and relax. Just letting the relaxation happen in whatever way it wants to. You know you can relax, and you can drift and float down into daydreaming type thinking. And just being here, here in the labour ward will bring back to you, all that you have learned during your pregnancy, all that you have learned that will be useful to you. And you can remember everything useful that you have already learned. Just being here, being in the chair or on the bed, just being here will help you remember the last time you were really relaxed, and as you remember the relaxation, you can feel it happening, comfort and relaxation, right here, right now. Just letting it happen, floating down.*

*And you can be as relaxed and comfortable as you can be for just now. And I don't know what it will be; maybe it'll be the sound of the midwife's or doctor's voice. I don't know what it will be that will help bring back everything helpful that you have learned, everything you need, without even trying, without even trying you can bring back all of your resources, everything that is useful to you, there in the deepest part of your mind, you can bring it back as you need it without even trying.*

*And as you listen to my voice, you can tune into what is helpful and you can tune out when it is less helpful. It's like you can turn up the volume in your mind when it is useful and helpful for you to do so, and you can turn the volume down in your mind when it is less helpful. And you can drift and relax, and you can breathe in and feel strong, breathe out and the shoulders sag and a wave of relaxation can flow all through you and you float down even deeper relaxed.*

*Let the jaw go, relaxed and easy. Let the shoulders go, let the hands go, palms open and easy, that's right, that's right. Letting the body drift down deeper and deeper relaxed, deeper and deeper down with every breath, just letting it happen in your own time and your own way, letting it happen the way it wants to. And you can look forward to meeting your baby for the very first time. You have the ability to do whatever you need to do to deliver your baby safely and comfortably. You have the ability and you have the freedom to do whatever you need to do for your own comfort and relaxation. You can relax, you are relaxed, and you can let the body do what it knows how to do. Trust in the body, the uterus knows what to do, and you can leave it to do what it knows how to do, and you know you can relax.*

*And you can relax into the flow and, let your body flow quite naturally, quite easily, and just go with the flow. Let the body flow. Trust in the body. And you can let your labour progress at just the right rate for you and your baby. And if you need to adjust your posture, you can be even more relaxed and comfortable than before. And you can use whatever is useful for you right now for your own comfort, because you know all*

*you need to know to deliver your baby safely and comfortably. You are prepared for the comfortable and safe arrival of your baby, the body is prepared, the body knows what to do, and you can relax deeper and deeper.*

*And sometimes the eyes might want to be open, and sometimes the eyes might want to be closed, and whether the eyes are open or closed, you can still be deeply relaxed. And any cares or worries — you can just offload them into a container. You can offload them and send them off and away into the horizon, smaller and further away, off and away. And as any cares and worries get very small and far away, you can feel a wave of relief and release flow all through you and, go even deeper relaxed. Any time any cares or worries arise, you can send them off into the distance; you are in control, you have the control, and you are relaxed. And you can tune in to only what is helpful for you. Tuning into helpful words, helpful comments, helpful sounds, and you can tune out anything unhelpful for you and your baby, as if it were a foreign language, or anything unhelpful like the white noise of an un-tuned TV channel. You are in control, as you tune into only what is helpful for you and your baby. Drifting and floating down, deeper and deeper relaxed. More and more relaxed with every breath. Breathing out any tension into the air. Letting go of any tension, more and more comfortably relaxed. And during a contraction, you can breathe in and feel strong and breathe out and relax and drift deeper and deeper relaxed with every breath. The contraction is a wonderful power working for you. During a contraction you can do whatever is right for you in your own special way, in your own time, and your own way — whatever is right for you. And during a contraction, a power working for you, you may drift down steps, deeper and deeper relaxed, deeper and deeper relaxed as you drift down closer and closer to the number 10. And you may drift down to your special place, your special place where you can be as relaxed as you can be for just now. And as you enjoy your special place with all of your senses, I wonder which sense will be the most vivid for you.*

*And you can drift, you can drift further and further away from the contraction, the contraction just moving into the distance, the contraction just fading away, and when the contraction is over, you can forget about it, you can forget about it because it's done its job, it's brought you even closer to the safe and comfortable arrival of your baby. And you can imagine your pleased and proud feelings as you meet your baby for the very first time. That's right, when the contraction is over, forget about it and enjoy your nice long rest. Closer and closer to the joy of meeting your baby for the very first time — that's right — enjoy your nice long rest. You can allow your labour to progress at just the right rate for you and your baby.*

