

USING HYPNOTIC SUCCESS IMAGERY TO REDUCE TEST ANXIETY

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Forty grade-7 primary students were matched on their Term 1 examination scores, one member of each pair being allocated at random to Group 1 or Group 2. At the beginning of Term 2, the former experienced two 30-minute sessions learning the success imagery procedure followed by a further 30-minute training session one week before the Term 2 examinations. Their results on this examination were compared with those of Group 2. In Term 3, Group 2 subjects experienced the same three treatment sessions as had Group 1. Their results on the Term 3 examinations were compared with those they had recorded in Term 2.

All 40 students completed the Test Anxiety Scale for Children (TASC) before the Term 2 examinations and at the end of the school year. They also furnished anecdotal reports outlining their impressions of the experiment both after the treatment sessions and at the end of the year.

Results indicated that test anxiety as reflected in examination results and TASC scores was significantly reduced after use of the success imagery procedure.

Experienced teachers have provided considerable anecdotal evidence that, when undergoing any form of performance evaluation, many students react with considerable anxiety. This is particularly noticeable when they are taking tests or examinations. Though moderate anxiety may enhance performance, high anxiety levels appear to be deleterious (Allen, 1980) in that behaviour prior to examinations tends to become both less task-oriented and more dependent on others (Wine, 1979).

Hill (1984) has suggested that as many as 10 million elementary and secondary school students perform below their true ability due to excessive anxiety. This view would find support with parents, many of whom comment on the extreme nervousness displayed by their children when the word "test" is mentioned. Physical symptoms such as rapid breathing, elevated heart rate, nausea, and hand tremors are often apparent at this time.

Supporting such anecdotal evidence are experimental results which affirm that test-anxious students achieve lower academic grades than their less anxious

peers of equal ability (Sarason, 1963; Sarason, Davidson, Lighthall, Waite, & Ruebush, 1960) and experience more difficulty in reading (Stanford, Dember, & Stanford, 1963). It would appear, in brief, that many of these anxious students do not record test performances in keeping with other indices of their academic ability and knowledge (Deffenbacher & Kemper, 1974).

Unfortunately, such inferior test performance exacerbates the existing anxiety. Through worry over a test, a student handles it badly, thus compounding the problem by generating further anxiety. This cyclical pattern between test anxiety and performance becomes entrenched over the years, producing diminished self-esteem and expectation of school failure (Campbell, 1986).

Some alleviation of test anxiety has been achieved through desensitisation-relaxation procedures (Barabasz, 1973; Deffenbacher & Kemper, 1974; Laxer & Walker, 1970; Mann, 1973; Mann & Rosenthal, 1969), and through the use of music (Stanton, 1973). Hypnosis (Pulaski, 1979; Stanton, 1977; Wolf, 1986) has also been used with some success in that it assists students to draw on their inner resources in a manner which may not have been previously available. One way of using this treatment modality is explored in the present study.

Hypnosis is normally considered as a cognitive-based procedure for, in the words of Ledwidge (1978), it "aims at modifying behaviour and emotion by influencing the client's pattern of thought" (p. 357). Like other cognitive approaches, hypnosis attempts to alter specific perceptions, images, thoughts, and beliefs in order to help people behave more effectively (King, Ollendick, & Gullone, 1990).

However, it is difficult to provide an adequate definition of hypnosis. Rossi (1986) draws attention to this problem when he says:

Since the inception of hypnosis more than 200 years ago, it has been impossible to find general agreement among professionals on just exactly what hypnosis is. No definition or empirical test has ever been devised to accurately assess whether or not a hypnotic state even exists. (p. xiv)

In the present study, hypnosis will be operationally defined as a procedure embracing the elements of relaxation, suggestion and mental imagery. As these three elements are normally present in the actual practice of hypnotherapy they are likely to help individuals handle threatening situations through the development of more constructive coping skills.

METHOD

Subjects

Forty grade-7 students, 18 boys and 22 girls, attending a middle-class primary school, took part in the study. They were included on the basis of their own and their teachers' expressed feeling that their test performance had been impaired through excessive anxiety. An administration of the Test Anxiety

Scale, TASC (Sarason et al., 1960) confirmed this subjective opinion, for all these students recorded scores in the top third of the range.

Choice of the TASC as a confirmatory measure seemed appropriate as it is the measure of test anxiety most frequently used in studies of school-aged children (Allen, 1980). This scale is both reasonably reliable (Mann, Taylor, Proger, & Morell, 1968) and valid, in terms of its high correlation with measures of school and general anxiety (Phillips, 1978). Further, the TASC has been adapted for use in Australian primary schools (Cox, 1960).

The Success Imagery Method

The actual hypnotic technique encompasses three steps, beginning with the use of six deep breaths. Focus is to be put upon the out-breath in that, as students exhale, they count "five," letting go with the breath. They count "four" with the next breath, letting go a little more, and continuing to do so with the next three breaths, counting "three," "two," and "one." On the final breath, as they let go as much as possible, they use the key word "relax."

Students then move to the second step in which they imagine themselves entering the room where the examination is to take place, sitting down, turning over the paper, noting down key points for all questions, starting on the easiest question, writing fluently and effortlessly, stopping to add more points to their notes for later questions, moving on to the next question, and finding each one becoming easier than the previous one. They might also imagine themselves talking with friends after the examination, realising they had provided correct answers and feeling satisfied that they had done themselves justice.

A very attractive success scenario is thus created in their minds so that, every time they think about it, they prepare their minds to repeat the performance at the actual examination. When they do come to sit the examination, as far as their minds are concerned, they have already handled it, mentally, many times. Thus, whenever the thought of an impending test crosses their mind, they are to immediately switch into imagining the success experience. This replaces the fear and anxiety with which they have previously contemplated such a situation. Evidence derived from the anecdotal reports indicates that the students, on most occasions, did make such a mental switch.

The final step repeats the six breaths pattern, this time emphasis falling upon the in-breath. As students breathe in, they count "one," imagining they are drawing in alertness and energy. This process continues as they count "two," "three," "four," and "five" with the next four in-breaths. On the final breath, as they breathe in, they use the key words "wide awake" to restore them to a state of alertness.

Experimental Procedure

The average score on eight subjects taken in common by the 40 students at the Term 1 examination was used as the basis for group allocation. Students

with approximately the same average score formed pairs, each member of the pair being allocated at random to either Group 1 or Group 2.

At the beginning of Term 2, Group 1 experienced two 30-min training sessions spaced one week apart, in which they learned and practised the success imagery method. The sessions were conducted in a classroom environment, students being trained as a group rather than as individuals. Group 2 students did not meet together, nor did they experience any treatment at this time.

Although the general applicability of the method to many of the situations facing students was stressed, particular emphasis was placed upon its value in the context of test-taking. Group 1 students were asked to practise the method by using it before attempting any task which aroused self-doubt within them.

A week prior to the Term 2 examinations, the students were taken through the technique once more in a single 30-min session. The applicability of the approach to test-taking was again emphasised. At this time, as well as after the examinations, the students completed an anecdotal report describing their experience in using the technique.

After completing the Term 2 examinations, Group 2 students were given the same three treatment sessions as had Group 1, thus they acted as their own controls with their Term 3 examination performance becoming the dependent variable. At the end of the year, both groups completed a second administration of the TASC.

