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The Effectiveness of a Hypnotic Ego-Strengthening Procedure for Improving Self-Esteem and Depression

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The study examined the effectiveness of an ego-strengthening hypnosis (ES) in improving state self-esteem (State Self Esteem Scale, SSES) and reducing depression score (BDI-II). Participants receiving the ES procedure were compared with a control group receiving a progressive relaxation (PR) procedure. In week one, groups of participants completed the SSES, Marlowe–Crowne Social Desirability scale, BDI-II, and Therapeutic Reactance Scale (TRS), and then received either the PR or the ES protocols. The Phenomenology of Consciousness Inventory (PCI) was completed in reference to each of the protocols. In week two, after completing the SSES and the BDI-II, all subjects experienced the Harvard Group Scale of Hypnotic Susceptibility (HGSHS:A). The PCI was also completed in reference to the HGSHS:A. On the average, the participants reported improvement in both self-esteem and depression in both the ES and PR conditions. Other results suggest that while the high hypnotisable subjects (based on the HGSHS:A) benefited more from the hypnotic procedure, the lows benefited more from progressive relaxation.

Many investigators, whether it is in the treatment of eating difficulties (Bennett, 1994), bulimia (Vanderlinden & Vandereycken, 1994), smoking (Barber, 2001), insomnia, acute and chronic pain (Mjoseth, 1997), sexual abuse

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(Darken, 1992), stuttering (Moss & Oakley, 1997), anxiety and depression (Stanton, 1979), or assertiveness (Stanton, 1990), recognise that building of confidence in one's ability to cope with or solve problems is a necessary ingredient of hypnotic interventions. This type of emphasis can also be seen in several articles on "empowerment" published in the October 1999 issue of the *American Journal of Clinical Hypnosis* (Daniel, 1999; Hornyak, 1999; Linden, 1999; Mutter, 1999).

More recently, Phillips (2001) observed that "ego-strengthening approaches originating from the hypnotic tradition can enhance the effectiveness of EMDR protocols" (p. 259). Hammond (1990) recommends the use of reinforcement, both in and out of trance, as part of hypnotic interventions. Barber (2001) includes ego-strengthening suggestions as part of a smoking cessation program through hypnosis, "to encourage and support the patient's healthy decision and to inspire the development of new behavior that competes with the old habit" (p. 258). Vanderlinden and Vandereycken (1994) used ego-strengthening suggestions in the treatment of obesity to reduce feelings of weakness and powerlessness against the person's problem and negative body image.

When one uses hypnosis as a tool to primarily improve self-esteem, the technique is known as ego-strengthening, a term popularised by Hartland (1971). The term ego-strength has been defined by Calnan (1977) as the efficacy of dealing with the environment, or more specifically, the ability to adapt to external demands and to adjust to internal demands. Therefore, ego-strengthening suggestions are intended to increase an individual's ability to cope with or adjust to difficult environmental demands. It is hardly surprising, then, that ego-strengthening is considered to be important to the process of psychotherapy (see Phillips, 2001).

McNeal and Frederick (1993) have regarded ego-strengthening as the foundation upon which other hypnotic techniques are built. Phillips (2001) observed:

> From a systems perspective, often applied to families and organisations, strengthening approaches attempt to increase client access to positive, healthful aspects of the system and extend their influence over immature, less constructive aspects. This is also true of hypnotic ego-state therapy, which works with the internal system of self to increase interaction between mature, functional aspects of personality and extend their influence over more childlike and dysfunctional states (McNeal & Frederick, 1993; Phillips & Frederick, 1995). (p. 248)

Ego-strengthening may have many beneficial effects: improved therapeutic alliance, heightened insight on the patient's part, increased thought clarity, improved self-esteem, and shortened average length of therapy; it is thought that patients may not be willing to give up their symptoms until they feel strong enough to do without them (Hartland, 1971; McNeal & Frederick, 1993)

A variety of types of suggestions, both direct and indirect, are employed for ego-strengthening. Direct suggestions may include a series of encouraging and affirming suggestions given to a person while in a hypnotic state (Calnan, 1977). Indirect suggestions may take the form of metaphors, stories, and images (e.g., safe place, inner adviser, inner helpers) with specific messages (see Phillips, 2001; Stanton, 1993), all aimed at restoring the patient's self-confidence and ability to cope with problems (Stanton, 1989). According to Hartland (1965, 1971) and Stanton (1997), patients tend to improve with generalised ego-enhancing suggestions that are not aimed at a specific symptom.