*During a contraction, you can do whatever is right for you in your own special way, whatever is right for you in your own time and your own way. And during your contraction, a wonderful power working for you, you may want to drift and float in your*

*own special anaesthetic spa, comfortably supported, down in your spa, the temperature just right for you, the little bubbles so refreshing, the local anaesthetic sinking down, down into all the tissues, producing that different feeling, that numb feeling, producing that useful comfortable feeling as you drift and float. And you always have as much local anaesthetic as you need. And you can drift further and further away from the contraction, the contraction moving into the distance, the contraction just fading away.*

*And when the contraction is over, you can forget about it, it's done its job, it's brought you even closer to the joy of meeting your baby for the very first time. So when the contraction is over you can enjoy your nice long rest, and as the contractions get stronger the rest between will seem even longer, the nice long rest seeming longer and longer as the contractions get stronger. And as the contractions get stronger, the contractions seem shorter, and you can be pleased to know that the contractions are even more effective knowing you're coming even closer to meeting your baby for the very first time. And as the contractions get stronger, you can breathe in even more deeply and feel even stronger. And as the contractions get stronger, you can breathe out and feel even more comfortable. More and more relaxed as the contractions get stronger and they seem even shorter ... you're even closer to meeting your baby.*

*And you can use your relaxation for any turn of events. You are in control as you relax, you are in control and you can use your relaxation for any turn of events. And the people around you know what to do, and you can feel so reassured knowing that they are there to take the best possible care of you and your baby. The people around you are there to look after you and your baby. And you can relax deeper and deeper. Deeper and deeper relaxed as you get closer to the number 10, as the cervix dilates from nought to 10. And thanks to all your nice long rests, you will have more energy than you could possibly need to relax and deliver your baby safely and comfortably.*

*And when you feel pressure in your bottom, the ligaments will stretch, stretch and expand and stretch and you will feel like there is so much room to deliver your baby safely and comfortably. Trust in the body and let it happen, you don't even need to try to remember, it will just happen. Trust in the body, the body knows what to do, and you can relax. You have the ability and you have the freedom to do whatever you need to do for your comfort and relaxation.*

*Do whatever you need to do in your own special way, in your own time, and your own way, you are relaxed, you can relax and drift and float deeper and deeper ...*

## **DISCUSSION**

A detailed description of the HATCh trial is published elsewhere (Cyna et al., 2006b). If shown to be effective, the audio CDs on hypnosis would be a

simple, inexpensive way to improve the childbirth experience and help reduce complications associated with pharmacological interventions. In addition, the intervention audio CDs could be easily provided to other maternity units and utilised to provide evidence that can guide clinical practice.

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## **ABSORPTION–PCI TESTING PROCEDURE: A SCRIPT DEVELOPED FROM fMRI HYPNOSIS TESTING PROCEDURES**

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This is an adaptation of a script that was originally designed for hypnosis testing in an fMRI scanner environment (see Egner, Jamieson, & Gruzelier, 2005). It has been specifically revised here for experimental (and potentially clinical) use in conjunction with the Phenomenology of Consciousness Inventory (Pekala & Kumar, 2007). The latter provides important clinically relevant information in its own right (Hutchinson-Phillips, Gow, & Jamieson, 2005). This script has been influenced by phenomenological approaches (e.g., Sheehan & McConkey, 1982) to measuring hypnotic responsiveness as well as the issue of testing experiential suggestions which may or may not be formally defined as hypnosis (cf. Wilson and Barber's, 1978, Creative Imagination Scale).

This (the present induction plus PCI) is a short procedure able to be administered in 10 minutes. It may be administered (in present form) without reference to hypnosis as an absorption induction. Alternatively (as in our fMRI work) it may be used (inserting the word *hypnotised* rather than *absorbed* in suitable places) as a hypnotic induction preceding further specific hypnotic suggestions. The present script is suitable as either an absorption or a hypnosis induction in experimental and clinical settings, including of course scanner environments. With the inclusion of the PCI it offers a sensitive way to assess the phenomenology of changes in consciousness associated with the induction process and potentially trait absorption and trait hypnotic susceptibility. These latter are the subject of an ongoing empirical inquiry.