RESULTS

After completion of the Term 2 and 3 examinations, the average mark on the eight subjects taken by the 40 students was computed. This was compared with that derived from the Term 1 examinations. As no sex difference was observed, the result of this comparison for all students is shown in Table 1.

An analysis of variance performed on these data ($F_{5,19} = 6.95, p < .001$) indicates a highly significant treatment effect. Two-tailed *t*-tests specify the precise differences recorded. The Term 2 mark of Group 1 is a significantly higher average than that of the non-treatment Group 2 ($df = 19, t = 3.56, p < .01$) and, when this mark is compared with its Term 1 performance, a significant improvement may be observed ($df = 19, t = 3.34, p < .01$). No such improvement occurred for Group 2 which recorded a similar average mark at both examinations.

It is of interest to note that Group 1 maintained its improved performance at the Term 3 examination, returning an average mark over the eight subjects of 67.9%. Although this mark was a little higher than that recorded at the Term 2 examination, the difference was not statistically significant.

The same improvement is discernible for Group 2 after treatment. A comparison of the average mark on eight subjects in the Term 2 examination with that recorded in Term 3 after the training sessions indicates a marked improvement ($df = 19, t = 4.98, p < .01$).

Table 1 Average mark and standard deviation for eight examinations taken on three occasions by two groups of Grade-7 primary school students ($N=40$)

	Time of Testing		
	Term 1	Term 2	Term 3
Group 1	56.7 (8.8)	66.9 (9.7)	67.9 (8.6)
Group 2	57.2 (9.6)	57.7 (8.5)	65.6 (9.2)

Table 2 Average scores and standard deviation for the TASC taken on two occasions by 2 groups of Grade-7 primary school students ($N=40$)

Group	Time of Testing	
	Pre-experiment	End of year
Experimental	23.2 (3.7)	15.8 (3.5)
Control	21.9 (4.2)	14.7 (3.2)

Table 2 sets out scores derived from two administrations of the TASC, one before the commencement of the experiment and one at the end of the school year.

A definite treatment effect emerges from an analysis of variance of these data ($F, 3,19 = 41.29, p < .01$). Comparison of the end-of-year TASC scores with those recorded before commencement of the experiment indicates a significant reduction in test anxiety level for both Group 1 ($df = 19, t = 8.32, p < .01$) and Group 2 ($df = 19, t = 6.72, p < .01$). This reduction in TASC score negatively correlated with increased examination score (Spearman, $r_s = -.79$).

DISCUSSION

In this study, the primary dependent variable employed was that of the actual examination scores. The results would seem to indicate that the success imagery technique is able to facilitate improvement in the examination performance of grade-7 primary school students.

A secondary alternative dependent variable was TASC scores. Changes in these scores were considered to be of subsidiary importance, for the motivating force behind the study was to ascertain whether students were actually able to record improved examination scores. If they were unable to do so, changes in TASC scores, no matter how large, would appear to be somewhat irrelevant. However, once significant improvement in examination results was observed, it became pertinent to consider whether the success imagery technique was also able to influence test-taking attitude as reflected in TASC scores. That it was successful in achieving this end provided additional evidence for the value of the technique.

Because the technique is such a simple one, it can be learned quickly and easily. This simplicity was a point made repeatedly in the anecdotal reports. It also emerged very strongly that students were eager to experiment with the technique in as many situations as possible. As such experimentation was usually crowned with success, most of the students became increasingly confident in the use of the method.

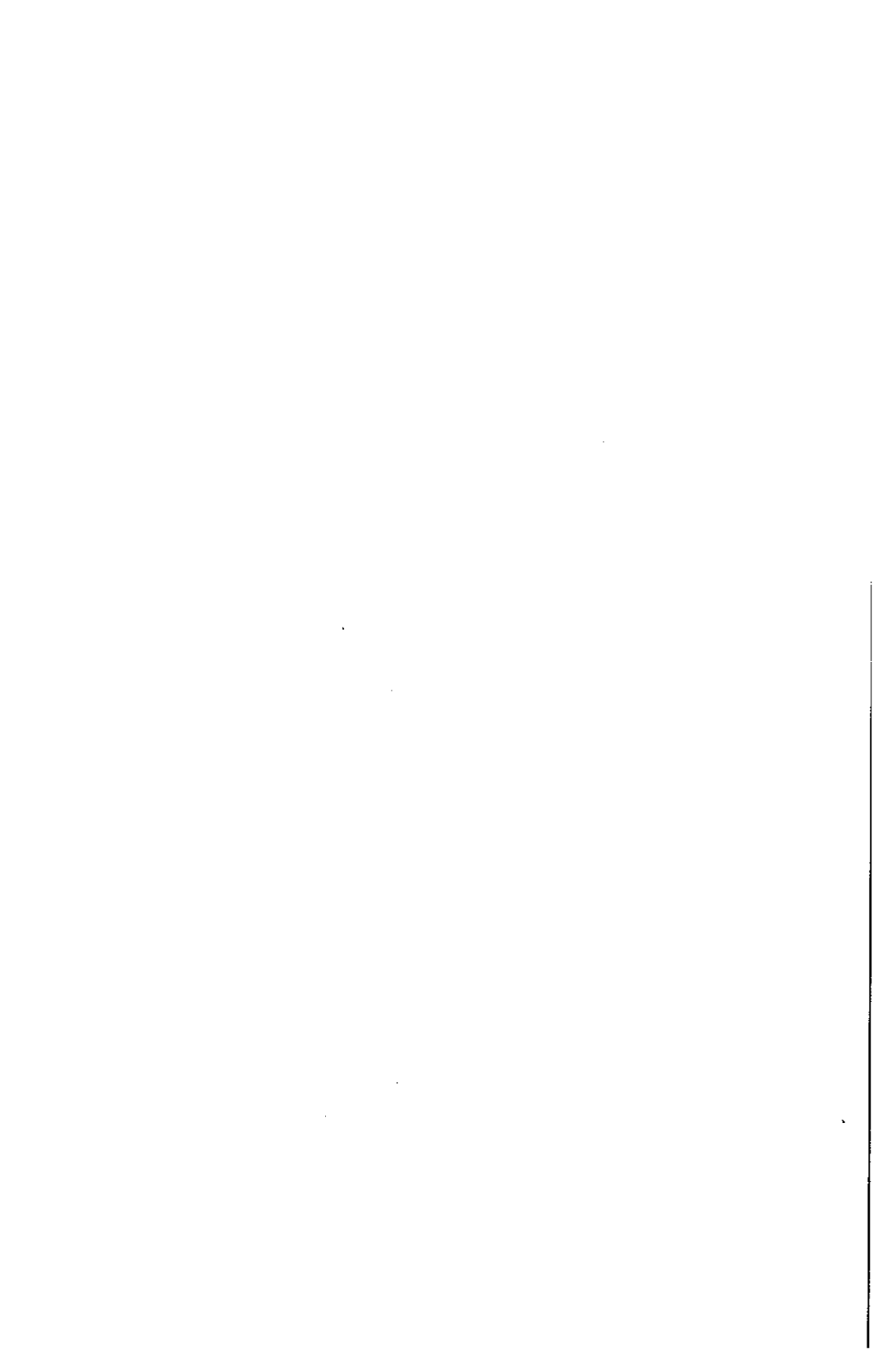
By the end of Term 2, Group 1 had produced a sufficient number of positive results to enable them to approach the examinations with a reasonable expectation of success, an attitude conspicuous by its absence in their previous examination attempts. Group 2 achieved a similar attitude change by the time of the Term 3 examinations, this again being reflected in a significant reduction in TASC scores and in anecdotal reports comments.

