

HYPNOSIS IN THE TREATMENT OF SURVIVORS OF SEXUAL ABUSE

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This paper outlines the problems of child sexual abuse and its long-term sequelae, often reaching down generations. In psychotherapy with survivors of childhood sexual abuse, hypnosis offers a flexible treatment modality and the paper focuses particularly on the use of hypnosis and self-hypnosis for the "reparenting" element of psychotherapy.

Child abuse is a major problem in our society, with currently over 70 cases per week being reported in Queensland alone. Current Canadian statistics indicate that 34% of females and 13% of males have been victims of sexual abuse. Child sexual abuse is sexual activity between a child and an adult or teenager. The activity may range from verbal abuse, to voyeurism, to genital fondling, to penetration. A combination of physical, emotional, and sexual abuse often occurs. Usually the offender is well-known to the child — a family member, family friend, teacher or community leader.

Sexual abuse is often a family disease, with abusing grandfathers, fathers, uncles and brothers (in my own case load, only 4% of sexual abusers were women). These dysfunctional family patterns can frequently be traced back two and three generations.

Generalised anxiety, eating disorders, sexual problems, addictions and depression are common presenting symptoms. The effects of childhood sexual abuse are pervasive and tragic and include the following:

1. Trust is not developed, or is shattered.
2. The self is linked to shame, terror, and deep depression.
3. The abused child often carries the family secret.
4. Feelings of inferiority are common, and there is no safe place.
5. The world is seen as hostile and the victim is powerless and helpless.
6. The self is experienced as split into compartments.

In psychodynamic terms, the individual employs various defence mechanisms as protection from the abuse and in order to survive. These defence mechanisms commonly include denial, repression, dissociation, splitting, and idealisation. Dissociation causes the person to be out of touch with her/his physical body and some of his/her feelings. Patients variously describe this as going blank, going shopping, being out of my body, hiding in my head, or cutting-off. This defence invariably leads to anorgasmia (in men to reduced libido and ejaculatory problems) due to the person's dissociating from pelvic perceptions. Splitting and idealisation result in the abuser being described in glowing terms, since the painful experiences are split off from consciousness. The family myth is thus perpetuated (e.g., "I always had a wonderful relationship with my father, I had a happy childhood"). When the patient is pressed for further details, there are childhood years for which she/he has no specific memories to substantiate these statements.

Hypnosis is valuable in the psychotherapeutic treatment of these patients. The techniques that can be used range from simple induction using progressive muscular relaxation and pleasant imagery, through ego-strengthening and mental rehearsal of desired behaviour and self-hypnosis, to age regression and reparenting.

Because anxiety is so common in these patients, progressive muscular relaxation with background music and favourite-place imagery is a useful induction technique. Rehearsal of new behaviours coupled with post-hypnotic suggestion is useful in improving confidence and performance levels.

Prerequisites to introducing age regression and reparenting are as follows:

1. Thorough history and mental state examination.
2. Development of rapport and trust.
3. Social supports — family, self-help group, friend.
4. On-going therapeutic relationship.

If the patient is unable to recall events in her childhood then these can be accessed using an affect bridge, Bandler's theatre technique (Stanton, 1988), or other age-regression methods. The original trauma, be it a single event or multiple events, is brought to conscious awareness, understood and integrated. This results in a lessening of the presenting symptoms (e.g., the bingeing may stop or the depression may lift). However, the underlying feelings of low worth, hopelessness, helplessness, and shame have been so closely connected to the core experience of the self that catharsis alone does not result in full healing of the injury.

A further complication can occur. Because the defences of denial and repression have been bypassed, the patient may suddenly realise how much has been missed in terms of happy childhood experiences and feel acute grief over opportunities lost in life. Expressing and validating this loss and accompanying grief is necessary in the therapeutic context, but still the patient may not feel complete. Some patients can unconsciously see the newly accessed knowledge as continuing the abuse. Pollard (1987) puts it this way: "The negative

Inner Parent is susceptible to the same weaknesses of neglectful and non-nurturing behaviours that the outer parents might have used. [It] can be quick to judge and lecture your Inner Child. It is common for it to warn, advise or berate the feelings of the Inner Child" (p. 39). One way of addressing these problems is reparenting, in which the patient works with an inner-ego state or states which can be called the inner child.

The idea of working directly with the inner child in hypnoanalysis has its origins in Gestalt therapy, psychodrama, and transactional analysis. Developmental theory postulates that there are stages of development that each person must successfully negotiate in order to progress to the next stage. In his theory of psychosocial development, Erickson described eight stages, each with its developmental task to be mastered, a conflict to be resolved. Blocks in development in stages 1-5 can be conceptualised as an actual inner child or adolescent caught in a time warp. Because of the block the patient has difficulty moving on to the next stage and at best is only partially successful in completing the development tasks of each subsequent stage.

In hypnosis, age-regression allows the patients to see, hear, and feel this blocked aspect of themselves as a child at the age the trauma occurred. It often happens that there are several inner children at different ages, even inner babies and inner teenagers. Some patients regress to the gestation period. With the use of trance logic and suggestion, the patient experiences an inner child with whom he/she can communicate on a very deep level. Healing this damaged self can then commence. Core beliefs about the self can be restructured. For example, it is a common belief of incest survivors that the abuse happened because they were intrinsically bad, even evil, and that it was this that caused the abuser to act. The core beliefs that move from the negative to the positive polarity are:

- I am unlovable — I am lovable;
- I am bad — I am good;
- I am unworthy — I am worthy;
- I should not exist — I'm glad I exist;
- I do not feel — I feel;
- I am ashamed — I respect myself;
- I am guilty — I am innocent.

During the hypnotic trance the inner child can be given new information about the abuse, and can be helped to understand that it is the abuser who is bad or sick or wrong and not the child. The patient is encouraged to comfort their inner child and to give her unconditional love and acceptance. Age-appropriate messages can be stressed. For example, an inner baby can be told, "I'll always be here for you, you are safe now." A toddler may need to hear, "You are a beautiful and wonderful child. It's okay to be angry and frustrated sometimes. I love you, you are a good child." For a four-year-old the message may need to be, "This is not your fault, you are not a bad

person." For many patients the abuse spanned their entire childhood, so the inner child may be experienced at different ages either in the same session or subsequent sessions. As healing progresses, the inner child changes from a crying, frightened, distrustful child to a being of love, spontaneity, and joy.

If the patient is unable to access the resources she needs to do this work, she can be asked to bring to mind some person who would have the skills she needs, and to use this person in the imagery of reparenting.

Self-hypnosis is a useful follow-on from the therapy sessions. Patients can be taught quick induction techniques such as Spiegel's (1972) eye-roll so that they can check in regularly with their inner child several times a day, even if only for a few minutes. I suggest that they schedule daily sessions of reparenting and that they keep a journal of their sessions, in which they record the dialogue and any new imagery as it arises.

Dream material indicates that, once started, reparenting continues at the unconscious level. This is an example of one such dream:

I am given a deformed baby boy. At first I did not want anything to do with it but then I hugged him and breastfed him and comforted him. He was really lovely and he gradually became normal like a one-year-old, extra smart and beautiful. The more I hugged him and cared for him the better he got.

Reframing of any recurrence of symptoms is helpful, so that instead of despairing that they are feeling anxious or depressed again, patients can say, "That's my little child telling me she needs some attention." They learn to listen to their inner child in the way a good mother or father would, disrupting the pattern of abuse and abandonment.

Resistance to therapy frequently occurs and takes many forms (e.g., cancelling appointments, arriving late, failure to do home sessions, sidetracking in sessions, making comparisons and minimising). Resistance from the therapist also occurs and includes sidetracking, ignoring an issue, and forgetting.