## ABSORPTION INDUCTION

*I want you to position yourself comfortably in your chair. Close your eyes and rest your hands on your lap. Now gently let yourself become aware of how your stomach moves in and out in time with each breath. Just let yourself become aware of the natural rhythm of your breathing and the movement of your stomach in and out, in and out. That's right ... hands comfortable now ... as you continue to breathe freely and naturally. I am about to give you some instructions that will help you to let go of your concerns and become more deeply involved in your internal experiences. I want you just to become aware of your breathing while you continue to listen to what I say. Your ability to become absorbed in your experience depends partly on your willingness to let go of your other concerns and partly on your ability to be aware of my words and of what I describe to you. Experience now the sensation of your chest rising and falling with each breath and continue to listen to my words, letting happen whatever you feel is taking place. Just let it happen.*

*Let go of your everyday thoughts and concerns. Instead let your awareness rest on the sensations of breathing. Maintain your awareness as steadily as you can. Should your mind wander away that will be alright ... just bring your awareness gently back to your breathing. After a while you may find that that you are no longer aware of the room in which you are sitting. You may feel that you are floating away, as though you were on a magic carpet taking you on a mysterious journey. Whatever happens just let it happen but continue to remain aware of your breathing for a while longer. There will come a time, however, when your body will feel itself floating away and you will no longer be aware of yourself sitting in this room. The everyday world will melt away. When this happens, just let it take place.*

*Allow yourself to feel the sensations of subtle energy that are moving through your body. Feel these sensations in your legs ... and feet ... Feel the subtle energy in your arms ... Feel the sensations of energy in your hands ... in your fingers ... Feel the sensations of energy in your neck, and your chest ... Feel this subtle energy moving throughout your entire body ... Let yourself float in these sensations. Letting go of distracting thoughts. Letting go completely. Letting go completely.*

*As you let go more and more, you may notice a feeling of lightness throughout your body. A sensation of subtle energy is flowing through your legs and your arms ... through your feet and hands ... throughout your whole body. Your legs feel light, light as a feather ... Your arms tingle ... Your whole body feels as if it is composed of energy. You float like an autumn leaf fluttering lightly in the breeze. You are letting go more and more. Your breathing has become natural and regular, natural, and regular. You are becoming more and more involved in this experience while the everyday world slips away.*

*You are becoming deeply immersed in your experience, but you are going to become even more involved, much more. Keep your eyes closed until I tell you to open them. Just keep listening to my voice. Pay close attention to it. Keep your thoughts on what I am saying ... listen carefully now. Soon you will be deeply involved in your present experience but you will continue to hear me. You will remain deeply immersed in your experience until I ask you otherwise. I shall now begin to count. At each count you will feel yourself drifting further into this fascinating experience. One ... you are going to become deeply aware ... Two ... drifting, drifting into an experience of deep involvement ... Three ... more and more, more and more deeply aware ... Four ... you are floating, floating into an experience of deep involvement. Nothing will disturb you. Pay attention only to my voice and to the things which you are presently experiencing. Five, Six ... deeper and deeper ... Seven ... although deeply involved in your present experience you can clearly hear me. You will always be able to hear me no matter how deeply involved you may feel you are ... Eight ... deeply aware of your present experience. Any sounds will not disturb you. You are going to remain deeply engaged with your current experiences. Perhaps you may feel like an astronaut piloting their spacecraft to a landing on a distant planet. Perhaps you may feel like you are warm and snug safe within a cocoon ... Nine, Ten. Whatever you feel you will continue to remain deeply involved in this experience until I ask you otherwise.*

*Now I'm going to stop talking for the next minute or so and during that time I want you to continue to experience the state you are in right now. That's right. For the next few minutes I'm going to stop talking and I want you to continue to experience the state you are in right now. So for the next few minutes just continue to experience the state you are in right now. After about two minutes, I will start talking again.*

[Pause two minutes.]