The data derived from students' examination results, TASC scores, and anecdotal reports would appear to indicate that the success imagery technique is an effective approach to the reduction of text anxiety. Through its use, students seem to achieve increased confidence in their ability to overcome the anxiety which had interfered with their previous examination performance. Further, as the anecdotal reports indicated, they also realised that it was a technique likely to be very useful on a day-to-day basis, assisting them to handle problem situations more competently than had previously been the case. That such a result could be gained from training which occupied a time period of one and a half hours is certainly impressive.

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THE TREATMENT OF IRRITABLE BOWEL SYNDROME USING HYPNOSIS

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A single case is reported of the hypnobehavioural treatment of a patient with chronic irritable bowel syndrome. The success of this treatment suggests that it has potential over and above relaxation and other behavioural techniques alone.

Irritable bowel syndrome (IBS) is a common gastrointestinal disorder. Somewhere between 50% and 70% of all patients with gastrointestinal symptoms suffer from it (Kirsner & Palmer, 1958). IBS is defined as abdominal pain and change in bowel habit (either diarrhoea or constipation) occurring in the absence of abnormalities on the appropriate physical and laboratory investigations (Latimer, 1983). IBS patients as a group can be distinguished from most other groups of gastrointestinal patients by the high incidence of accompanying psychopathology, for example, anxiety and depression (Young, Alpers, Norland, & Woodruff, 1976).

A number of treatments arising from various models of IBS have been offered, namely, medical (increased dietary fibre), pharmacotherapy (bulking agents), psycho-pharmacotherapy (tricyclic anti-depressants and anti-anxiolytics). There is little existing evidence, however, to support these treatments in providing effective, long-term relief from IBS symptoms (Latimer, 1983).

A number of psychological techniques have been offered for the treatment of IBS. These include psychotherapy (Hislop, 1980), biofeedback (Radnitz & Blanchard, 1988), systematic desensitisation (Garrick, 1981), relaxation therapy (Blanchard, Schwarz, Neff, & Gerardi, 1988; Mitchell, 1978), and hypnotherapy (Whorwell, 1987).

In general, proponents of these treatment techniques view IBS as the result of learned maladaptive behaviour in which psychological and cognitive activity have become desynchronised (Latimer, 1983; Whitehead, Winget, Wooley, & Blackwell, 1982). To explain further, patients may feel pain or report changes in bowel activity during normal bowel responses or they may fail to report symptoms during times of such activity.

Several hypnotic techniques have been utilised in treating IBS. Most involve a standard hypnotic induction and deepening with suggestions involving warmth and linking gut symptoms to various visual and tactile images. Whorwell, Prior, and Faragher (1984) instructed patients to place their hand on their abdomen and generate a sense of warmth. Patients are then told that they will be able to control bowel activity in the same way they were able to generate a sense of warmth. Whorwell (1987) has also used the visual image of a meandering river with locked gates which need adjusting. A 50% reduction in symptoms has been the accepted criterion for success with cognitive behavioural interventions (Neff & Blanchard, 1987). Whorwell (1987) suggests that a reduction of more than 50% is possible using hypnosis.

For patients less responsive to direct suggestion, hypnobeavioural techniques have also been recommended because success does not depend on the patient's hypnotic capacity (Mitchell, 1978). Proponents of hypnotic techniques have argued that this approach is superior to non-hypnotic techniques in assisting individuals to influence physiological mechanisms not thought to be under conscious control. Generally the aim of psychological and hypnotic treatment is to assist patients to gain control over their bowel habits.

The aim of the present study is to demonstrate that: (a) Hypnosis is effective in reducing IBS symptoms; and (b) the effect of hypnosis is a result of suggestion rather than relaxation or education about the nature of IBS symptoms.

CASE HISTORY

The patient was a 45-year-old married father of two who had been previously diagnosed as suffering from IBS for six years. He was referred for assessment and treatment of work-related stress. The patient said that his "innards didn't work" and that this had been caused by stress in his workplace. He had previously been treated by a gastroenterologist and psychiatrist who ruled out a physiological basis to his symptoms. A referral had been made to a dietician and the patient had commenced a high-fibre diet 18 months prior to treatment. It had been suggested to him by his dietician that high-fibre foods would alleviate his symptoms somewhat. This had not been the case. There was no other relevant medical, psychological, or psychiatric treatment history. His history suggested a stability of IBS symptoms over a six-year period in spite of previous dynamic and medical treatment. The patient was a good historian and his stability of symptoms can be regarded as the best available baseline against which to measure outcome (Mott, 1986).

ASSESSMENT

Assessment focused on elucidating details about bowel function, depression, and anxiety. Bowel and anxiety symptoms were self-monitored for two weeks prior to and throughout treatment. The patient reported abdominal pain, diarrhoea, and constipation. He also reported abdominal distension, numbing and gurgling in his bowel, greater frequency of movement (up to six times daily, as compared to his pre-morbid frequency of once or twice), hypersensitivity to food intake, and pain relief following bowel movements. Assessment of mood via the Beck Depression Inventory yielded a score of 20, indicating a moderate level of mood disturbance which was secondary to his IBS and psychosocial stressors. Further questioning revealed rumination over issues related to his job, family, and finances and a belief that low-fibre foods led to discomfort and pain. This belief was based on the dietician's advice that improved diet would alleviate symptoms. The patient had maintained his belief in a high-fibre diet in the absence of beneficial effects on his IBS symptoms.

The patient reported difficulty sleeping and relaxing and had lost over 1½ stone over the six years he had experienced symptoms of IBS. He had been prescribed Xanax to facilitate sleep while working shiftwork for approximately five years prior to treatment and continued to take 25 mg throughout treatment. The patient was also taking Colofac (an antispasmodic) and Agiolax (a laxative) at the time of treatment.

Results of the assessment led to a diagnosis of a general anxiety disorder accompanied by IBS and depressive features. The depressive features were not considered contraindicative to the use of hypnosis as they were not severe and suicidal ideation was not present.

There were no other contraindications for hypnosis: The patient presented as a man of average intelligence who was highly motivated to improve his symptoms. Assessment of his hypnotic capacity using the Spiegel Induction Profile Scale, (Spiegel & Spiegel, 1982) however, indicated relatively low hypnotic capacity. Therefore, a hypnobehavioural approach to therapy, that is, one involving both hypnosis and measurable behavioural techniques, was chosen as being the most appropriate.

PROCEDURE

Stage 1

Stage 1 involved education about the role of anxiety/stress in IBS and explanation of IBS. A diagram of the bowel was shown to the patient and both normal and dysfunctional bowel activity were explained. The self-monitoring initiated during the assessment phase was also continued throughout treatment.

Stage 2

Stage 2 comprised general deep muscle relaxation that was taught in therapy and then practised by the patient on a daily basis at home with the use of a taped version. The patient was also asked to restrict his bowel movements to once daily.