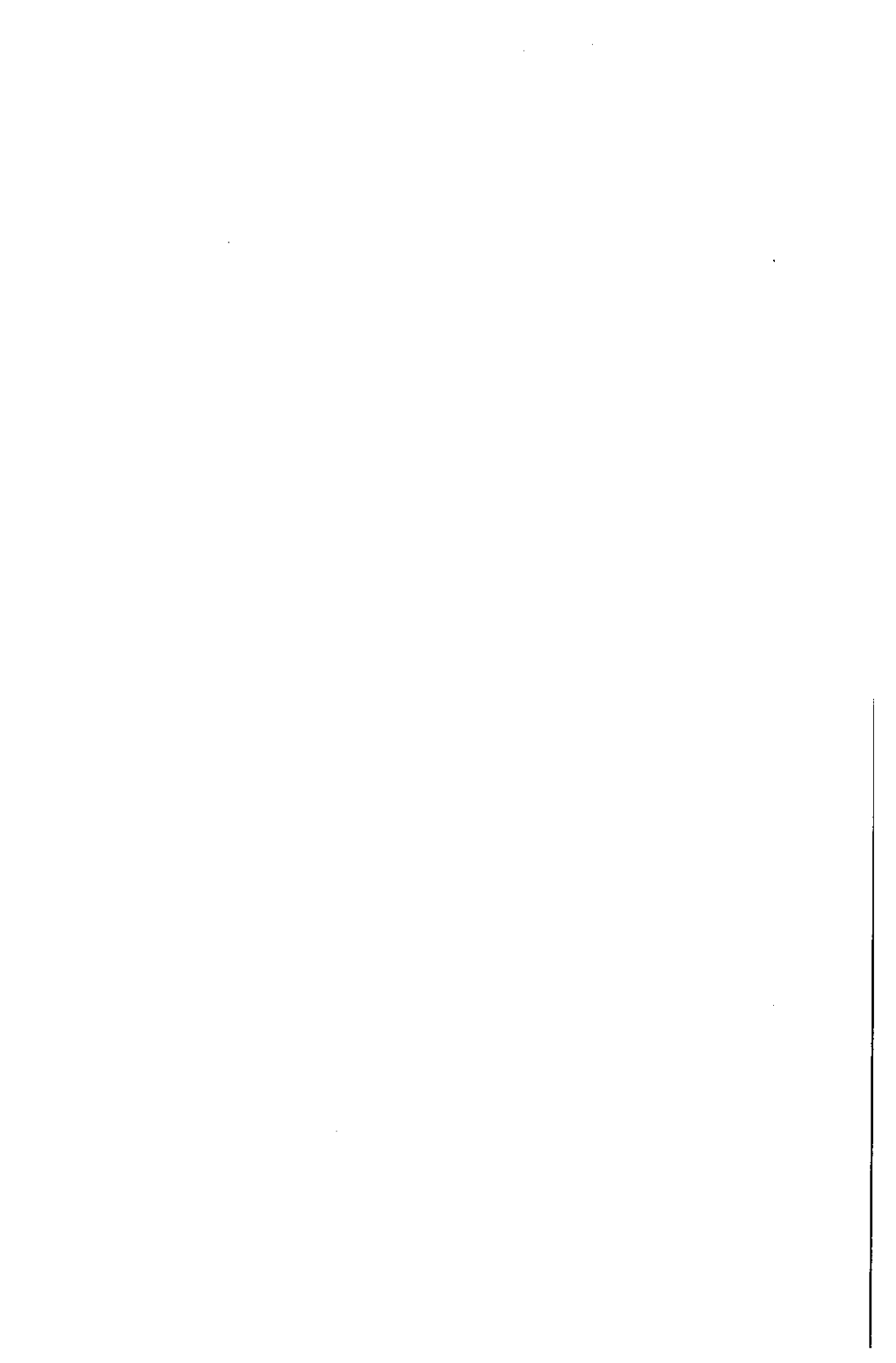
As I work with survivors of sexual abuse I am amazed at the resilience and courage of these men and women, and by the unique creativity of each individual. Healing the damage caused by childhood sexual abuse is difficult and time-consuming and at times very painful. The techniques outlined here do not provide any short cuts, but they facilitate the process and help patients regain mastery in their lives.

Many therapists are now using these concepts, but the playwright Arthur Miller expressed the idea of reparenting many years ago in *After the Fall*:

I dreamed I had a child and even in the dream I saw it was my life and it was an idiot and I ran away. But it always crept on to my lap again, clutched at my clothes until I thought if I could kiss it, whatever in it that was my own, perhaps I could sleep. And I bent to its broken face and it was horrible but I kissed it. I think one must finally take one's life in one's arms.

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SINGLE-SESSION HYPNOTIC TREATMENT OF INSOMNIA IN RELIGIOUS CONTEXT

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A case of chronic insomnia and anxiety is presented which responded to single-session treatment by hypnosis/flooding done in the context of the patient's religion, after traditional medical and psychological treatments were unsuccessful. Flooding and hypnosis are discussed to develop the argument that the flooding session, involving absorbing imagery and peace/relaxation, was actually one of hypnosis. The purpose of the paper is to demonstrate that a patient's religious belief can be used to enhance the effectiveness of psychological therapy.

In my practice of psychological therapy, I have found the patient's religion to be sometimes an obstacle but at other times a help. One patient, due to his rigid religious upbringing, refused to fantasise during orgasmic reconditioning (Keller & Goldstein, 1978). Two patients felt it as their religious duty to seek permission from their priest before consenting to undergo hypnosis, but their priest refused the permission on the ground that hypnosis was a technique to "change the mind." On the other hand, the religious belief of a patient has been therapeutically utilised in the context of obsessive-compulsive neurosis (Singh & Oberhammer, 1980), and the use of Buddhism with behaviour therapy has been proposed (de Silva, 1984). However, there are very few, if any, case examples to guide a practitioner who may be faced with the clinical necessity to synergistically utilise the patient's religious belief with psychological therapy.

This paper presents a case demonstration of utilisation of a patient's religion in the practice of hypnosis.

THE PATIENT

Miss R. aged 29 years, was a single woman, working as an office secretary. She was referred to the author by a physician for her complaints of insomnia and anxiety. She suffered a peptic ulcer, which sometimes caused her pain

and for which she sometimes took analgesics. In the view of her physician, it was not of sufficient severity to cause the insomnia and severe anxiety that she suffered. The physician stopped medication for her anxiety and insomnia when referring her for psychological therapy. In any case, the medicine for insomnia was only causing her drowsiness and the physician considered psychological treatment more appropriate. Miss R. had difficulty getting to sleep despite intense effort, which included various measures to obtain noiseless surroundings. She would only get drowsy and doze off for about an hour. She had to go to the toilet to urinate many times in the night due to her autonomic arousal, which prevented her from going into "real sleep" throughout the night.

The duration of her presenting symptoms was four years. Seven years ago, she was once successfully treated for her insomnia by a priest. In her place of work she was a meticulous worker, liked by colleagues. She started to worry that if her insomnia persisted, she might go crazy, lose control of herself, and do "funny" things (e.g., spitting on her colleagues in the office). She was so meticulous that she would interpret even a petty, inconsequential oversight on her part in the office as a prelude to her impending psychiatric illness, which would eventually cause her to lose her job. She bought a new house four years ago, but was not happy with its design and found that she could not sleep in it. She was sleeping alone in a separate room and other family members were careful not to make any sound while she was "sleeping."

Her hypnotisability scores were 3 and 3 on Spiegel's (1972) eye-roll and upgaze tests. Her eyes turned to her right 42% of the time, suggesting that she had right hemispheric dominance (Bakan & Svorad, 1969).