Although there is some research that shows that ego-enhancing suggestions can assist individuals gain control over their lives (Stanton, 1997), or be effective at improving one's quality of life in general (Calnan, 1977), there is little systematic research that supports the use of ego-strengthening procedures in specifically improving self-esteem. Even less is known about the generalised effects of improving self-esteem suggestions on reducing specific ailments. Traditionally, self-esteem has been looked upon as a relatively stable personality trait (Rosenberg, 1986). Perhaps the trait viewpoint and a lack of an appropriate instrument to measure changes in self-esteem may have hampered research on improving self-esteem through hypnosis. However, Heatherton and Polivy's work (1991) suggests that self-esteem can improve or lower in response to success or failure of interventions. Thus, they developed the State Self-Esteem Scale (SSES) to assess "momentary changes in self-esteem that occur as a result of laboratory manipulations" (p. 905).

Spencer, Kumar, Pekala, and Conte (unpublished) used the SSES in a study in which a hypnotic intervention was used with the intention of improving self-esteem. In their study, subjects were tested for their self-esteem (SSES, Form 1) in the first week and then tested for their hypnotisability either with the Harvard Group Scale of Hypnotic Susceptibility, Form A (HGSHS:A, Shor & Orne, 1962) or the phenomenologically based Hypnotic Assessment Procedure (PCI-HAP, Pekala, 1995a, 1995b). In the following week, the subjects received an ego-strengthening protocol, a revised version of Pekala (undated, unpublished) self-hypnosis protocol, and then the subjects completed

the SSES, Form 2 (items from the SSES, Form 1 were reordered to form the SSES, Form 2). Spencer et al. found that hypnosis did result in an increase ($p < .001$) in mean self-esteem scores from pre-test to post-test. Examining their data differently, they noted that 8% showed a decrease in self-esteem scores (- 1.0 SEM change), 60%, no change (± 1 SEM), and 32% showed an improvement of 1 SEM. (The SEM here refers to the standard error of measurement of the difference scores.)

Spencer et al. were also interested in determining how well the change in the SSES scores were predicted by the two assessment instruments, the HGSHS:A and the PCI-HAP. The predicted Harvard Group Score (pHGS) were computed from the participant's responses to the Phenomenology of Consciousness Inventory (PCI; Pekala, 1982/1991b) completed in reference to the PCI-HAP procedure. The pHGS scores, also referred to as the hypnoidal score (Pekala & Nagler, 1989), may be regarded as a measure of subjective hypnotisability, giving an estimate of a person's trance level achieved in reference to a stimulus situation. In contrast, the HGSHS:A score is usually seen as an objective or behavioural measure of hypnotisability. The pHGS scores were also computed from the PCI, in reference to the ego-strengthening protocol (subjects completed the PCI in reference to a sitting quietly period embedded within the protocol), thus assessing the extent of subjective hypnotisability experienced during the intervention itself. They observed that while the HGSHS:A was predictive of changes in self-esteem as a result of an ego-strengthening intervention ($r = .246$, $p < .001$), the pHGS scores of the PCI-HAP were not ($r = .047$, $p > .10$). However, the pHGS scores from the PCI were better at predicting the change in self-esteem scores when computed in reference to the ego-strengthening protocol ($r = .301$, $p < .001$), supporting the notion that trance levels achieved during an intervention are important to the success of the intervention. A recent study by Pekala and Kumar (2000) replicated the above results with the pHGS scores. Specifically, they found a significant correlation ($r = .44$, $p < .01$) between the pHGS (obtained from the PCI completed in reference to a two-minute sitting quietly period during the ego-strengthening intervention) and change in SSES scores at one-week follow-up. The correlation approached significance at approximately two-week follow-up ($r = .31$, $p < .06$).