Stage 3

Hypnosis was induced using the Standard Eye Fixation and Distraction (SEF&D) hypnorelaxation technique. The relative length of the SEF&D technique, the ability to facilitate eye closure through direct suggestion, and the incorporation of relaxation provided the rationale for this choice of induction technique.

Once hypnosis had been induced, the patient was asked to generate warmth in his hand. This feeling was then transferred to his gut and linked to relaxation and alleviation of gut pain. Visual imagery based on a river with locked gates that need to be adjusted was also used. A typical description of the scripts used was as follows:

As you sit there I wonder which one of your hands will become noticeably warmer. When you have decided which hand is warmer than the other, focus on that feeling of warmth. Notice how your hand has become warmer still. Good. Now I want to ask you to place your warmer hand on your gut. Notice how your gut is able to feel the warmth. Gradually you'll notice your stomach warming up and as it does it will gradually relax as if the warmth is helping it to feel smooth and comfortable. Also, notice how you have been able to make your stomach warmer. You may find that in the same way that you have been able to warm your gut, that you can control sensations in your gut. While you are comfortable allow your gut to relax and let the warmth that you create help to control the sensations . . .

You are in an aeroplane looking down at a winding river with gates that are locked and need adjusting. Now you can go down into the river yourself and adjust the gates so the water runs smoothly and freely. This is the same as your stomach. Allow yourself to adjust the gates so that the contents flow smoothly.

The suggestion to restrict bowel movements to the same time once a day was repeated. The patient was told that he might feel some discomfort; however, the therapist had every confidence that he would be able to achieve this goal.

At the completion of the procedure, the patient was given a post-hypnotic suggestion to recall the feelings experienced during hypnosis when he began to feel somatic symptoms. He was instructed to place his hand on his stomach and take slow breaths until symptoms had subsided. Autohypnosis was taught which the patient was encouraged to use.

Stage 4

Stage 4 consisted of cognitive restructuring. Issues concerning the relationship between worry and bowel function were addressed via cognitive restructuring. Also, the patient was persuaded that IBS was primarily a psychological rather than a physiological problem and that no sinister disease was present. The issues of dietary control and medication and their use as "talismans" were discussed and the patient was encouraged to test his belief that low-fibre foods caused his unpleasant symptoms (via self-monitoring). For example, the patient conceded that the medication did not reduce his symptoms yet he had not been willing to cease it because it provided security and assurance. Similarly, the patient admitted that dietary change had not been effective in reducing his symptoms yet he continued with a high-fibre diet and linked pain and constipation to consumption of low-fibre foods. The hypnotic suggestion involving restricting bowel movements to once a day that had been given during stage 3 was also discussed when the patient expressed some concern that he would not be able to achieve this goal.

MEASUREMENT

The goal of treatment was at least 50% reduction in IBS symptoms as measured by the patient's number of visits to the toilet, Subjective Units of Discomfort (SUDs) measures on a scale of 1-10 associated with each visit to the toilet to defecate, and a visual analogue scale of control over symptoms. Relaxation was also measured via the patient's self-report on a visual analogue scale (before and after treatment). He also reported "good twitches" and tightness and discomfort in his "guts."

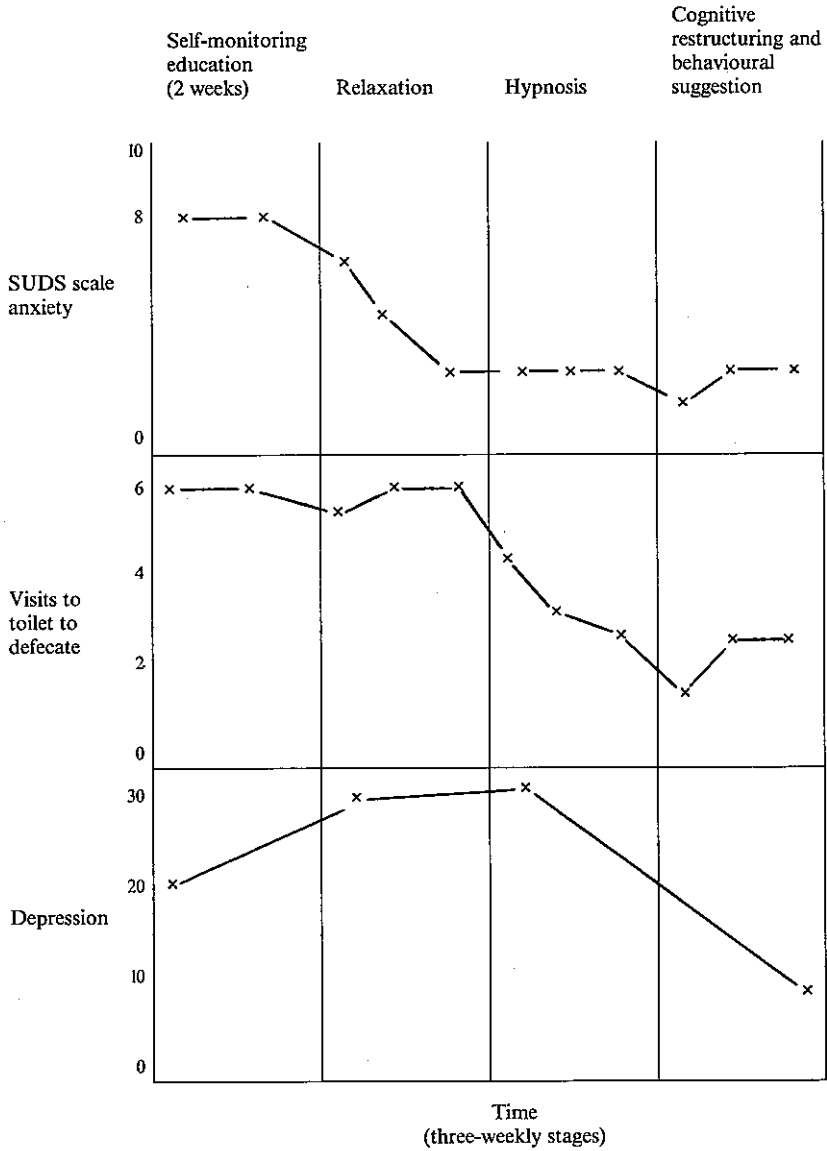
RESULTS AND DISCUSSION

The patient made rapid recovery from his IBS symptoms. Prior to treatment, he was defecating six times a day on average and reported anxiety associated with each visit to the toilet at an average of 8/10. He felt that he had little control over symptoms (20%) and experienced much discomfort, pain, and tightness in his "guts." Following treatment, the patient was defecating once or twice a day (as was his pattern prior to the onset of symptoms) and had made gains over his level of general anxiety, rating his average SUDs associated with defecating at between 2 and 0. He also reported 80% control over his symptoms. Pain in his "guts" had been replaced by "good gurgles" and "twitches." This verbal self-report was supported by the patient's self-monitoring charts.

Interestingly, treatment had little effect on the patient's level of depression until his "stress case" had been resolved (see Figure 1).