PROCEDURES

Hypnosis was proposed to her but Miss R. insisted on seeking her priest's permission first. The priest stopped her from going for hypnosis because "hypnosis was a technique to change the mind." However, she did not feel the need to consult the priest for other psychological techniques. Therefore, paradoxical intention technique (Ascher & Efran, 1978; Frankl, 1960) was given a trial. Due to her overall anxiety and worrisome cognitions, she could not sincerely intend "non-sleep". Having failed at the paradoxical intention, out of desperation she finally opted for hypnosis without the knowledge of her priest. She was highly hypnotisable (so, did she unwittingly self-hypnotise herself into the illness?) However, possibly due to her overall anxiety, she took more than one hour using the relaxation method to get into sleep. The fact that she was in hypnosis was verified by induced eye and hand paralysis and loss of reflex to the prick of needle. Sleep was suggested to her during hypnosis, and she slept for half an hour, verified by her escort; later, she denied that she had slept at all.

Other techniques were tried, amongst them stimulus control (Lacks, Bertelson, Gans, & Kundel, 1983; Turner & Ascher, 1979) and correction of

her misconceptions (Wolpe, 1982) — for example, that she would go crazy and get fired from her job. As a result of this she was sometimes able to get a three-hour sleep. Then a new script of hypnotic suggestions was prepared, in which she was to imagine that the God (of her religion) was telling her to surrender herself to Him fully. She was not to try to sleep because, after her surrender, it was the God's business to give or not to give her sleep. However, next day she telephoned me at my house to ask if she was to merely imagine the God telling her to surrender or to really surrender. She also went to another priest of her religion who told her, "Only complete surrender to God can bring peace."

By now it had become obvious that her real problem was fear of total surrender, which triggered images of losing control, going crazy, and doing crazy things in her office. It was to frontally attack her fear of surrender and the consequent images of craziness that a flooding (Wolpe, 1982) session was undertaken, and this became the last treatment session.

Miss R. was asked to close her eyes and totally surrender herself to the God. Now it was up to Him to give her peace or to doom her into mental illness. She was urged to imagine and deeply experience the worst consequences of her surrender. Using the "directed fantasy technique" of Feather and Rhoads (1972), she was asked to imagine the worst that could happen to her and to go ahead and genuinely feel it. In the earlier part of this one-hour session she resisted imagining and cried profusely; but later she co-operated, although sobbing intermittently. Thus she imagined herself having gone insane, being admitted to a mental asylum, stinking, with worms crawling out of her sexual organs.

At this point, after some quiet minutes, she reported "complete peace." But, to ensure that she had fully surrendered herself, I went on to urge her to imagine and feel herself saying to the God: "I am not requesting you to heal me because I am totally surrendered to you and I am at your mercy — whether you heal me or not." So, He decided to send her to Hell. I then asked her what the worst was that was happening to her in the Hell, and she supplied the imagery of Hell fire in which she was being fried. After silently experiencing the scene for some minutes, she said: "Now nothing worse can happen. Already I have been through the worst, and I am totally surrendered to Him, and I have complete peace."

I concluded the session saying to her: "Stay in this state. Now sleep is not important. You are totally surrendered to Him." She looked cheerful and reported feeling "a strange glow" around herself. No further sessions were required, but occasionally I telephoned her to follow up.

RESULTS OF FOLLOW-UP

Follow-up was done by telephone and, later on, by letters. Sleep was not discussed for some weeks, but Miss R. reported feeling peaceful. The few times when I specifically asked about her sleep, she said she was getting about

six hours' sleep, but it was not as satisfying as it had been before her illness. I told her that everything changes with time, that sleep would come according to her body needs, and that, in any case, she should leave the matter of sleep to the God as she was now totally surrendered to Him.

She continued to improve after the above-mentioned clarification. I then moved to a different city, from which follow-up was by letter. Follow-up at six and twelve months showed that not only was she satisfied with her sleep, but she had become once more a happy, outgoing person. For the first time in several years, she took a long tour, looking a different person, and she recently chose to visit me in my new location.

DISCUSSION

One feature that emerges from this case presentation is that direct suggestion aimed at symptom removal may not be effective. When cognitive misconceptions and anxieties are associated with the symptom, they have to be treated by bypassing the presenting symptom. Moreover, during history-taking, the patient's religion and its possible role in treatment have to be considered.

On reflection, the last session with the patient — namely, flooding — can be regarded as an hypnotic session for the following reasons:

1. Although no mention was made of "hypnosis" in the flooding session, the patient very likely privately believed it to be an hypnotic session. The patient was not informed that it was *not* an hypnotic session, and the patient had undergone an hypnotic session involving similar imagery prior to the flooding session.

2. Deep imagery to the extent of intense experience of feeling was involved. According to the reciprocal inhibition model, both flooding (Wolpe, 1982, pp. 241–242) and hypnosis (Rubin, 1972) invoke the mechanism of reciprocal inhibition. Moreover, hypnosis has been equated with: (a) a deep state of relaxation (Edmonston, 1981), which is a reciprocal inhibitor in Wolpe's paradigm of behaviour therapy, and (b) absorbing imagery (Hilgard, 1974), which is also the basis of flooding/implosion. The deep feeling of peace reported by the patient at the end of the session, much as in the case of hypnosis (Rubin, 1972) and flooding that is continued to the point of diminution of anxiety, served as reciprocal inhibitor.

The mechanism of the effective session essentially seems to have worked at two levels: cognitive-cortical and emotional-autonomic. Cognitively, the stress of having to get sleep was removed when the patient resigned to the effect that sleep was now the God's job, not her job. At emotional-autonomic level the mechanism involved was possibly reciprocal inhibition of anxiety, including the anticipatory anxiety related to insomnia, by means of the counter-anxiety (hypnotic) *state* of "peace" that she spontaneously reported having achieved at the end of the session as a result of her realisation that she could surrender and lose control of herself, yet not go crazy.

Could this be a case of pseudoinsomnia? The question cannot be answered in the absence of whole-night EEG recording. However, clinically it was unlikely to be pseudoinsomnia because Miss R. had severe anxiety, which disrupted her sleep.

The following considerations influenced my clinical decision to integrate her religion in her treatment: The facts that on one occasion she was successfully treated by a priest and that one priest told her that only complete surrender could bring her peace. The concept of complete surrender sounded to me not much different from paradoxical intention in her case, as surrender implied stopping the struggle to get sleep, not doing anything — not even wishing — to sleep. In other words, I believed complete surrender in her case could be the mechanism by which she could be induced to eventually go into the (hypnotic) state of autonomic peace in which she would feel relieved from the stress of her concern for sleep.

It should be remembered, on the other hand, that direct use of religion in hypnosis in the form of hypnotic suggestions for symptom removal might not be effective. For example, the hypnotic suggestion that the patient's God/priest says to her that henceforth she will get good sleep might not be effective because the core stimuli to her anxiety (e.g., her private cognitions/images of going crazy, spitting on colleagues etc.) would still remain untreated and would go on causing her anxiety which would prevent her from sleeping.

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COMBINING MUSIC AND WORDS AS A PATHWAY THROUGH HYPNOSIS: PRACTICAL GUIDELINES

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Music in itself has powerful effects on consciousness and, combined with appropriate hypnotic words to guide attention and experience, makes a congenial and delightful pathway into hypnosis. This paper provides practical guidelines rather than a theoretical analysis. In its simplest use in the hypnotic situation, music makes an effective and widely acceptable deepening technique and clinicians are advised to begin with this use of music to acquire their own communication skills in the area. However, music can also be used as the primary focus of attention for induction as well as deepening and, when hypnosis is achieved, it can be a very effective vehicle for carrying verbal suggestions, a primary stimulus for production of emotional experiences, or a background for therapeutic fantasy, guided imagery or imaginal rehearsal. Music makes a gentle and positive pathway out of trance and it can provide a safe and appropriate vehicle for self-hypnosis in stress-management.

It has long been known that music has impact on consciousness, and to remind ourselves of this we have only to think of the kinds of music available in a well-stocked music shop: loud pop music with a powerful and accentuated rhythm, jazz ("classical" and modern), Gregorian chants, folk songs, meditational music, an extravaganza of classical music, Renaissance songs and dances, religious music (old and new), music of non-European cultures, war music, dance music — the list goes on and on. When not using music as the central focus of attention, we are used to it in the background of experience. Music is used to create emotional background or to augment emotional response in movies and in television productions; we tend to have music playing when we are driving cars, doing the ironing, even weeding the garden. Radio and television programs have their own signature music, and advertisers use music (often well-known and well-loved) to manipulate emotion and attitude in relation to their product.