*Alright now, please listen to me. I want you to make a mental note of what you were experiencing, what you were thinking and feeling when I stopped talking, because I will afterwards ask you to complete a questionnaire in reference to your experience of that time. That's right, just take a moment now and take note of what you were thinking, feeling, and experiencing when I stopped talking. [Pause 15 seconds.]*

## **Deinduction**

*Continue to remain with your present experience but pay close attention to what I am going to tell you next. In a moment I shall begin counting backwards from ten to one. You will gradually return to your ordinary awareness of the world. By the time I reach five you will open your eyes. When I get to one you will be in your normal state of awareness, focusing once again on the world around you and the tasks ahead.*

*After you open your eyes, you will feel yourself ready for the tasks ahead. I shall now count backwards from ten to one. At five, but not sooner, you will open your eyes and at one you will be ready to move on to the next task ... Ready, now: 10, 9, 8, 7, 6 ... halfway now, 5, 4, 3, 2, 1. You are now focused and ready for action in your everyday state of awareness!*

For the benefit of any participants who may not have returned to normal alertness and awareness, it is recommended after 10 seconds to add: *And if you have not already opened your eyes, you can do so now, because it is time to be normally alert and awake.* If they do not respond, then just say more loudly and firmly: *You can all wake up now! Yes, that's right, awake and alert back here in this room.*

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## REVIEWS

### **Ideomotor Signals for Rapid Hypnoanalysis: A How-to Manual**

*Dabney M. Ewin and Bruce N. Eimer.*

Springfield, IL: Charles C. Thomas. 2006. 268. \$US63.95

The senior author, Dr Dabney Ewin, would be known to many of us. It was my pleasure to first meet him at the combined ASH/ISH meeting held in Melbourne, Australia, in 1979, where he presented an excellent paper on the application of hypnosis with burns patients. He impressed me then as a caring and competent practitioner of the healing arts. He presented again at the ASH Conference in Sydney in 2005, and I met him unexpectedly at the ISH meeting in Mexico in 2006. My first impression has not changed over the years.

Bruce Eimer is a clinical psychologist with particular interests in the “how” and “why” of behaviour and the “what” of experience. After much searching for effective solutions, he encountered Dr Ewin’s techniques, and was mentored by him in their application. He writes in the preface of this new book: “Rapid hypnoanalysis enables us to help our patients understand how and why they have been experiencing what they have been experiencing. It enables us to find reasons for symptoms and better solutions to our patient’s problem.”

This book is the distillation of over 30 years of clinical experience and a refinement of a deceptively simple process of hypnoanalysis which can allow a therapist to explore a patient’s problems more deeply, while, paradoxically, being even briefer. There have been several presentations of this technique by competent clinicians at ASH meetings over the years, but this is easily the most comprehensive explanation, and really IS a “how-to” manual.

At the commencement of Chapter 1, the authors say that:

Insight-Oriented Therapy is often much more effective and permanent than direct or indirect suggestion. We know that when we can change an idea, we change an illness. But what is the fixed idea that the patient clings to that makes him sick? Often it is NOT what seems apparent to the therapist or the patient's family, and it is not consciously available to the patient. (p. 5)

Some powerful examples of this are given. On page 41, the treatment of a patient suffering from penile warts is described. His stated problem was reluctance to break off a stale affair and return to his wife. He received only one treatment session, and at follow-up three weeks later there was no sign of the warts. Another case, starting on page 133, describes a 42-year-old female PhD psychologist who had had a constant headache for as long as she could remember. Finger signalling identified the origin as the tenth day of her life, where she heard her father say, "She is going to die ... she is dead." She believed then that pain in the head was the only way she could be sure that she was alive, and this had carried through for all of her life. Two sessions were used, and the patient was pain free within three days, and continued to be so at follow-up 11 months later.

It seems unlikely that the patient's report in this case could be literally true, as she is hearing and understanding, at the age of 10 days, words spoken by her father. It is far more likely that this is a temporal distortion of some later experience, which she believes unconsciously to have occurred at that early age. The veracity or otherwise of her report does not affect in any way the dramatic nature of the cure of her headaches.

I have found finger signalling to be of use in many areas of hypnosis, not only hypnoanalysis. Patients can be asked to communicate their inner, or "unconscious" state, or to indicate readiness to proceed further with treatment. Occasionally a patient will later express surprise at the unconscious movement, but this only serves to ratify the trance experience. It can be used in clinical dentistry by suggesting to patients that they can maintain their relaxed state very easily, but if they should experience any anxiety, their unconscious mind will cause the (left or right) first finger to rise to indicate this. The choice of left or right is determined by which hand is superior on the patient's lap. I choose a finger, rather than a thumb, because of the possible negative connotations with the latter.