Nevertheless, Spencer et al. cautioned that the correlations of hypnotisability with their outcome measure (changes in self-esteem) were quite small regardless of the conditions. For example, the HGSHS:A only accounted for about 6% of the variance in the changes in the self-esteem scores, implying that using the HGSHS:A as a screening instrument is likely to result in many false negatives.

THE PRESENT STUDY

There has been little research, like that of Spencer et al.'s (unpublished), done to assess the effectiveness of ego-strengthening procedures in actually raising self-esteem. This study was designed to replicate and extend Spencer et al.'s study with some modifications in design and using an improved ego-strengthening protocol. The main purposes of this study were to examine: (a) if the revised ego-strengthening protocol improved self-esteem scores, relative to a control group which received progressive relaxation instructions; (b) if increases in self-esteem generalise to reducing symptoms of depression; and (c) the relationship between hypnotisability and improvement in state self-esteem score and depression scores.

As in Spencer et al.'s study, both objective (HGSHS:A) and PCI-based subjective measures were used to assess hypnotisability. The PCI-based measures were obtained both in reference to the HGSHS:A as well as to the ego-strengthening protocol and a control protocol of progressive relaxation. However, this study differed from Spencer et al.'s in a number of ways. In the latter study, a pre–post design was utilised where ego-strengthening was done once and students' self-esteem was tested one week prior to the intervention (prior to HGSHS:A) and immediately after the intervention a week later. In this study the effects of intervention were tested after one week (i.e., subjects completed the SSES in week one, then received the ES, and in the following week were retested with the SSES). A second difference between the present study and that of Spencer et al. was that this study employed a control group, which received progressive relaxation. Unlike the previous study, the HGSHS:A was administered in the second week following the assessment of self-esteem. Given that hypnotisability is regarded as a trait (Piccione, Hilgard, & Zimbardo, 1989), it was thought it should not make a difference whether it was administered prior to or after the intervention. Administering the HGSHS:A during the second week allowed a more efficient use of time in that it allowed the completion of the study in two weeks and examination of

the effects of intervention over a one-week period. Spencer et al. assessed hypnotisability by means of the HGSHS:A and the PCI-HAP, and they also assessed subjective hypnotisability by means of the PCI completed in reference to the intervention protocol. In this study, the PCI-HAP measure was not used. However, the PCI was used to obtain a measure of subjective hypnotisability in reference to the HGSHS:A, as well as the progressive relaxation, and the ego-strengthening protocols. Additionally, two other measures were included: the Beck's Depression Inventory-II and the Therapeutic Reactance Scale (TRS; Dowd, Milne, & Wise, 1991).

The TRS, conceptualised as a trait measure of an individual's resistance to therapy, was included to see if it was related to the two treatment outcomes. The Marlowe–Crowne Social Desirability (MCSD; Crowne & Marlowe, 1960) scale was used as a possible covariate to statistically control for possible demand characteristics operative in the experimental situation. Heatherton and Polivy (1991) found that the SSES scores tend to be correlated with social desirability, results that were replicated in Spencer et al.'s study. However, in the Spencer et al. study, although the social desirability scores were correlated with the pre- and post-test SSES scores, they were not correlated with the change in the SSES scores. Thus, the latter study did not use the MCSD as a covariate. It is possible that in that study, the use of the shorter version of the MCSD may have resulted in lower variability and in turn to the lack of a significant correlation with the change in SSES scores. Thus the full MCSD scale, and not the shorter version, was used in this study.

METHOD

Participants

Undergraduate students (n = 224) from West Chester University's Introductory Psychology classes participated in the study to fulfil a departmental research requirement. Participation was voluntary inasmuch as they could participate in any of the ongoing projects or complete a project under advisement. Participants could terminate their participation at any time with impunity.