Music has a long history of use for manipulating mood and motivation, in religious traditions for producing alterations in consciousness and also in

healing traditions. M. Clynes (1987) defines music as an organisation created to dictate feelings to the listener. He separates the response to patterns of pulse or rhythm, automatic and inbuilt in our central nervous systems and receiving both the regularity and variation of rhythm (as do the central nervous systems of other living creatures; cf. the mating songs of insects and birds) and melody, which he considers to communicate essential form, emotional meaning, which, when pure, is recognised and responded to automatically, though the individual needs some familiarity with the language of the music of his/her culture for this automatic response to take place. Clynes also discusses tone colour and timbre. He distinguishes two modes of emotional experience, Dionysian and Apollonian. Dionysian, which we share with animals, involves the whole body and self. The Apollonian mode involves a complex of intellectual evaluation and emotional response, is more muted, involves awareness of separateness from the stimulus input, and is central to aesthetic experience.

Brown (1991) notes how the neurobiology of hypnosis overlaps with the neurobiology of music and cites Rouget's work from an anthropological perspective suggesting that trance state is linked with dance and music throughout the world:

Throughout the world, the trance state is associated with dance and music, but the relationship is not a simple one. The types of dance and music vary markedly from culture to culture, as does their role (Rouget, 1985). Music is used variously to induce, deepen, or end trance. As Rouget has shown convincingly, it is not simply a question of some music being "hypnotic"; rather, variations in rhythm and sound have been assigned a particular meaning by the people who use them. (pp. 59-60)

The question of whether certain pieces of music are universally "hypnotic" or not remains unanswered; though it would seem likely that there are some inbuilt, non-learned components, along with learned ones. For example, being familiar with the style of music trains one to focus attention on it and shift to "passive/receptive" mode of consciousness, and there is likely to be a component of the experience from the learned connotations of melodic and rhythmic patterns in a particular culture. In any case, it is not outrageous to propose that some music of our cultural tradition is useful in facilitating hypnosis for those who are receptive to the hypnotic ritual. And further, that the right kinds of words would be useful to focus attention and partly define the experience by suggestion.

Josephine Hilgard (1979) noted that her highly hypnotisable subjects were more likely than less hypnotisable ones to become absorbed in classical music rather than pop or jazz, like their absorption in pleasant natural phenomena such as landscapes; this suggests that music would be a congenial pathway to hypnosis for responsive subjects. Snodgrass and Lynn (1989) reported differences in self-reported absorption and imagery elaboration in response to music rated high and low for "imaginativeness" by high, medium, and

low hypnotisable subjects. High hypnotisable subjects reported higher levels of absorption, regardless of the "imaginativeness" of the music, and higher levels of imagery elaboration when the music was "imaginative." Hypnosis was not used, except to classify hypnotic responsiveness on an earlier occasion.

Thus it would seem that hypnotic responsiveness is related to reports of absorption in some kinds of music. This suggests that the music itself may be a pleasant and natural pathway into hypnosis. Based on my own research and that I have supervised (Reeve, 1973; Rottenstein, 1985; Walker, Rippingale, & Diment, 1973), it would seem that, in hypnosis, the response to music is different from that in the waking state. Affective response, the emotion experienced, is amplified and tends to be similar for different subjects for the same piece of music. Sensory imagery elicited by "imaginative" music is more vivid and subjectively real in hypnosis than in the waking state and sensory imagery tends to be highly individual across different subjects. (I do, however, have reports of a small number of highly hypnotisable subjects who regularly experienced synaesthesia in response to music and, in hypnosis, they tended to experience the same colours in response to certain "visual" pieces of music, e.g., some pieces by Vivaldi.) There is more loss of self in the experience of listening to music in hypnosis than in the waking state.

On the other side of the coin, there is a loss of awareness of change over time, and a lack of appreciation of development and repetition of themes; response to music in hypnosis is very much in the here and now, to runs and sequences of notes, unless the subject spontaneously or by instruction builds the ongoing music into a sequence of imagined experience. There is also a lack of the critical aesthetic judgment; interpretation and the excellence of performance of the musician is not appreciated or compared with other performances. Part of the essence of being in hypnosis, of course, is the here-and-now, lost-in-experience quality. This calls to mind the Dionysian/Apollonian categories of Clynes (1987).

A COMBINATION OF MUSIC AND WORDS AS THE PATHWAY INTO AND OUT OF HYPNOSIS

Over some 20 years, since my first dabbings in music and hypnosis with Chris Rippingale and Tony Diment, I have made a great deal of use of music, not as a background "mood setter" as in the movies, but as a primary focus of attention in at least part of the hypnotic session. It is my contention that, if one combines hypnotic instructions with the right sort of consciousness-altering music, the two inputs augment each other. Music as a focus of attention is more pleasant, more familiar, and more attention-holding than watching a spot on the wall; with words as well to keep focusing attention and to provide instruction about *how* to listen, the experience of moving into hypnosis seems less awkward or strange and is less plagued by intrusive thoughts. As Tony Diment and I pointed out some time ago (Walker & Diment, 1979), music is particularly useful with highly hypnotisable subjects who have conflicts

about loss of autonomy, with gifted subjects who have less than optimal imagery, with subjects whose movement into hypnosis is disrupted by intrusive doubts and thoughts, and with medium to high hypnotisable subjects who want to enjoy a delightful pathway to optimal working depth, for clinical work or research.

There has been very little research in the domain of hypnosis on the effects of the induction and deepening, or pathway into trance on what is experienced in hypnosis. The major techniques we still most often use to take our patients or research subjects into hypnosis are, to my mind, a bit boring, stilted, power-ridden and outdated, and probably not even the most effective. We do not know if hand levitation has the same implications for a subject as eye-fixation, or as a "confusional" technique in the Ericksonian tradition. However, even if these different pathways *do* take our hypnotic subjects to one and the same domain of experience, they will have implications for the interpersonal relationship between hypnotist and subject, which is very important in the clinical situation. Also, the different pathways would surely set different expectancies and demand characteristics. In clinical uses of hypnosis, I dislike techniques that set up the hypnotist as all-knowing, clever, and dominating. The hypnotic ritual itself, involving that unique trust of handing over to another person the role of directing the stream of consciousness, involves enough trust on the part of the subject and influence on the part of the hypnotist without using communication techniques which further convey dominance and power. Consumer responses to my inquiries over a couple of decades have revealed that over 75% of my patient and research subjects have evaluated music for induction and/or deepening as their preferred method of entering hypnosis, and that those who preferred another method did not find music noxious. Being given time to enter hypnosis pleasantly was frequently given as a virtue of the method and some subjects said that their appreciation of music was spontaneously enhanced in everyday life.

Many years ago, as well as using music as a pathway into hypnosis, I also began using music to produce special results in hypnosis, or to augment suggested fantasy experience, guided imagery, or imaginative rehearsal activities. Over the last 10 years or so I have been using music as a pathway out of trance as well. Central to the effective use of music with hypnosis is the proper planning of the session, which I like to do in collaboration with my patient.

In conceptualising the different uses of music, I like to keep the structure in my head (no matter how the parts merge into each other, are abbreviated or extended) that the hypnotic session falls into six parts: (a) pre-hypnosis discussion including informed consent, (b) induction, (c) deepening, (d) content, (e) de-hypnotising and (f) debriefing. The use of music gives the hypnotic session an easy flow, an apparent lack of rigid structure, but I keep the structure in mind so that none of my important tasks is left undone. Beginners are advised to make themselves worksheets with headings for the six parts of the session and to plan beforehand what will go in each section. In that way,

if the hypnotist becomes a little absorbed in the music him/herself, things will not be omitted.