The book is divided into three parts. Part 1, Basic Concepts, covers ideomotor signals and how to set them up: Principles of Hypnotherapy and

Treatment Planning. It has a very useful section of Special Intake Questions for Hypnoanalysis, and this is expanded considerably in one of the appendixes, so that it will be very useful for anyone beginning to use this technique to work with a patient.

The second part, Basic Applications, is a guided tour of the areas of greatest application. This includes psychosomatic disorders, recovery of lost memories, preparation for surgery, and treatment of persistent pain.

The third part, Annotated Clinical Session Transcripts, consists of five chapters, each devoted to a different problem: complex and simple smoking cessation, hypersensitive scar tissue, asthma, and dystonia.

There is also a comprehensive reference section and index.

On reflection, the title of this book says it all; the authors have compiled an excellent text which is very easy to read and provides a sound foundation to be able to start using these techniques in clinical practice.

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*Dental surgeon*

## **More Hypnotic Inductions**

*George Gafner*

W. W. New York: Norton. 2006.140. \$US21.95

It is indeed another book on hypnotic inductions, and it is an excellent text for students of hypnosis to have and for experienced practitioners who want to add different scripts to their repertoire. Gafner has provided us with stories as inductions, inductions for sleep, inductions suitable for children, and directive and confusional inductions.

Unlike many authors, Gafner clearly states his position as a hypnotherapist and who he thinks is not a suitable candidate for hypnosis. For instance, on page 6 in the Introduction, he notes that he does not do age progression or regressions and suspects that a client who wants to explore past lives is most likely not ready to do the hard work required to change their current situation. He obviously is not impressed by clients who want the “magic bullet” (p. 6). Those of us who have had to cope with the magic wand effect and “do it all in one session — that’s what you do in hypnosis, isn’t it?” know how frustrating that can be. Gafner points out to the readers his stance on hypnosis, which

is that it is an adjunct to treatment, something that is often difficult for us as practitioners to get through to new clients.

The essential difference in this book is that Gafner has followed the NLP tradition in terms of analysing the script and process and so in several examples, not only do you have the typed script, but next to it (see, for example, the Going Inside Induction on pages 43–47), you are able to note the exact components in the hypnotic process that the script is based on: suggestion, age regression, age progression, misspeak, confusion, pun, etc. Thus while Gafner does not “do” age progression and regression per se, he is pointing out that they exist normally within hypnotic scripts.

In other examples, such as the Sound Sleep Induction on pages 51–54, he underscores truisms, hypnotic language, implication, catalepsy, time distortion, amnesia, discharging resistance, etc. Now interestingly in the Godzilla Induction (pp. 74–77), designed for a 9-year-old boy with encopresis, he adds another column of analysis: actions of the client; so while Cesar is being inducted, every significant movement he makes is recorded: sits back in chair, fidgets and squirms, slumps lower in chair, resumes swimming, makes anchor, and wakes up with a broad smile. Personally, being a child at heart, I liked the Sleeping Bears Induction (pp. 77–78) and The Little Monster Induction (pp. 84–85) the best.

After each script, Gafner makes a clinical comment. For example, on pages 34–35 after the Catalepsy script, he suggests that aiming for complete immobility may be unrealistic and suggests we allow clients some movement. On pages 98–99, he notes after the Remorse Induction, that he uses no deepening with that script because he believes that people “tend to deepen their experience with continued practice” (p. 8).

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### **Why is Process Healing Different?**

*Gary A. Flint*

*This overview is given by the author Gary Flint to clarify some points about the book that he has written. It is displayed here before the review by Kathryn Gow, who has also seen this overview.*

The Process Healing Method is different from traditional approaches. In the paragraphs below, to put the book in perspective relative to current beliefs, I elaborate on the difference between the approach in the book and traditional approaches for treating dissociative phenomena. This introduction may allow you to read this book with this new way of thinking in mind. I hope my use of words is not too idiosyncratic.

Most thinking about dissociative phenomena and compartmentalisation addresses the phenomenology of normal or dysfunctional human behaviour by describing the symptoms and naming the dissociative condition. The treatments employ meta-interventions that serve to change or eliminate the dissociative condition. Meta-interventions usually involve negotiation or the use of group dynamics reframing the trauma situation and the effects of trauma. When ready, the parts are integrated by collapsing anchors in some way, practising coconsciousness, or by using a treatment intervention such as EMDR or an energy psychology technique such as EFT or TAT to integrate the dissociative parts.