Gut-related suggestions were found to be important in treatment. The patient reported benefiting from the relaxation utilised prior to hypnosis. Subjectively,

Figure 1. Change in IBS Symptoms Associated with Treatment Stages



he reported an increase in relaxation and decrease in anxiety which suggested reduced levels of general anxiety. Relaxation, however, had little impact on IBS symptoms. Once therapy focused on symptoms specially related to the gut, the patient's IBS symptoms diminished rapidly. The importance of appropriate suggestions focusing on the gut has been emphasised by Whorwell (1987) and the present study supports this finding.

Another explanation for these findings may be that there is a lag phase between relaxation and changes in bowel habits. As this patient was seen in a clinical practice, a return to balance between treatment phases was not possible and it is not possible to rule out this alternative explanation.

The patient did not, however, begin to restrict the frequency of his bowel movements until this suggestion was given in hypnosis. Although this instruction was given during stage 2, the patient expressed doubt that he could achieve this and indeed did not do so until hypnotic intervention was initiated. Interestingly, even after the suggestion was given the patient still expressed concern and required hypnotic affirmation that he would be successful.

The patient's belief that foods low in fibre caused pain and discomfort was initially resistant to treatment. Even when this belief was tested via self-monitoring of diet and subsequent effects on bowel movement and no evidence was found to support his belief, the patient persisted in his hypersensitivity to food. His persistence seemed related to general anxiety and this finding emphasises the discrete relationship between IBS and psychopathology.

The belief was eventually altered via further hypnotic intervention which involved the patient indicating whether there was a reason for his unwillingness to change his belief in the face of the evidence. This was achieved via ideomotor hand signals. The patient indicated he had been convinced that eating habits were causally related to bowel function, that is, low-fibre foods led to pain and discomfort while high-fibre food resulted in good bowel function. Once revealed, further cognitive restructuring led to resolution of this difficulty. This result suggests that hypnosis may have facilitated the cognitive therapy.

Another issue concerned the patient's use of medication. As anxiety levels decreased, the patient withdrew bulking agents and found that his IBS symptoms did not re-emerge. However, once the patient experienced anxiety over his employer's failure to support his stress claim, he again resorted to taking bulk medication. At the conclusion of treatment, the patient continued to take small quantities of Agiolax, Tofranil and Xanax while maintaining good treatment effects. At follow-up, the patient had eliminated all medication except the Xanax and reported defecating only once daily. Further defecation was associated with low SUDs rating.

Although these outcomes relate to a single case, they exceed Blanchard's 50% reduction in symptoms. The patient reported a 60–70% reduction in bowel movement and associated discomfort. Case study results do not, however, provide sufficient evidence to indicate that IBS symptoms will necessarily

diminish by more than 50% in each case where hypnosis is used and further research is needed.

In summary, these results underline the potential for treating IBS using hypnobeavioural techniques and suggest that hypnosis provided a contribution to treatment which may be above and beyond relaxation and cognitive restructuring. It facilitated the development of rapport and assisted in the acceptance of behavioural suggestions and issues discussed in the cognitive stage of treatment. In particular, hypnotic suggestions may have been useful in assisting the patient to restrict his bowel movements to once daily, to deal with pain, and to alter his belief that diet and bowel pain were related. These results support previous findings that gut-related suggestions are superior to muscle relaxation in reducing IBS symptoms.

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"HYPNOSIS OR NOT?": BRIEF INTERVENTION WITH HYPODERMIC NEEDLE PHOBIC

Kathleen A. Moore

Deakin University

Fear of needles and needle phobia are especially debilitating in medical patients who require regular medical and blood checks. This case study highlights a 12-year-old patient's need for perceived control and choice in such a regime. It also details a brief 15-min cognitive-behavioural intervention enhanced by the use of hypnotic suggestion to reduce this fear and allow the patient to assume a degree of choice for treatment. The positive carry-over effects of this intervention are also reported.

Fear of needles may vary from mild disturbance of routine medical treatments to potentially life-endangering behaviour when a patient who is highly needle phobic resists essential ongoing medical monitoring (Horne & McCormack, 1984). Thus, when a 12-year-old girl, whose condition required constant surveillance, developed a needle phobia while waiting for organ transplant, the implications were considerable.

Case discussion meetings recorded that the phobia had developed over several visits when staff had difficulty locating veins and it had culminated on the occasion when, failing to find a vein after several attempts, staff had used physical restraint.

The circumstances of the present treatment were such that there was no time available to take a longitudinal history or to establish and work through the more usual hierarchy of fears (Wolpe & Lazarus, 1966) over several visits (Turnage & Logan, 1974). The treating physician required blood samples to be taken that morning and informed the highly anxious patient that she needed to talk to a member of the team about her problem. She asked to see me, whom she had met briefly on two earlier occasions.

A brief successful 15-min intervention using cognitive-behavioural therapy in conjunction with hypnotic techniques is reported. The details of this intervention are considered relevant for, as Mott (1984) stated, many clinical reports do not provide an explanation of the inductions, hypnotisability,

interactive relationship, or suggestions used — “and it is difficult for another practitioner to replicate or implement that clinical procedure” (Fuller, 1986, p. 47). Issues of control, motivation, and therapist/patient rapport are suggested as highly contributive to a successful outcome.

TREATMENT PROCEDURE

Only 10–15 min were available for the intervention before going down to the blood bank. Thus there was no time to obtain a detailed history of events leading up to this fear, nor the life events which may have been compounding it. The patient merely stated that she was scared of needles: “They hurt.”

“True, they do hurt, but let’s see if we can do something about that, if you want. You are sick, well no, you are okay but your *organ* is sick and you come here to have treatment for it. Do you want that treatment?”

“Yes, I do.”

When asked about her impending transplant, she replied that she wanted to have it and that it did not hurt as they put you to sleep with a little needle.

“Oh, it’s only a little needle?” Caught out, she hastily replied that they hurt. “Well, it’s up to you. You’re the boss, if you want to come and have treatment that’s terrific, but we can’t give you the best possible treatment unless we can use needles to do all the important tests — we don’t use them more than we have to. Do you want the best treatment?”

“Yes.”

“Well, that’s good but are you sure, have you really decided — you’re the boss.”

“Yes, I want the best treatment.”

“Great. You know that means needles, which no-one likes to have. I could help you have the needles, would you like me to help you?”

“Yes.”

“Okay, just sit there and relax for a moment. Comfortable? Right, now put both your arms out in front of you like this [— but no attempt was made to ask her to close her eyes]. Good. Now I think you might find that your right hand will begin to get heavy then heavier, until it gets so heavy it will start to drop down into your lap” . . . as the arm began to move, she watched, fascinated. When her right hand touched her knee I suggested that she place both hands comfortably in her lap and that the right hand would feel its usual self again.

In order not to rush her too much or focus too quickly on the needle phobia, I asked her if she was ticklish. She replied that she was but she could turn it off. I then stated that I was going to tickle her, but she was not to turn it off. I made exaggerated movements of my hands and arms as if to tickle her but stopped short of actually touching her; all the time laughing and stating “I’m going to tickle you, yes I am.” She giggled and

squirmed on her seat as anticipated. "Okay let's stop that — 'cause you know," I shared, "if I am being tickled and I don't *stop myself* I can get so ticklish that I kick and scream and nearly go crazy."