THE SIMPLEST USE OF MUSIC: DEEPENING

The simplest use of music, which still has quite potent clinical uses, is for the deepening stage of the hypnotic session to involve listening to music. While excellent subjects can “jump” straight into hypnosis at a signal, all of my best subjects tell me that they *prefer* an induction ritual, however brief, and also that they *need* a time of deepening to get a comfortable working depth, either for research or therapy. Music makes a very pleasant and effective deepening stage for the therapy session. Further, for the hypnotist, learning to use music for deepening with some personal style and flair is the ideal way to learn how to combine hypnotic words with music.

Using music for deepening is simple and very pleasant, for both patient and therapist (for what therapist would be foolish enough to use music that is noxious to him/her?) I have already noted (Walker, 1984) that music for deepening can be quite varied but generally should be music that runs and ripples, with predictable rhythm, no great changes in tempo or volume and no sudden changes in pattern to cause arousal. As I define the music as “a moving pathway of sound to carry you further and further into hypnosis,” this definition partly defines the kind of music I use. It includes flute, guitar, and lute music of Bach, Boccherini, Vivaldi, Handel and others, and Celtic harp music, where the notes dance like sunlight on running water.

Music used for deepening hypnosis need not be your typical soporific music introduced with a sleepy voice. Hypnosis is not sleep. Remember this is the imaginative involvement part of the domain of hypnosis and a quietly involved, story-telling voice may be the appropriate one for the verbal component.

When music is to be introduced as a deepening technique after a standard induction, I discuss this in the waking state, get permission and explain the use of the music. Remember that many powerful expectancy factors are set by suggestions before hypnosis. I explain how the music will become a moving pathway of sound that will carry the subject further into hypnosis. I explain that tastes differ in relation to how much I talk with the music and ask my subject/patient to have a guess how much I should talk with the music, in rough categories of *very little*, *a moderate amount*, *a fair bit*. If the proportion of talking is not optimal, then at least the patient has been a participant in the decision-making and will have no qualms about giving me the feedback to fine-tune my performance.

After induction, say by modified eye-fixation, and after counting from 1 to 20 with the usual suggestions of going further with each count, I would introduce the music, played at normal listening volume, along the lines:

In a little while I will start the CD player and you will listen to the music in a special way. You will let the music pick your mind up and carry

it further and further into hypnosis . . . The music will be a moving pathway of sound to take you further into hypnosis . . . (*Music starts and you weave your words through the music.*) Listen to the music, let the music take over your mind and carry it on and on into hypnosis. Let your body relax and relax, quite automatically, as your mind becomes more and more absorbed in the music, carried along by the music while tension dissolves from your body. (*You can introduce an imagery component if you wish, kinaesthetic for dancing music, or visual.*) As you move further into hypnosis with the music, delightful images will form in your mind, but most of all you will focus on the music . . . Let the music become your moving pathway of sound to carry you further and further into hypnosis, and as you move, you will become more and more absorbed by the experience of listening . . . the further you go, the more absorbed you will become in the music and the more responsive you will become to it . . . The music itself is delightful, so the pathway will be a beautiful and a happy one as you move further and further into hypnosis. (*To manage distraction with less than optimally hypnotisable patients/subjects.*) If your mind should wander from the music, don't worry, simply re-focus on the music and let it carry you further.

These suggestions are repeated as often as seems to be necessary or desirable for that particular subject. At the extremes of the continuum of taste or personal need, some people like me to introduce the music, to give the suggestions, and then to say nothing until the end of the deepening, which may be some 10 minutes; at the other end, some find it both enjoyable and comforting to hear my voice almost constantly weaving in and out of the music. If your patient has no idea how much you should talk, you will have to make a guess and use a moderate amount of talking woven into the music.

Begin your own learning as a musical hypnotist by using a piece you know well yourself. Baroque chamber music can make excellent deepening music, and one can suggest that the subject feel the rhythm of the slow drone, resonating peace and relaxation through the body, while focusing attention on the melody (often of the violins), which delight and enchant the mind further and further into hypnosis. Pachelbel's "Canon," especially a slow rendition (not a pretty, fussy one), can be powerful as a deepening pathway. Renaissance dance music can also be very effective, and then the suggestion would be that the mind dance into hypnosis with the music.

The essential ingredients of the suggestions with the music are set out below and you repeat them in different orders as the music goes on, as often as is appropriate:

1. In a little while I will start the CD player and play some music, and you will listen to it in a *special way*.
2. You will let the music pick your mind up and carry it further and further into hypnosis.

3. The music will be a moving pathway of sound to take you further into hypnosis.
4. If your mind wanders, simply lock it into the music again and keep moving further and further into hypnosis.
5. The more you become absorbed in the music the more responsive you will become to it.
6. It is likely you will experience delightful imagery in response to the music, but most of all it will be a moving pathway of sound to take you further and further into hypnosis.
7. The music is itself intrinsically delightful, so your pathway will be an elegant and happy one as you move further and further into the meditational state of hypnosis.

One does find differences among subjects in what kind of music works best for them and some like quieter, less involving music than Baroque chamber music or the music for the Irish harp by O'Carolan. One thought I have had and want to investigate is that high hypnotisable subjects probably prefer music that *captures* consciousness (e.g., Baroque), while less hypnotisable subjects probably respond more to a less powerful stimulus and one wonders about Satie and even some of the modern meditational music by, for example, Stephen Halpern. Research by Dragutonovich and Sheehan (1986) on evoked potential among subjects of varying hypnotic responsiveness is relevant here, with its suggestion that the highly hypnotisable may be "stimulus hungry."

You are able to select among the hypnotic modalities better if you know about the hypnotic gifts and deficits of your patients and the possible differences between the moderately hypnotisable and the hypnotic virtuosi are important in the use of music. Of course it is silly to use hypnosis if the patient is not at all responsive, though combinations of music, guided imagery, and relaxation can be devised. For the low hypnotisables there are plenty of therapeutic magics other than hypnosis and I like people to have a success experience.

As you develop your own confidence and skill in weaving in words with music for deepening, build up your own set of tapes or CDs that delight not just your patients while taking them further into hypnosis, but also *you* the therapist. To test them, try them out on yourself or, if you are not very hypnotisable, get a highly hypnotisable spouse or friend to "test" your pieces as pathways further into hypnosis without the use of words.

To end the deepening phase, fade the volume of the music and give some kind of input to end that sequence:

Now the music is fading . . . listen carefully now to what I say . . . let your mind go calmly, peacefully blank. Let yourself float calmly and peacefully and listen while I map out the next part of the session . . .

With highly hypnotisable subjects, it is quite illuminating to ask them to tell you what they experienced as they moved with the music along their pathway into hypnosis. Although they can be told to remember everything that happened, gifted subjects often remember only a faded shadow of their hypnotic experiences and the content may be therapeutically relevant or may be useful to you, the hypnotist, in refining your suggestions for this patient. In any case, it is quite sure to be interesting.

MUSIC AS PART OF THE CONTENT OF THERAPY

Music has many uses as part of the content of therapy and can provide a great range of input, depending on your own creativity and your particular goals. These goals might include producing particular ranges of *emotions*. It can be illuminating and very therapeutic for a patient, caught in grim conflict or overstressed by the external demands of life, to spend 15 or 20 minutes exploring the many faces of active joy (why not Handel's "Royal Fireworks"?), or the many faces of gentle serenity and peace (what about Gluck's "Dance of the Blessed Spirits"?), or (if it be to the taste of patient and therapist) explore a more spiritual dimension with the religious music of J. S. Bach and experience being part of the overall glory of the universe and the proximity to God. With AIDS sufferers, and with the terminally ill, I use music as a powerful way of producing joy, wonder, the feeling of being loved, the feeling of being powerful, enthusiastic, valuable.