Instruments

1. *The Phenomenology of Consciousness Inventory (PCI) Form 1* (Pekala, 1982/1991a) consists of 53 items completed retrospectively in reference to a stimulus condition. The PCI provides scores on the following major and

minor dimensions: (joy, sexual excitement, and love); negative affect (anger, sadness, and fear); altered experience (body image, time sense, perception and meaning); visual imagery (amount, vividness); attention (direction, absorption); self-awareness; altered states of awareness; internal dialogue; rationality; volitional control; memory, and arousal. The PCI has shown evidence of both adequate reliability and discriminant validity (See Pekala, 1991a, for supporting studies).

2. *The Therapeutic Reactance Scale* (TRS; Dowd, Milne, & Wise, 1991) consists of 28 items that investigate one's level of opposition towards any therapeutic intervention.
3. *The State Self-Esteem Scale* (SSES; Heatherton & Polivy, 1991) consists of 20 items modified from the widely used Janis–Field Feelings of Inadequacy Scale. Rated on a 5-point scale, the items are aimed at measuring the individual's current thoughts about their self-esteem. The SSES has three correlated factors: performance, social, and appearance self-esteem. For the current study, only the total self-esteem score was of interest.
4. *The Marlowe–Crowne Social Desirability Scale* (MCSD; Crowne & Marlowe, 1960) consists of 33 true or false items. The MCSD examines the individual's tendency to appear favourable in the eyes of others. It is correlated with approval dependency, vulnerable self-esteem, defensiveness, and impression management (Jorgensen, Gelling, & Kliner, 1992).
5. *The Beck Depression Inventory-II* (BDI-II; Beck, Rush, Shaw, & Emery, 1979) is a popular measure of a participant's state of depression over the past two weeks, including the present day. However, in the present study, the participants were asked complete the BDI-II in reference to how they felt in the past week, including today, as opposed to the past two weeks. This change was made in order to assess changes in depression during the one-week interval between the pre- and post-intervention sessions.
6. *The Harvard Group Scale of Hypnotic Susceptibility, Form A* (HGSHS:A; Shor & Orne, 1962) is a popular measure of hypnotic susceptibility for administration in groups.

Protocols

1. *Progressive Relaxation* The protocol by Pekala (undated, unpublished), used in this study, consists of instructions for tensing and releasing muscles in order to enhance one's state of relaxation.

2. *Ego Strengthening Protocol* Pekala and Kumar's (1999) ego-strengthening hypnosis protocol includes body scan relaxation, mind calming, and ego-strengthening suggestions, along with a two-minute sitting quietly period. This protocol was a revision of the one used in Spencer et al.'s study. The primary modification for the previous protocol was in increasing the number of ego-strengthening suggestions.

Design and Procedure

Sessions lasted approximately one hour in length each and were spaced one week apart. Participants were tested in groups, up to a maximum of 70 students at a time. Groups were randomly assigned to one of two conditions, experimental or control, with the restriction that there would be about an equal number of subjects in each of the two groups. The experimental group received the ego-strengthening procedure (ES) whereas the control group received progressive relaxation (PR).

In both conditions, the participants were informed that (a) the purpose of the study was to examine the relationship between aspects of personality and hypnotisability, (b) they would first complete some questionnaires and then experience a hypnotic procedure during which they will receive suggestions for relaxation to help them cope better with everyday situations, (c) following the procedure they will be asked to complete another questionnaire, and (d) they will experience a standardised hypnosis test when they return next week and complete some questionnaires. As can be noted, in the above instructions (a) no reference was made to the term self-esteem so as to make the instructions suitable for both the control and the experimental conditions, and (b) the word hypnosis was used in the instructions for both conditions to allow for the same type of expectancy effects to occur in the two conditions.

In week one, following the completion of the questionnaires (the MCSD, SSES, TRS, and BDI-II), the subjects experienced the ES or the PR protocols, read verbatim by the experimenter. Near the end of the protocols, the participants were told:

> For the next minute or two, I want you to become aware of what it feels like to be in the state you are now in. For the next minute or two, I'm going to stop talking and I want you to just continue to relax and experience what it feels like to be in that deeply relaxed, self-hypnotic, quiet state you are in. Be aware of what it feels like to be so relaxed and so at ease, and, at the end of 2 minutes, I will start talking again. Begin now and just enjoy the deeply relaxed state you are in.