"Me too," came the surprised reply. "I didn't know that happened to anyone else."

"Well, it can happen to me," I replied. "Okay this time, I want you to know that I am going to tickle you and you will *turn it off* so that you don't tickle." I repeated the above performance and stopped short of any indication that she might laugh. "Great. You were terrific. Do you think you could do that with other things?"

"Sure."

"What about with needles?"

"No."

"Why not?"

"They hurt."

"Okay, they do a little bit. So what I would like to do now is for you to place both your hands on your knees, and think about your right hand, think about it getting warmer and warmer." At this point I placed my hand over her hand to facilitate the operation of warmer and warmer, and asked: "Is your hand feeling warmer?"

"Yes."

"Good. Now I want your hand to begin to go numb just like when your foot is asleep. Understand?"

"Yes."

"Good, your hand is going number and number, how does it feel?"

"Well . . ."

"Okay, that is good, just let it stay warm and let the numbness that is my hand gradually go into your hand, the numbness is going out of my hand into your hand, feel it?"

"Yes."

"Good."

My hand was then removed, and I noticed that she had closed her eyes. I gently poked her hand with my forefinger and asked: "What was that?" She did not know. I then gently scratched along her hand with my fingernail, but she could not identify that sensation either. "Great. It seems that your hand is feeling really numb and you see for yourself that you cannot feel things very well. What about if I do this" — and I pinched her flesh.

"Yes, you pinched me a little."

"Yes I did, but it didn't hurt much, did it?"

"No," and she opened her eyes.

"Okay. If you make your arm warm and then numb so that you don't feel much, what do you think about going down for your tests? I'll come with you if you want. It is up to you, you are the boss."

"Yes," she replied. "I'll go."

"Good. Do you want me to come with you?"

"Yes."

As we waited for the elevator, I asked the secretary to telephone ahead to advise the pathology staff the patient was anxious. We were ushered in straight away. The young patient calmly seated herself and removed a jacket without being asked. I reinforced her choice to come down to the blood bank and that she was the boss of whether she would, or would not, have the needle. As the nurse approached with the tourniquet I suggested to her that her arm was becoming warmer and warmer, and indeed it appeared to *pink up* even before the tourniquet was subsequently tightened. The nurse was sensitive to the circumstances and volunteered that, although she was very good at giving needles, she would go and get the very best person.

There was barely time for us to say how great this was before the second nurse appeared and began to tighten the flapping tourniquet on the now *pink* arm. Meanwhile, I had suggested that the warmth in the arm was turning numb, numb, very numb now.

The nurse swabbed the arm and inserted the needle without a sound or movement of protest, withdrew 10 ml of blood, then withdrew the needle with the same ease. All present congratulated a proud and beaming young lady.

As we were less rushed upon our return to the medical unit, I gave the patient her own needle and syringe, still in their packs, for her to open when she chose. I explained that it was only the tip of the needle that went into her arm, the rest of the mechanism were merely the pieces that made it work. She was to practise drawing up milk or water with the syringe, then, as the end of the syringe was too thick to be practical or to insert into veins or most other things, she could affix the needle so that she would be able to inject an orange or, on her suggestion, her Cabbage Patch doll. She was told that she was in charge of this equipment, it was hers but that she was not to practise on herself or any other person.

She stated that she knew that. She then went to show her parents her new equipment, announcing that it was only for use on dolls and things, not on people.

Subsequent blood gas tests were taken from this patient's right radial artery on two separate occasions without any local anaesthetic. As this can be a painful procedure her decision to have the tests and her compliance were strongly reinforced. She agreed to undergo her next routine blood test without any assistance and proudly reported her subsequent success.

DISCUSSION

This case study highlights patients' need to have perceived control over their treatment. It was possible that no-one, either hospital staff or family, had ever given this patient such choices before. This factor, combined with the

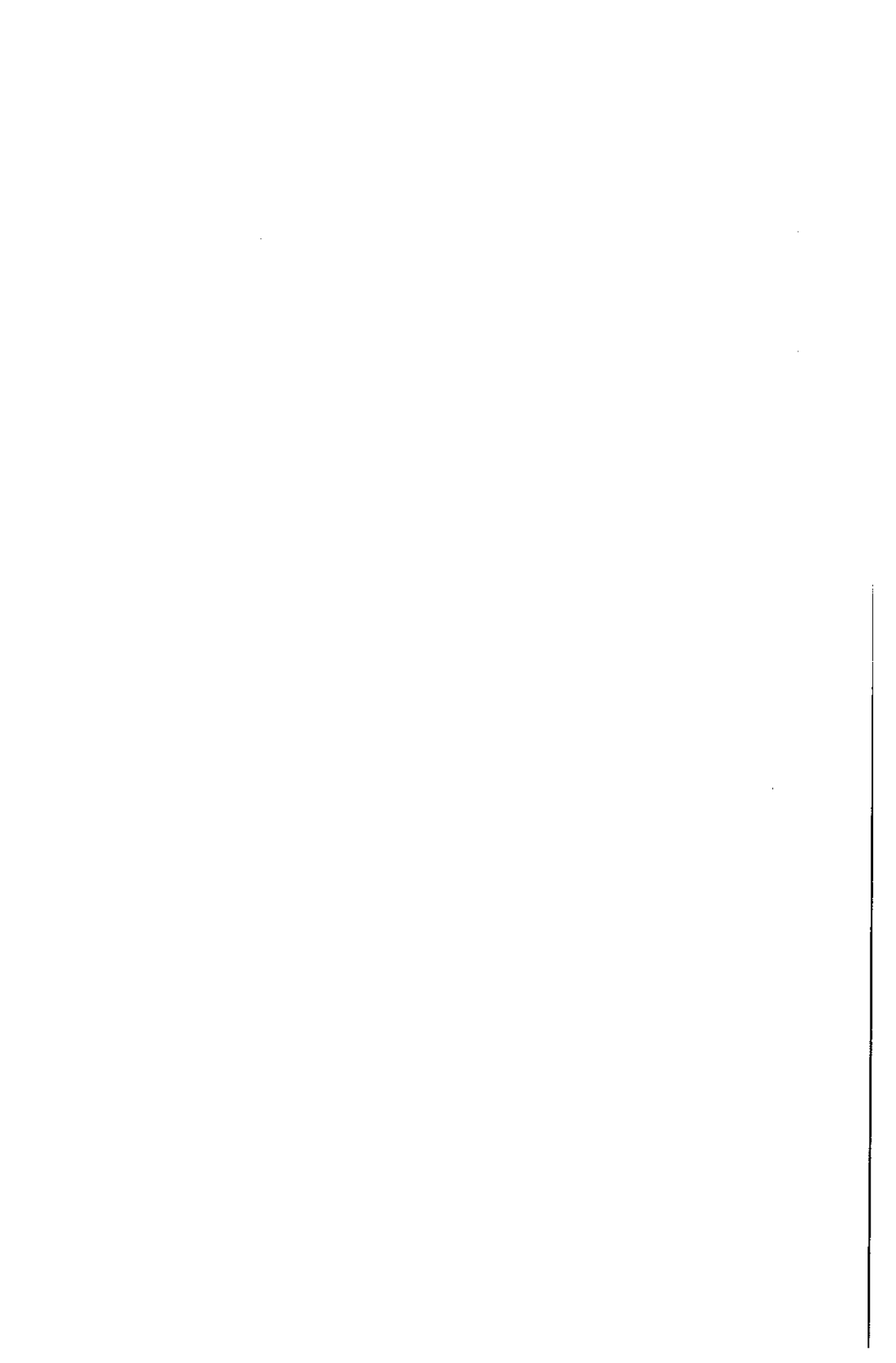
motivation of the patient to overcome the problem, forms the basis of the technique.