You would introduce the music by telling the patient the range of feelings to be experienced, and you would have the option of building in a suggested fantasy activity along with listening to the music, with the feelings developing and being savoured as the music continued (Walker, 1991a). You might simply suggest that each movement of the music (such as Handel's "Royal Fireworks" or "Water Music") would produce a different scene, each beautiful. You would know the music yourself and would introduce each by saying something to the effect:

The next movement is quietly (boisterously, gracefully, etc.) joyous and as you listen, a scene will build itself vividly in your mind as you experience the quiet (boisterous, graceful, etc.) joy of the music . . .

You can keep the CD player on "pause" while you make your suggestions. A little practice makes one quite skilful at the staging of such experiences. Another alternative is to suggest what the scene will be for each movement and let the patient elaborate on it as the music continues, perhaps with the occasional suggestion woven in.

Of course, after this section of experience, you would have options. You could ask the patient to describe his/her experiences and discuss them. You would certainly bridge the experience across to waking experience by appropriate suggestion, put in with and over the music for maximum effect, and these suggestions would involve such notions as:

1. Experiencing these feelings reminds you of other aspects of living you had almost forgotten; you will find that the very experience feeds a quiet but persistent faith and optimism back in the real world of everyday life.
2. You had almost thought you were incapable of experiencing such feelings and to do so in hypnosis today will increase your self-esteem, make you feel a more interesting, complex, and positive person.
3. You will automatically seek out stimuli to such feelings in everyday life. You will pause to notice the colours of the sunset, sunlight shining on leaves, birdsongs, sparrows bathing, and all the things that are absorbing and delightful to children but that we so often close out of our adult consciousness. Such experiences will feed your optimism, your self-esteem. Joy is the great anti-stress feeling.
4. Each time you experience positive feelings in response to music in hypnosis with me, the experience will be more powerful, more positive, more growth-provoking and you will be increasingly aware, in your own time in between, of the sheer miracle of the gift of life.

Clearly, a great range of music can be used in this phase of the hypnotic session, not limited by the needs of the deepening situation for predictability and a sense of moving on and on without rapid change.

For AIDS patients, the suggestions about response to the music would include a sense of *wellness*, which would be bridged by suggestion over to the waking state. Suggestions could include boosting immune functioning, which could be encapsulated in an image to take away and repeat (why not a fountain of coloured light?)

Although imagery in response to music is individual, the range of feelings produced by music is much more predictable. You can, therefore, select music that generally produces strong, joyous or gentle, peaceful feelings and augment that by *suggesting* the kinds of feelings that will accompany listening to the music, leaving the patient to create the accompanying imagery or fantasy experience him/herself. You will always remember to inquire about the experience, but, of course, how could you resist?

Before leaving the production of emotions as a specific goal, I would suggest that two combinations of feelings are likely to prove of enormous therapeutic value when we learn more about the body chemistry of primitive, pure emotions. One is the combination of wonder and joy, encapsulated for me in the image of a small child holding a tiny, new kitten or a fluffy chicken; the other is that profoundly elevating combination of peace and joy, which to Christians is typified by the image of the new-born Christ; it is elicited by quite a lot of the music of J. S. Bach (for example, the chorale "Kommst du nun, Jesu, vom Himmel", BWV 650).

We are quite accustomed from the movie and video screen to associate visual imagery with music, and music can be a delightful way to augment suggested imagery in therapy. In this case the imagery will be *suggested* and

the music will help with increasing involvement and in the creation of the required mood and feelings.

As an example, I might have a recording of Irish harp music by the blind harpist O'Carolan, which sounds like Irish folk music written by J. S. Bach, O'Carolan having been much influenced by Baroque music. I might start the CD player softly and suggest that the patient is sitting in a lovely green forest (the music is not that of the Australian bush). I might describe the light speckling down from the green canopy of leaves, little wild roses blooming, a soft, gold haze of light . . . then slowly turn up the volume and suggest that the patient's attention is caught by a harpist playing a small folk harp, a blind harpist, with a boy behind him holding his horse, his long fingers rippling over the steel strings of the harp and producing the beautiful, haunting, dancing little melodies . . . I would then suggest further things, absorption, getting lost in music, the feelings appropriate to the piece . . . I may then construct a story that has a metaphorical significance for that patient, or I may let the story take over and let the patient go on constructing it, with me silent.

Another powerful use of music during the therapeutic work stage of the hypnotherapy session is the use of music, with or without suggested imagery, to carry the hypnotist's suggestions so that the words, the music and the imagined imagery will all be woven into a very involving and powerful experience. I believe that the music in this use is particularly good for patients who are only moderately hypnotisable and helps prevent self-watching and self-criticising about the production of imagery, helps the whole experience become more involving and complete. For the highly hypnotisable, however, the experience is a very powerful and quite absorbing one and the actual suggestions are often not available to recall after the session.

Patients, even in depth psychotherapy, love a few sessions from time to time given over to music with the general suggestion of promoting the experiencing of positive feelings and self growth. Remember that many of our most potent *suggestions* are often those given *before* hypnosis begins, setting very powerful expectancies. This helps bridge the hypnotic experience across to the waking state, which is separated by a qualitative gap in recall for very gifted subjects; not usually total amnesia, but a gap such as we have when recalling a dream. I believe that the act of putting the experience into words in hypnosis facilitates more detailed recall back in the waking state.

In simple stress management and anxiety control, use of music as deepening and/or content (and the two can merge), with use of music as the content of self-hypnosis (lazy man's meditation) to be done each day, comprise the core of a very effective and non-meddlesome package. The suggestions incorporated with the music are, of course, selected with care, sensitivity, and, one would hope, some imagination and flair. Always remember that these little sessions should be suggested as sensitising the patient to other sources of peace, joy, wonder, etc. and, of course, adding to the general feeling of being centred and in control of one's own life.

When anger, guilt, and bitterness are an ongoing problem (for example, with AIDS patients), the going-into-hypnosis music can be used to dissolve these corrosive feelings away. Thus Bach's flute and harpsichord music might be a clear, rippling stream of sound that carries him/her on and on into hypnosis and at the same time lightly washes away anger, bitterness, sadness, and the feeling of being trapped . . . The music will ripple and dissolve these away like clear water running through the soul (or whatever). Remember, *the words must suit the values and tastes of the patient.*

There is a great range of music, Renaissance dance music, harp music, lute music, religious music, etc. that my patients/subjects and I find magical with hypnosis and as long as the music is appropriate to the therapeutic purpose we have in mind, people do not mind using the music I have available. Some people love modern meditational music and environmental sounds and it is useful to have some of these, especially for young patients, who can then be lured to Baroque music if you wish. A very nice thing is to make your patients individual audiotapes: induction and deepening (over music or just voice), content, music with suggested feelings and therapeutic suggestions over the music, de-hypnotising (over music if you want to be polished, but it is a good idea to count backwards over the music as well).

For those who like environmental sounds as well as music, I have found that the sound of a tap running onto my dogs' drinking bowl can well mimic a waterfall and that, combined with music from my CD player and the trailing ferns and patterns of light and shade from the words, create an effective and absorbing audiotape for use at home; the sparrows I feed in the backyard have contributed some lovely bird twitterings over music for my hypnotic audiotapes.

THE WHOLE HYPNOTIC SESSION TO MUSIC

My latest style, well received by my patients, is to do the whole session with and over music. It goes like this:

Induction

After a brief statement of how it will work, the patient is asked to close his/her eyes, told to listen to the music which is in itself trance-inducing (Pachelbel's "Canon," Bach's "Arioso") and I weave in the going-into-hypnosis suggestions:

1. Focus on music, let it carry you into hypnosis.
2. Let the body relax and relax as the mind becomes absorbed in the music.
3. I might talk a little about breathing as you listen to music, to relax as you quietly breathe in, relax as you pause, relax as you breathe out as if through your skull, but always listen to the music which carries you into a quiet meditational state.