Process Healing avoids treating dissociative phenomena by conceptualising trauma and treatment metaphorically at the level of memories. A memory has neural structure associated with a collage of memories that cause brain and body activity. I make a distinction between active memories and dormant memories. Creating the next response only involves active memories. Dormant memories are not involved and therefore do not form any associations with the current behaviour.

The model defines dissociation and compartmentalisation as normal brain processes. Dissociation is a memory process that associates to all or some of an active memory to move the dissociated portions of the active memory from active conscious experience to active unconscious experience. Compartmentalisation is defined as the creation of a new personality memory structure, with executive function, during an intense trauma when the emotional intensity is very high *and* (important) there is no previous experience in the memory of the main personality to manage the situation. The intense emotions elicit memories related to the trauma situation independent of the main personality. This forces the main personality into dormancy. The rapid exit of the main personality and rapid return of the main personality when the emotional intensity is low results in few or no associations with the new personality part. The absence of associations causes the amnesia.

Treatment with the Process Healing Method addresses the symptoms of the diagnosed condition of the patient. This involves problem-solving and an

evidence-based outcome. A treatment process for treating the emotional pain associated with target memories is taught to the subconscious. When working with the subconscious and treating an issue, you either observe change in the symptom or you don't: A phobia goes from subjective (SUD) score of 10 (high) to 2 (low), intrusions become infrequent or stop, grief reduces to a comfortable level, trauma memory becomes neutral, anxiety moves from 10 to 2, the kinaesthetic component to thought insertion is removed, etc. A therapist can measure almost any symptom and, therefore, by the end of the session or at the next session you can determine the effectiveness of your treatment. It usually works well with all mental disorders and especially with DID. The patient or his or her parts, including fragile parts, does not usually experience intense emotions during the treatment process. As an added benefit, the subconscious can be enabled to treat issues between sessions. Treating patients is not always easy or fast, but if the patient continues with therapy, the problem-solving approach usually works.

#### REFERENCE

Flint, G. A. (2006). *A theory and treatment of your personality: A manual for change*. Vernon, British Columbia: NeoSolTeric Enterprises.

### **A Theory and Treatment of Your Personality: A Manual for Change**

*Garry A. Flint*

Vernon, British Columbia: NeoSolTeric Enterprises. 2006. xix + 459.  
\$US24.95

Firstly, let me admit that the agreed reviewer for this book, who thought it was a wonderful manual, took ill and the book was delivered back to me with just two days to go before production cut-off date for this issue of *AJCEH*. I say this, as when I opened the book I immediately had to fight off the ghosts of the false memory fiasco that many American and Australian health professionals were confronted with over the past two decades and that are still not laid to rest. Thus, I would like to see a note early in the book about such warnings and some comments on recent research on memory and regression. Then I could proceed happily to enjoy what the original ideas in the book have to offer.

Moreover, in commencing the review of this book, I ask you to adopt the position that there are a considerable number of therapies that are based on beliefs about memory and theories of personality which actually create positive change in their clients, and on that understanding the Process Healing Method is put forward as one such therapy that may guide clients towards change in their lives. The fundamental assertions in the book may not necessarily be correct in terms of recent research about memory, but the author makes it clear that he is working with a set of beliefs and concepts that in his experience lead to healing experiences in his clients.

There are two major parts (10 chapters) to this book and a range of appendixes containing treatment techniques and useful glossaries. Part I is directed at the self-help reader, while Part II is for the therapist. Establishing communication with the subconscious (which Flint defines as being very different from the unconscious) is critical to this healing method.

So let us start with Part II: Chapter 9 deals with the treatment of personality issues and Chapter 10 focuses on treating symptoms in complex issues. Note that Gary Flint utilises NLP terminology and tools and ensures that the therapist understands predispositions and future pacing. He gives a range of presenting problems, such as sleep issues, grief, fear of change, and anxiety and then dialogues the interventions, acting as a coach for the therapist reader. When the therapist has been schooled in basic symptom treatment, the writer moves them on to more complex mental disorders such as OCD and depression, giving the necessary warnings about suicidal ideation and noting that care of the client is paramount.