As no formal assessment was attempted other than hand-lowering it is not possible to state whether she was hypnotised or not, but she was certainly suggestible. This suggestibility was reinforced by physical parameters such as gravity for hand-lowering, and the warmth of my hand over hers during the suggestion that her hand was getting warmer. It also seems likely that the suggestion of warmth in her arm facilitated the blood flow and engorged her veins. It was noted that the nurse did not ask her to open and close her fist as is generally required to bring up the vein, but after looking at the arm, she swabbed it and inserted the needle.

A final element which may have contributed to this successful outcome was the rapport which quickly developed between therapist and patient — an intangible and difficult concept to convey.

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CASE NOTES, TECHNIQUES, AND ANECDOTES

This section of the Journal is a forum to which readers are invited to contribute brief items drawn from their own experience. These may be vignettes of case situations, unusual or ingenious devices and techniques, or simply thought-provoking experiences.

Correspondence regarding these items is also invited.

SOME THOUGHTS ON *JULIA PARADISE*

Lorna D. Channon-Little

The first two parts of Rod Jones' novel, *Julia Paradise* (1986) present an intriguing and perhaps typical Freudian case study set in Shanghai in 1937.

Julia's presenting symptoms, as described by the "kindly, intelligent" Methodist minister who is her husband, are periodic episodes of daytime drowsiness, when she talks in "snatches of German," her father's native tongue. She also suffers from hallucinations of highly unpleasant animals, rodents, insects and — most particularly — snakes.

Julia enters into therapy with Ayres, a 34-year-old Scottish physician who has studied for a year under Freud in Vienna. We learn relatively little about Ayres except that he has a sexual predilection for "young girls with almost pre-pubertal bodies" and that "he always took them in the same position: from behind."

Ayres hypnotises Julia in regular sessions and obtains a history. The most salient features of her childhood (in northern Australia) relate to her father, a naturalist. As a small girl, Julia wandered into his laboratory and found him with their servant woman "in the act of penetrating her from behind." The trauma resulted in Julia's becoming deaf and mute for several years.

When she reached puberty, her father began to abuse her sexually, after he realised that she had been watching him making love with a prostitute and "knew it was with jealousy not shame that the girl slunk away, her childhood finally *behind* her" (emphasis added).

The sexual abuse continued until, in a major flood, the pregnant Julia steered their boat downstream, passing her father who was stranded on the

roof of a brothel with his favourite whore, and was rescued by the minister who became her husband.

In true Freudian fashion, Ayres doubts the picture of Julia's childhood described in hypnosis. He wonders if they are products of her subconscious and whether in hypnosis she is "speaking her dreams." Certainly, the description is at odds with the accounts given by Julia in the waking state and by her husband. On the other hand, Julia's veracity outside hypnosis is questionable too, as when she tells Ayres that she nearly died shortly after arriving in Shanghai. A check of hospital records reveals that her illness was minor.

The time frame is accurate. Dissociative tendencies are usually expressed in terms of "socially acceptable" phenomena. The functional mutism and deafness began in 1910, when such "hysterical" responses were relatively common. In the 1990s she would perhaps present with a multiple personality syndrome.

Julia is a good hypnotic subject and, like many "grade 5s," has hypnotic-like experiences in everyday life (Spiegel & Spiegel, 1978). The high hypnotic capacity is consistent with her history of childhood sexual abuse (Hilgard, 1970, 1974).

The bare account given above does not do justice to the richness of Freudian (and Jungian) imagery in the book. Julia's father kept snakes in formalin in the laboratory where many of his amatory interludes took place. Julia developed a phobic fear of snakes, ropes, and even her father's dressing-gown cord. Julia was pregnant (not menstruating) when she met her husband and later in their marriage he regularly celebrates her birthday with red fireworks.

I have not yet mentioned the central theme of identification. Julia's father not only initiated and maintained a sexual relationship with her, but also dressed her in her dead mother's clothes when he took her into town for tea. Julia married a minister (a father?). She also finds a therapist with certain clear-cut resemblances to her father.

As would have been standard practice in 1937, the time of the therapeutic intervention, the interpretation of transference forms a central component of Ayres' Freudian approach. Rycroft (1972) defines transference as "the process by which a patient displaces onto his analyst feelings, ideas etc., which derive from previous figures in his life . . . by which he relates to his analyst as though he were some former object in his life."

The essential rule is that the analyst does not enter into any kind of complementary role to the one offered by the patient and is thus able to interpret the patient's behaviour as an inappropriate re-enactment of a former relationship. In Ayres' case, however, he enters willingly into the role-playing and commences a sexual relationship with Julia, mirroring the sexual practices of her father.

So we have a classical case history, but not a classical analysis. I suggest that you put the book down at the end of Part II and formulate your ideas about outcome.

And then, as they say in all the best serialisations, read on . . .

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THE USE OF NEGATIVE AFTERIMAGES IN HYPNOSIS: A TECHNIQUE FOR INDUCTION AND THERAPY

Douglas Farnill

My interest in negative afterimages in hypnosis was stirred by reading Wagstaff's (1986) account of investigating negative afterimages following visual hallucinations of coloured forms. Subjects reported afterimages according to what they thought they ought to see rather than in the complementary colours that would more naturally occur if an actual sensory experience of a colour had taken place. Although negative afterimages are not unusual during the ordinary course of experience, it seems that their quality of complementary colour can still be a surprise to some people.

Clinical applications of this interesting visual phenomenon came to mind, especially for those clients who may respond well to novel techniques. In my inductions I like to incorporate observations of what is happening to the client. Thus, when I first notice eye flutter or eye moistening, I suggest that the client will begin to notice that this is happening. Negative afterimage phenomena are fairly predictable and so are amenable to those kinds of anticipatory suggestions. In my first uses of the technique I had my clients stare steadily for about 30-45 seconds at a dot in the centre of a 2-cm circle of glossy coloured paper cut from discarded packaging material. The coloured circle would be well lit and at a reading range. While they fixated on the dot I reminded them not to move their gaze and offered induction suggestions as I would in a more typical eye-fixation induction. Next, I had them blink their eyes twice and refix their gaze steadily on a dot on the wall of my office (of a fading beige colour) some three metres in front of them, at which point a negative afterimage would typically appear.

Negative afterimages have a colour that is the complement of the fixation stimulus. Thus, fixation on the dot at the centre of a red stimulus circle would produce a green or green-blue afterimage, a saturated yellow stimulus a blue afterimage, a white stimulus a dark grey-brown and so on.