4. I might draw attention to components. For example, the lower bass drone, its slow beat, and the deep notes will resonate peace and relaxation through your body; the higher melody, for example, defined by the violins, will enchant and delight your mind, carry you further and further into hypnosis.
5. I generally repeat themes of relaxation and peace resonating through the body, the mind becoming absorbed in the music and increasingly responsive to the music.
6. I would continue interweaving these suggestions to comprise an induction and deepening of at least 10 to 15 minutes, not feeling I had to talk all the time.

Content

Content would vary according to the taste of therapist and patient and the therapeutic goals. As the induction music ends, the patients is told that another piece will be played that will, for example, lead him/her on a tour of all the faces of joy. The therapist will talk with and over music, defining the general parameters of the experience and, towards the end of the content music, will make the therapeutic suggestions, including the bridging over to the waking life of what has been experienced and learned in hypnosis.

Alternatively, the therapist will use that music to merge with and augment suggested therapeutic imagery, walking along a beach, through a forest, watching a waterfall, sitting by a still pool.

There is, remember, a very real place for suggestion; the fact that we are working in the imaginative involvement dimension does not mean we can not use the increased responsiveness to suggestion in hypnosis, both in the sense of compliance and (more subtly) of incorporating suggested input into the self-concept. Music can be a powerful vehicle of suggestion (just try Albinoni's "Adagio" after an effective musical induction), so powerful that the words might not be remembered. In this case be very careful that the suggestions are entirely acceptable to the patient; I always work this out with the patient before the hypnosis session and this does not in any way interfere with effectiveness. I would hate to think someone was changing my psyche without my fully informed consent and active collaboration! Further, remembering that the induction with music very likely takes people further into an altered state of consciousness than the traditional inductions, and remembering that subjects in deep hypnosis take our words very literally, do not set up conflict and unhappiness by careless or insensitive wording of suggestions. If your choice of music is inappropriate, then your patient will not feel comfortable with it and will not go far into hypnosis; if you have proper communication and a good, collaborative relationship, the patient will tell you and you will use another piece of music or another induction technique. However, this is not the case with the right music, augmenting the hypnotic depth and then the wrong words in suggestions.

De-hypnotising

Remembering that pauses do not matter to the subject in hypnosis and that spaces that would be unbearable in conversations feel really pleasant in hypnosis, change to your coming-back-with-good-feelings music, your pathway back out of hypnosis. All kinds of music can be effective, depending on how you wish to define the waking world. I have suggested that, for those women who are born dominant but feel guilty about it, Handel's "Arrival of the Queen of Sheba" makes a dramatic and positive way to return to the waking state (Walker, 1991b). Much of the music of Vivaldi is appropriate and delightful as a pathway back to a world that will look brighter after the session. Instructions go along these lines (with and over the coming-back music):

1. This delightful music will be your pathway back to the real world and the waking state.
2. There will be no hurry, time to enjoy the feeling.
3. The music will start leading you back but, after a while, I will count also from 20 to 1, your eyes will open at 5 and you will be wide awake and most pleasantly alert at 1.
4. Coming back with this lovely music will leave you aware of the many sources of peace, joy, and delight in the real world as well as in hypnosis
5. If the music is being used for some special effect, this effect will be suggested.
6. I always weave in with the music counting backwards from 20 back to 1 as a more insistent signal of return to the alert waking state.

Leave the music playing for just a little while and turn the volume down gently.

Debriefing

Do not forget your debriefing stage of the hypnotic session. Asking about the experience and memory of the music and hypnosis will give very useful guides for the refinement of *your* technique. Also, discussing the session in the waking state helps to bridge the magical hypnotic experience across to the waking state and everyday experience.

MUSIC AS A PATHWAY FOR SELF-HYPNOSIS

While self-hypnosis is harmless enough for the moderately hypnotisable, for the hypnotic virtuosi who are psychologically damaged, hypnosis without the safety and guidance of the hypnotist/therapist may permit the reactivation of old traumas, when what was aimed for was peace and relaxation.

If instructed to use self-hypnosis at home, the gifted subject *can* go into trance very readily, giving him/herself the hypnotic instructions. However, like the sorcerer's apprentice, such a patient does not always maintain a positive directing of experience and imagery. In my experience, the hypnotic virtuoso patient needs careful instruction

in exactly how to carry out self-hypnosis and in exactly what is to be done in that altered state of consciousness. (Walker, 1990, p. 57)

Music makes a safe pathway for hypnotic virtuosi and an elegant pathway for self-hypnosis for less hypnotisable patients. With my own patients, who are used to music as deepening and even as the major pathway into hypnosis in the clinical sessions, it is a comfortable and congenial extension of the familiar to use music for self-hypnosis. It is very effective for stress-management and I train patients how to use it in clinical sessions. These days, becoming increasingly aware of the straight teaching/learning component of therapy, I tend to give patients printed instructions for self-hypnosis, written for them individually, with their active collaboration, their own self-hypnosis workbook. Instructions vary for the individual, but, for example, for stress-management self-hypnosis with a patient who was reasonably well adjusted but in the midst of a chaotic life situation, I would give the instructions first during an hypnosis session and would then have the patient return to the waking state and have a short practice run, with me there to prompt the self-suggestions. We would then go to my computer and type and print these instructions. The general line of suggestions would be:

1. You can use the experience of hypnosis at home to break the spiral of mounting tension and anxiety in everyday life.
2. Each day, when you come home from work, you will take 20 or 30 minutes just for yourself. You will select an audiotape or CD of the right sort of music, warn the family to leave you alone for the time, start the music playing, and lie down quietly.
3. You will close your eyes and say to yourself "Now I am going into hypnosis," and focus your attention on the music, just as you do with me when you are using music as your pathway into hypnosis.
4. You will quietly, almost automatically, let your body relax each time you breathe out, as you focus your attention on the music, as you let the music take over your mind and become a moving pathway of sound that carries you peacefully and happily into hypnosis.
5. The further the music takes you, the more involved you will become in listening to it and the further things around you will fade away beyond the peripheries of awareness.
6. As you go on listening to the music, losing yourself in the experience of moving further with it, your body will become profoundly relaxed, while you experience whatever delightful fantasies or images the music makes in your mind.
7. Whatever you experience will be pleasant, since the music will structure your experience and rule out the possibility of your thinking or feeling anything negative.
8. As the music goes on, you will go further and further into hypnosis.

9. When the music ends, no matter how far you have gone into hypnosis, you will register that the music has ended and you will calmly, peacefully, and very deliberately bring yourself back to the waking state.
10. You will feel very refreshed after the session.
11. Each time you practise self-hypnosis in this simple and delightful way, it will become easier and more effective. It will break the build-up of tension from the working day before you join the family circle.
12. Should someone barge into the room or the phone ring, there will be no problem. You will simply let your mind slip back to the waking state with no more disruption than waking from a light sleep.
13. This is a special way of listening to music and you will only do it *on purpose* to get into hypnosis, only when you say to yourself: "Now I am going into hypnosis." You will *never* do this accidentally when you are listening to music in the ordinary way. It will *never* happen when you are driving a car. It is a special experience that you will only produce on purpose.
14. Now we will return to the waking state and afterwards I will play a piece of music and you can practise putting yourself into hypnosis here with me, then you will be confident by yourself.

If a moderately hypnotisable patient has difficulty maintaining concentration on music at home during times of particular stress, a powerful method is to combine active self-talk related to breathing while concentrating all possible effort on the music. This involves responding as fully as possible to the music as the primary focus of attention, while saying (in time with breathing), "Breathe in peace and joy . . . breathe out fear and pain." This is easier said than done and the effort tends to drive out intrusive thoughts and images, while the words have their own effect. The pain can, of course, be mental or physical and the fear can be of failure in the current situation of self-hypnosis or fears from life in general.