Part I is actually a manual which gives the reader, who can follow the instructions towards healing, many different examples of the way the processes work. Chapter 3 shows a detailed and illustrated outline of the Process Healing Method which is easy to follow; it summarises the steps involved in the method and on page 49 gives a one-page flow diagram for Process Healing. It is written in the manner of self-help books and the style will not be unfamiliar to readers who have read different psychologically based how-to-do-it healing books; but this book takes things further and turns the theory into a method and then dialogues the various treatment techniques under broader categories such as problem solving,

This book has been written in a very thorough manner and it must have taken the author a long time to work through all the examples and the methodology of the different techniques in the healing processes. It is well structured, which is a very important aspect of a self-help guide book.

The language, which would be familiar to hypnosis and NLP practitioners, may not be familiar to lay readers and so Flint has outlined, in glossaries in the appendixes, the concepts referred to in Part I such as state dependency and executive function.

Right now, I am wondering if I could use the protocol for healing addictions (pp. 400–402) on eating chocolates, which is a new unwanted habit for me.

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### **Hypnosis as Portrayed in Films**

Some of our film reviews to date have focused on the way the media portray the influence that hypnosis has on people and some of the misperceptions that the public holds about hypnosis. Deidre Barrett in the *American Journal of Clinical Hypnosis* (2006) has undertaken a major review of the way hypnosis is portrayed in film and television. She condenses into a table (see pp. 22–26 of that article) factors by which the portrayal of hypnosis films can be analysed: the name of the film; its year of production; its genre; its suggestion that hypnosis is a coercive influence; and how the transformation in the person occurred.

Barrett's genre category includes drama, comedy, etc; its coercive influence covers aspects of whether the film portrayed hypnosis as being able to influence people to commit crime, or to seduce people; the column labelled Transformation indicates whether the transformation occurred through recovered memories, past-life regression, increased performance such as in sports, psychotherapy, or other dramatic gains such as in artistic, intellectual or physical abilities.

In her review of 230 films Barrett gives as examples, with stills pictured in the article, the types of films where hypnosis is incriminated in crimes such as *The Jade Scorpion*, or used for seduction with the power of Svengali's eye-stare. To quote Barrett: "Even when the depiction of hypnosis is positive, the emphasis is virtually always on it as a means to influence or control another person" (p. 21). If you are interested in how hypnosis is portrayed in film, then Barrett's article is an interesting one.



## On a Lighter Note: Fantasy Proneness and Absorption

In this May 2007 edition of the *AJCEH*, the film review focuses on *Miss Potter*, and references to *The Indian in the Cupboard* and *Gulliver's Travels* are made to depict ways in which practitioners and teachers of hypnosis may expand on the scientific examples of fantasy proneness and absorption and cite examples of trance-like phenomena.

Fantasy proneness is a term well known to us in the hypnosis literature. For example, those people who demonstrate intense imaginal involvement appear to be able to move in deep fantasy and appear to be capable of deep hypnosis (Lynn & Rhue, 1988). Another creative ability is being capable of becoming deeply absorbed into what one is doing. In the November 2005 edition of *AJCEH*, Graham Jamieson analysed absorption and its relationship to hypnotisability. He referred, on page 120, to the fact that when Tellegen and Atkinson were formulating their scale they “proposed an initial definition of the shared content of absorption items in terms of deep involvement (thus absorption) with the object of experience. This involvement was first formulated in terms of ‘total attention involving a full commitment of available perceptual, motoric, imaginative and ideational resources to a unified representation of the attentional object’” (Tellegen & Atkinson, 1974, p. 274, in Jamieson, 2005, p. 120).

Thus let us move into the world of talking animals, little people, big people, and hypnotic phenomena.

*Miss Potter* (2006)

*The Indian in the Cupboard* (1995)

*Gulliver's Travels* (Charles Sturridge 1996, also filmed 1977, 1939)

Those of you who have met Miss Beatrix either in her books or this latest film, *Miss Potter* (2006; U.K., directed by Chris Noonan), will realise that there are a range of fundamental psychodynamic issues that might need to be resolved if she sought you out as a therapist. It has been suggested that by becoming so absorbed in these fantasies, she was able to cope with a very restrictive and unfulfilling life.

However, we are going to leave aside her psychological and mental states and simply observe her creative abilities. Not only could she write highly imaginative books, she could produce the most incredible life-like drawings and paintings. Starting first with her own many pets, she was able then to move beyond her pets to other animals and have them tell their adventures.