Afterimages soon begin to deteriorate, and after 10 seconds or so, interspersed with induction suggestions, I would allude to the predictable colour of the image and suggest that the image would begin to fade in colour and definition and that the client could simply let it go. Suggestions would link the fading away with deepening relaxation and trance. After a half minute, if the eyes had not closed already, I would suggest that the eyes be allowed to close and that any residual image would be smaller — with eyes closed the image appears much smaller because the previous three metres' projection to the wall exaggerated the size of the retinal image. Also, with eyes closed without a fixed focus, an afterimage tends to "roll off the screen."

The method has worked remarkably well as an induction technique with a number of clients and some have adopted it as their preferred method.

A more recent and highly successful development of the technique has been with a psychotherapy client who owned a particularly ugly and extremely distressing thought (of a sexual-racial kind) among his symptoms. This unwanted thought intruded into awareness and left him feeling helpless and guilty. We had tried other approaches without much success when I prompted him to "visualise" the thought in terms of size, shape, and colour. He described it as a large, ugly, black-brown shape, with sharp spikes. The potential for an afterimage technique occurred to me. Very quickly with scissors I cut an irregularly shaped star from white paper, marked a fixation point in its centre, and placed it on the seat of a black vinyl chair. I had him fixate for 45 seconds and then shift his gaze to the wall. The representation of his ugly thought materialised in size, shape, and colour on the wall. Then, accompanied by suggestions for control and relaxation, we had the shape fade in colour, reduce in size (with eye closure), and lose definition of form as the afterimage dissolved. We repeated this twice more in the session, emphasising his control and relaxation. He reported that the intrusion of the thought is much rarer and its effective component far less troubling — such that he does not worry about it any more.

I would be delighted if other clinicians would develop the technique and correspond about their applications of it.

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BOOK REVIEWS

The Change: Women, Ageing and the Menopause. Germaine Greer. London: Hamish Hamilton. 1991. vii + 472. £16.99.

Germaine Greer is predictably and justifiably unsatisfied, not to say incensed, by the notion of menopause as a disease of oestrogen deficiency, as described by the medical (and largely male) "Masters of Menopause." Her book, however, is far more than a diatribe against the medicalisation of menopause. Greer views menopause in the context of overall ageing and against a social background where "men see menopause as the cancellation of the only important female functions, namely attracting, stimulating, gratifying and nurturing men and/or children" (p. 19). It is a life stage where women very properly need to carry out extensive self-evaluation and holds the potential for a re-emergence of what Emily Hancock (1989) refers to as "the girl within," the self-identity the woman had as a pre-pubertal girl, before she became Greer's "tool of her sexual and reproductive destiny" (p. 62).

Early chapters discuss the state of our knowledge (and ignorance) about menopause and the problems faced by women in a society where relatively few positive roles exist for the ageing woman.

A further section considers the available treatments for menopausal distress, allopathic, traditional and alternative, the last of these including a brief reference to treatment using hypnosis. "The marked placebo effect in HRT trials would seem to indicate that removal of the fear of being without oestrogen, of 'not being a woman any more,' by hypnosis, would have a marked effect upon the patient's subjective impression of well-being and this in turn would stimulate her internal secretions" (pp. 252-253).

Greer considers women's responses to menopause next. She sees grief (resulting from the loss of childbearing capacity and an enhanced awareness of her mortality and limitations) and its expression as an essential developmental step. Of course, our society has a "cultural intolerance" of grief. Misery, resulting from the awareness that she is taking on the role of an older woman, stigmatised by age and sex, is quite a different matter, self-defeating and confidence-sapping.

The final sections examine the available roles for older women in our society. "Sex and the Single Crone" starts with the premise that about half the female population over 50 is without a male partner. For many women, a heterosexual physical relationship is simply not an option. In line with her earlier views, the author feels that the lack of a sexual relationship may be regrettable, but is better than the alternative of bad sex. The role of the "Aged Wife" may be equally as unappetising, especially if a husband is unattractive or

a poor lover (possibilities rarely canvassed by the male-dominated researchers in the area). In "The Hardy Perennials" Greer points out that it is entirely possible for women to use their good health, good spirits, intelligence, and style to retain influence over men. She also takes an entertaining side swipe at the Liz Taylors, Jane Fondas and Joan Collinses of this world who continue to aspire to the role of a younger woman. Perhaps a more viable option, certainly more fun, is to become an "Old Witch." After all, perhaps "the assumption of a witch role represents a coherent protest against the marginalisation of older women and a strategic alternative to it" (p. 401). "Why not befriend a toad today?" (p. 412).

But the greatest hope is to achieve "Serenity and Peace." Since the middle-aged woman "no longer has the options of fulfilling the demands of patriarchal society" (p. 424), she has the opportunity to "transcend the body that was what other people principally valued her for, and be set free from their expectations and her own capitulation to them" (p. 430).

Detailed examples from biography and literature illustrate Greer's points in a credible and interesting way, while putting menopause and ageing into a social and historical framework. And who can resist her iconoclasm? From her denouncement of the "Masters of Menopause" to her description of Simone de Beauvoir's views as expressed in *Old Age* (1977) as "repellently male-oriented," the book is thought-provoking, entertaining, and eminently readable.

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Buster's Fired a Wobbler: A Week in a Psychiatric Hospital. Geoff Burrell. Harmondsworth, Middlesex: Penguin. 1989. 178 \$11.99, paper.

This book attempts to capture the atmosphere of a British psychiatric hospital as it is seen by a psychiatric nurse. It is not a pretty picture: The administration is incompetent, the staff culture is corrupt and violent, and much of the patient care is inhumane and demeaning. The few exceptions are seen as the work of dedicated and skilful individuals who are operating in spite of the system rather than being encouraged and supported by it. There are some powerful images in the book, and readers will sometimes be disgusted and saddened by them. It ends with a polemical argument about the failures of the system as the narrator leaves the hospital for the last time.

The author is a mental health nurse who says that he described his experiences over several years, and compressed them into a week. He attempted to weave the experiences into a single story, but this is only partly successful. As a

result it leaves the reader with a sense of several somewhat disconnected images and stories. More importantly, the author has clearly chosen some of the more spectacular (and often amusing) events, and as a result the book reads somewhat like a Sunday tabloid's description rather than a balanced diary. The bawdy humour adds to this impression.

How accurate a picture does it paint? If this were a description of in-patient treatment 30 years ago, it might be very close to the truth. But we would like to think that the major changes in the last 20 years — the reduction in length of in-patient stay, the movement towards in-patient units within general hospitals, the improvement in training of psychiatric nurses, and the growth of community facilities — have changed the picture. The book raises the question of whether the changes are as great as we believe. Although the changes in psychiatric practice have probably been greater in Australia than in the U.K., there is no room for complacency, and many similar events could well occur here.

I would be cautious in using this book as a text for trainees. Despite its powerful images and its potential as a trigger for discussion, it gives a misleading view of the current attitude and practice of psychiatric treatment, at least in the Australian setting. Like other similar sources of powerful images such as *One Flew over the Cuckoo's Nest*, many of the issues are no longer contentious. In addition, the issues are often presented in a simplistic manner and the suggested solutions are often rather naive or superficial. However, if it makes students more aware of the negative potential of hospitalisation — the negative modelling, the distress from observing others' symptoms, and the threats to human rights — it could be very useful.

Overall, the book presents no new insights or fresh approaches. But it does offer a graphic description of life within a psychiatric institution — even if it is a rather jaundiced view.

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