CONCLUDING COMMENTS

For those clinicians who are comfortable with music and enjoy it, music and words make an effective and very pleasant therapeutic modality. It is advisable to begin with use of music as a focus of attention for the deepening phase of the hypnotic session, and to begin with familiar pieces of music, so that one's own style of verbal communication with the music can develop without too much performance anxiety. Once the clinician is comfortable in talking before, during, and after the music, the uses of music to elicit emotions and to accompany fantasy and imagery in hypnosis are limited only by the joint creative imaginations of therapist and patient.

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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 or techniques, or simply thought-provoking experiences.

Correspondence regarding these items is also invited.

A CASE OF AGORAPHOBIA CURED BY HYPNOTHERAPY

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As a principle, certain problems with which patients present should be treated in confidence. To that end, much of the therapy I do is structured in such a way that I am not privy to the underlying psychopathology — and very often neither is the patient. In this case a dissociative technique is used in which neither of us knows the cause but the effect is present nonetheless.

In early October 1985 a local psychiatrist sent me a patient who had been seeing him for two years because of severe agoraphobia. At this stage she was not capable of even being driven by her husband for more than a mile or two without feeling very nauseated and developing an extremely dry mouth, so much so that during our initial interviews she was constantly sipping water. This was one of the reasons why, initially, she was unable to relax enough to go into trance.

Before the problem she was a fairly-well-paid and competent accountant, but as a result of her agoraphobia had been unemployable all this time.

After four sessions of talk, getting used to me and the idea of trying to relax in my presence, she was eventually able to go into trance and once this had been achieved faster progress was made.

The hypnotherapy employed was to initially use the progressive relaxation technique of sitting in a chair, looking at a spot on the wall, and progressively

relaxing all the muscle groups from the toes upwards to the eyelids. The imagery was suggested of walking along a desert island beach and taking herself further and further into trance with each step as she walked. Then, while in the progressive deepening of this, she was encouraged to stay there with her conscious mind while I talked to her unconscious mind about the following issues:

1. General relaxation and the importance of practising this.
2. Being able to sit in and travel in a car.
3. Being able to eat and drink as well as ever.

I then said to her unconscious mind that it should get the three parts together, confer and come up with a plan of campaign to enable her to cope with these things. The unconscious mind was then asked for an ideomotor signal to indicate that this strategy had been worked out and was acceptable. Her unconscious was then asked to rejoin her conscious mind on the beach and continue to walk at ease to further relaxation.

After that the "secret place" fantasy technique was used, encouraging her to "throw out" any negative things in her life (making it quite clear that she could lose those private problems which she, and only she, needs to know about). After allowing her to accustom herself to her "secret place" and telling her that she may always return there whenever she wishes when practising self-hypnosis, she was brought back to her normal state of awareness.

After just two sessions she had reached the stage of being able to go away for a weekend at the family shack 200 kilometres away. Another eight sessions and she was feeling so good that she drove herself to my rooms.

From then she has continued to make steady progress and is now coping with a full-time job with a local company.

BOOK REVIEWS

On Jung. Anthony Stevens. Harmondsworth. Penguin. 1991. x + 292. £8.99, paper.

"It is not possible to give a complete outline of Jungian psychology in a volume of this size and critics will find much that I have left out or treated too superficially" (p. 275). Thus does Stevens pre-empt the criticism which can always be made of introductions to, and summaries of, the works of the great.

The first section of the book summarises Jung's unique contributions to psychology. Stevens discusses the self, persona, shadow, anima and animus, the archetypes, the adaptive and compensatory nature of dreams, the personal and collective unconscious, and the biological basis of the psyche. The status of these concepts *vis à vis* the body of analytical theory and points of disagreement, particularly with Freud, are appraised. Where appropriate these disagreements are related to the intellectual fashions of the period. Jung's analytical psychology and Freud's psychoanalysis are nicely differentiated. Jung is more or less cleared of the charge of Lamarckianism, on the basis of misunderstanding of his earlier (at times prolix) writings. Stevens tells us, with supporting quotes, that Jung resolved this and other misinterpretations in his later works. The period of apprenticeship to Freud, the fruit of this collaboration, thence Jung's separation from his one-time father figure are neatly charted.

The second and third sections of the book are structured around the stages of life from birth, early maturity, mid-life through to death. Stevens cheerfully acknowledges that he has stressed "the biological foundations of Jungian theory and its application to the developmental problems of childhood and adolescence" (p. 276), these being his own particular interest. Having acknowledged this interest, Stevens nevertheless gives a satisfying account of Jung's writings from the latter half of life, and of course the life and productivity of the Grand Old Man himself bear witness to his own theorising. "My life is what I have done, my scientific work; the one is inseparable from the other. The work is an expression of my inner development" (C.J. quoted on p. 3).

While reminding myself that it is not the function of this review to comment on Jung's work, I cannot resist recommending the section on late-life transition and late maturity (i.e., older age) to those who find themselves dismayed and demoralised by the tyranny of the young. "What I am saying here is not for the young" (C.J. quoted on p. 208). "The idea that even in old age we

are growing towards realisation of our full potential distinguishes the Jungian approach to developmental psychology from virtually all others" (p. 225).

Stevens has written an able introduction and done some very neat splicing of the development of Jung's theories with his life process, supported by numerous quotations from the autobiography, the collected works, and from other well-known psychologists. The book is well laid out, soundly documented, well indexed with ample bibliography and useful references for further reading following each chapter. He has succeeded well in his endeavour "to give the reader a feeling for the nature of the man and his work by tracing through his life — the life cycle of our species — what I see as certain crucial threads" (p. 275).

The emphasis on the biological foundations of Jung's theories will come as a surprise to the inhabitants of the cosmic cabbage patch who pick up only the esoteric aspect of Jung's work and soar into mystical orbit with no awareness of the biological grounding of such concepts as the archetypes and the collective unconscious.

The book is a good read and gives a reasonably accurate account for the beginner — student, questing general reader — to decide whether he/she wishes to continue the exploration but has been daunted by the volume of Jung's collected works. For the non-Jungian psychologist it is a useful starting point. The text abounds in enticing quotations, for example: "The prerequisite for a good marriage is the licence to be unfaithful" (C.J. quoted on p. 158). For further elaboration please heed Stevens' plea to continue to the original works.

One small complaint — why does Stevens continue doggedly to refer to "superego" when Jung himself is dismissive of Freud's superego concept as too simplistic and restrictive for what he terms "the moral complex"?

And what a relief to be able to read without the irritation of typos — well almost — two minor slips on my count.

MARGARET KERANS, Edgecliff.

The Practical Application of Medical and Dental Hypnosis. Milton H. Erickson, Seymour Hershman, and Irving I. Sector. New York. Brunner/Mazel. 1990. xv + 464. \$42.00

Don't be fooled by the publication date. This book is a re-issue of the 1961 volume with a new foreword by Jeffrey Zeig. He lists 10 fundamental postulates of Ericksonian hypnosis, giving a good framework for understanding the way Erickson worked as exemplified in this book and others.

Much of the material is derived from postgraduate clinical seminars conducted by the authors. There are plenty of tidied-up semi-verbatim transcripts of demonstration sessions, and the reader will rapidly gain an understanding of the approach embodied in them.

Early theoretical chapters on the history and theories of hypnosis, the phenomena of hypnosis and hypnotisability strike one as very dated. For

example, even though the majority of Ericksonian practitioners do not approve of standardised measures of hypnotisability, at least some mention of their existence might be made. These areas are such that a simple reprinting of the 1961 text is simply not good enough.

On the other hand, the practical chapters on induction techniques, surgical anaesthesia, obstetrical hypnosis, hypnosis with children, and some uses of hypnotic techniques in general medicine, psychiatry, dentistry and psychology present the most approachable presentation of Ericksonian techniques that I have so far seen.

The practitioner will find "recipes" for dealing with many common symptoms, but the greatest value of the book is that it outlines fundamental principles and gives sufficient examples for the clinician to adapt the techniques to his or her own practice.

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