Immediately after the 2 minutes when the experimenter stopped talking, known as the two-minute sitting quietly period, participants received the following instructions:

> Just remain calm and relaxed, calm and at ease. Please make a mental note of what you are experiencing, what you were thinking and feeling when I stopped talking, because I will afterwards ask you to complete a questionnaire in reference to your experience at that time. That's right, just take a moment now and make a mental note of what you were thinking, feeling, and experiencing when I stopped talking.

The participants were given one minute to make a mental note and then asked to complete the PCI in reference to the two-minute sitting quietly period.

In week two, both groups first completed the SSES and the BDI-II at the beginning of the session. Next, both groups experienced the HGSHS:A. Following the HGSHS:A, participants completed the PCI, in reference to a two-minute sitting quietly interval immediately following the eye catalepsy item but prior to the post-hypnotic suggestions and amnesia instructions. In preparation for the two-minute sitting quietly interval, participants received the following instructions: "For the next minute or so I'm going to stop talking, and I want you to experience the state you are in right now. That's right. For the next several minutes, I'm going to stop talking, and I want you to continue to experience the state you are in right now."

After the two-minute sitting quietly period, the participants were given an additional minute to make a mental note of what they were experiencing. After the counting out sequence of the HGSHS:A, the participants completed the amnesia item, the PCI and the remaining 11 response items of the HGSHS:A.

RESULTS AND DISCUSSION

Preliminary Analysis

Complete data, over both weeks, were obtained from 213 out of the 224 students (ES = 117 & PR = 96) who participated in the study.

The PCI ratings were obtained using a 5-point scale, but were linearly transformed to a 7-point scale to facilitate the interpretations of the scores per norms given by Pekala (1995a). Each subject's responses to five pairs of duplicate items were examined to assess intratest reliability on the PCI. The average reliability index for each subject was computed by dividing the sum

of the absolute difference between the item pairs by 5. Those subjects whose average reliability index exceeded 2.0 were excluded from the analysis (see Pekala, 1991a for the rationale for this method of computing reliability). Only the analyses pertaining to the PCI were based on subjects who responded reliably to the PCI.

Changes in Self-Esteem as a Function of Experimental Conditions and Hypnotisability

A purpose of this study was to examine if the participants' state self-esteem scores (SSES) improved as a result of the intervention and if the improvement in the scores were related to their hypnotisability. Change in state self-esteem scores were derived by subtracting the pre-intervention from the post-intervention SSES scores. Three groups of hypnotisability subjects were formed using the cut-off scores used by Kirsch, Council, and Wickless (1990) for the Harvard scale: low = 0 – 4; medium = 5 – 9; and high hypnotisability = 10 – 12.

Analysis of Covariance The MCSD was included in the present study for use as a possible covariate to control for demand characteristics, since prior studies have shown it to be correlated with the SSES scores (Heatherton & Polivy, 1991; Spencer et al., unpublished). In this study, the correlations between the MCSD and SSES pre-test scores ($r = .419$, $p < .001$, $n = 96$), SSES post-test scores ($r = .300$, $p < .003$, $n = 96$), and changes in SSES scores ($r = -.223$, $p < .029$, $n = 96$) were found significant in the PR condition. In the ego-strengthening condition, the MCSD scores were significantly correlated with the SSES pre scores ($r = .314$, $p < .001$, $n = 117$), and the SSES post scores ($r = .318$, $p < .001$, $n = 117$), but not correlated with change scores on SSES ($r = -.006$, $p > .10$, $n = 117$).

Given that there were significant correlations between the MCSD and the SSES scores, it was decided to include the MCSD as a covariate. The analysis of covariance (ANCOVA) design used was a 2 (between) × 3 (between) × 2 (within). The between factors were condition (progressive relaxation and ego-strengthening) and hypnotisability (low, medium, and high groups). The within subject factor was the effect of intervention (i.e., pre- vs. post-test scores on the SSES).