It seemed that after a time she became absorbed into the drawings, as if

there was no separation between her and the animal and she was able to imagine, with all her senses, the animal interacting with her; she could see them moving, hear them talking, feel their emotions and no doubt smell them.

We have no way of knowing if her absorption was so total that she would not be able to hear someone pounding on her door, but the absorbed state seemed to be able to be brought on at will almost the instant she focused on her task, whether it be the rabbit, the duck, or any other animal.

The delightful film *The Indian in the Cupboard* (directed by Frank Oz and based on the original book by Lynne Reid Banks) is the story of a 9-year-old boy, Omri, played by Hal Scardino, who has a propensity to be fantasy prone. Note the role of the mother in passing on beliefs about some matters that others might regard as fantasy, such as the existence of the grandmother's ghost. Thus he has the mindset to think beyond the *evidenced based rational world* that was established while he was growing up in his family.

Omri not only has the power to make things come alive (which is a very powerful position to hold in life) but he can also make them just objects again. So there is a hint of negative hypnosis when he opens up the small magic cupboard and the Indian (an Iroquois from the 18th century — instant time reorientation — named Little Bear) is just a 3–4 inch inanimate plastic toy again, alternating with positive hypnosis when Omri hears the Indian knocking on the inside of the cupboard wanting to get out. This film is full of magic and so the boy, having worked the miracle with one object, proceeds to do likewise with other inanimate objects and produces a miniature cowboy from the next century named Daniel Boone (played by David Keith), along with other characters.

Now in the film *Miss Potter*, having worked the miracle with one animal drawing — Peter Rabbit — Potter proceeds to do likewise with other animal drawings (e.g., Jemima Puddle-Duck) and soon has the whole room full of live creatures who interact with her — as real as real.

Note that while other senses are involved, it appears to be the visual sense that is most critical in fantasy proneness; whereas talking and hearing and then touching seem to be the most critical in absorption. The person accesses the ideas through their visual impressions and then deepens them through hearing and touching/tactile involvement of some kind.

It is interesting that in *The Indian in the Cupboard*, it is the other personified object (the Indian) who suggests that fantasy is in play here. At one point, early

in the film after the Indian has become mobile and fully interactive, he says not just once, but at least twice in similar words: *Is this magic? I think you are only a dream.* Remember that high fantasy prone people are convinced that what they see and hear is “as real as real”:

*Omri comments: You are so real?*

*Little Bear answers: Yes, are you?*

Suggesting to clients that things can grow smaller and larger is a technique that hypnotists and NLP practitioners use in their practice. The long standing tale of *Gulliver's Travels* (directed by Charles Sturridge) not only raises issues about the perception of fantasy proneness and absorption as being psychopathological (they could lock him away for ever for his compelling stories about little and big people he met on this travels), but brings forward in a powerful way the phenomenon of full bodied catalepsy (being tied down by little people, and thus immobile, is visually suggestive that others are doing this to the person, and in this case Doctor Lemuel Gulliver projects the cause of the catalepsy onto external agents — the Lilliputians — and thus displaces his sense of powerlessness in his home country onto other fiction-like forces). There is no doubt that his Superego has been kept firmly in place by the Id while he experiences life more widely than at home in England.

Gulliver, who has returned from eight years of travelling abroad (today it may have been called a fugue state), tries to bridge the gap between himself and his son by telling him stories of adventure. The film makes these adventures graphic, while in the original novel by Jonathan Swift in 1726, the writer had to rely on the reader to use their visual fantasising ability to make the story come alive.

The stories are metaphors about what really happens in life and as such can be regarded as part of the world's myths and tales for children that have a teaching function embedded in a web of enjoyable fantasy of adventures to attract and keep the interest of a child. Miss Potter's creatures all have a message for younger children, while *The Indian in the Cupboard* has been called a metaphor about friendships, responsibility, and ethics by James Berardinelli ([http://www.reelviews.net/movies/i/indian\\_cupboard.html](http://www.reelviews.net/movies/i/indian_cupboard.html)).

The book by George Burns on *101 Healing Stories for Kids and Teens: Using Metaphors in Therapy* (reviewed in the November 2005 edition of *AJCEH*) might be helpful for those practitioners who want to utilise metaphors when working with children.

If you think that stories are only for children, you would probably score low on fantasy proneness, but remember all one needs to benefit by such metaphors is a moderate amount of fantasy ability.

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