The results showed that neither the main effect of experimental condition (F [1,206] = .70), nor hypnotisability (F [2,206] = .61) were significant. Likewise, the experimental condition × hypnotisabililty interaction was not

significant (F [2,206] = .46). However, the main effect of intervention (post – pre) was significant (F [1,206] = 11.63, p = .001). The adjusted means for the SSES post-test scores were higher than pre-test scores (post M = 72.33 and pre M = 69.26), suggesting that there was an improvement in self-esteem scores across both conditions. The effect of intervention (post – pre) × experimental condition interaction was not significant (F [1,206] = .58). The effect of intervention × hypnotisability interaction was not significant (F [2,206] = .26). However, the three-way interaction between hypnotisability, condition, and the effect of intervention (post – pre) was marginally significant (F [2,206] = 2.703, p = .069). The adjusted means for this interaction are displayed in Table 1.

An examination of the means in Table 1 suggests that the more hypnotisable participants showed a greater improvement in their self-esteem, relative to their low counterparts, in the ES condition. In contrast, the lows were more responsive than the highs in the PR condition. The medium hypnotisable participants seemed equally responsive to both PR and ES interventions. Although, this interaction effect was only marginally significant, it is consistent with the expectation that high, relative to the low, hypnotisable participants are more likely to respond better to a hypnotic intervention. The finding that low hypnotisable participants responded better to progressive relaxation is not easy to explain, but is remindful of Wickramasekera's (1988; see also Pekala & Kumar, 2000a) observation that biofeedback or cognitive therapy may be more useful for low hypnotisable clients, but hypnosis is better for high hypnotisable clients.

Table 1: Adjusted Means for the Three-Way Interaction Between Hypnotisability, Condition, and the Effects of Intervention

	Hypnotisability					
	Low		Medium		High	
Condition	Post	Pre	Post	Pre	Post	Pre
PR	71.69	66.31	70.70	67.60	73.25	71.33
	(n = 27)		(n = 40)		(n = 29)	
ES	71.18	69.76	73.17	71.10	74.00	69.50
	(n = 28)		(n = 63)		(n = 26)	

PR = Progressive relaxation; ES = Ego-strengthening.

Given that the participants knew that they were participating in a hypnosis experiment, an interesting question raised was whether in the PR condition the low hypnotisable participants achieved a higher level of subjective trance (as indicated by the pHGS scores), and if in the ES condition the high hypnotisable showed higher levels of subjective trance relative to the medium and low groups. An earlier study by Pekala and Forbes (1988) found that "progressive relaxation and hypnosis may be relatively equivalent methods to induce hypnoidal effects for highs. In contrast, the low hypnotically susceptible individuals appear to have greater hypnoidal effects during progressive relaxation than hypnosis, although those hypnoidal effects for lows were less than those obtained by highs during either hypnosis or progressive relaxation" (p. 129). A 2 (condition) × 3 (low, medium, and high hypnotisability, based on the HGSHS:A) analysis of variance on the pHGS scores did not support the above assertion inasmuch as the interaction effect was not significant (F [2,176] < 1.0). Additionally, the main effect of the experimental condition (F [1,176] = 1.91, $p > .10$) was not significant. However, the main effect of hypnotisability was significant (F [2, 176] = 9.28, $p < .001$) suggesting that higher levels of objective hypnotisability (HGSHS:A) were associated with higher levels of subjective hypnotisability or subjective levels of trance (the mean pHGS were as follows: low = 4.54, medium = 4.96, and high = 5.87), replicating previous work (Pekala & Kumar, 1984, 1987).

An analysis was also done to see if participants who had low pre-intervention SSES scores showed the greatest amount of change as a result of the interventions. Three groups were formed—low, medium, and high self-esteem—based on the SSES pre-test scores. The three groups corresponded to those scoring at or below quartile one, at or above quartile three, and those falling in between the two quartile points. A 2 × 3 two-way analysis of variance with condition (PR vs. ES) as one factor and the three pre-test-based SSES groups as a second factor was performed. The dependent variable was the change in SSES scores. The results showed that the main effect of condition was not significant (F [1,207] < 1.0). The main effect of the pre-test groups was significant (F [2,207] = 13.84, $p < .001$). The experimental condition × pre-test groups interaction was not significant (F [2,207] = 1.93, $p > .10$).

An examination of the main effect of the pre-test-based group means suggests that indeed it was the participants with low self-esteem that showed the greatest improvement in self-esteem (M = 6.33) followed by the medium group (M = 3.00), and the highest group showed almost no change (M = -.70). The Scheffé's post hoc test showed that the three groups differed

from each other significantly ($p < .05$). The students with high SSES pre-test scores do not have much room for improvement, but they could have shown a decrease in self-esteem scores. However, it seems that, at least, the high scoring students maintained their initial level of self-esteem over the one-week interval. Pending replication, these results suggest that the progressive relaxation and ego-strengthening hypnosis may serve both improvement and maintenance functions.

Correlations of the Objective and Subjective Hypnotisability Measures with Change in the SSES Scores The relationship between hypnotisability and improvement in the SSES scores in each of the two conditions were examined by computing the correlations between change in the SSES scores (post – pre) and the HGSHS:A scores, with and without partialling out the MCSD scores. In the PR condition, the partial correlation between the HGSHS:A and SSES change scores was marginally significant (partial $r = -.186$, $p < .071$). In the ES condition, the partial correlation between the HGSHS:A and SSES change scores was significant ($r = .193$, $p < .039$). The zero-order correlations (between the HGSHS:A and SSES changes scores) for the PR and ES conditions were -.239, $p < .019$, and .192, $p < .038$, respectively. These results are consistent with our previous analysis suggesting the tendency of the low hypnotisable participants to benefit more from the progressive relaxation procedure and the high hypnotisable participants to benefit more by the hypnotic procedure.

The pHGS scores were obtained not only in reference to the HGSHS: A, but also in reference to the two treatment protocols (i.e., PR & ES). Thus, we could compare how well the objective (HGSHS:A) and subjective hypnotisability scores (obtained in reference to the intervention protocols and the HGSHS:A) predicted the changes in SSES scores. The partial and the zero-order correlation of the pHGS scores obtained in reference to the PR protocol in week one and in reference to the HGSHS:A in week two in the PR condition were all not significant ($p > .10$) and thus are not reported here.

In the Spencer at al. study, the pHGS scores and the change in SSES scores were significantly correlated when obtained in reference to the HGSHS:A and in one of the intervention conditions; thus, the above results were inconsistent with those found by Spencer et al. However, consistent with the results obtained by Spencer et al.'s study, the HGSHS:A correlated low, albeit significantly, with the change in SSES scores.

Frequency of Change Scores in SSES The frequency distribution of the SSES scores was examined to see if the frequencies of students who showed a

decrease, no change, or improvement in the scores were a function of the experimental conditions (PR vs. ES). The advantage of this analysis, as opposed to examining changes in mean scores, is that one could evaluate changes in terms of increases, decreases, or no change in self-esteem in reference to some pre-specified cut-off change scores. The cut-off scores were determined by using the criterion of ± 1 (SEM or the standard error of the difference between pre and post scores across both PR and ES conditions). The SEM of the difference score being 5.25, the students were divided into three groups, no change (0 ± 5), decreased self-esteem (– 6 and below), and improved self-esteem (6 and above).

A chi-square analysis (see Table 2) showed no significant association between the experimental conditions (ES vs. PR) and change in the SSES scores (χ^2 = .486, p > .10). The percentages of people, who showed improvement in self-esteem, across both conditions, were 31.9%; 56.3% showed no change, and 11.7% showed a decrease in self-esteem. Spencer et al. had also found that approximately 32% of the participants group showed a positive change in their self-esteem due to their ES protocol. Our results extend those of Spencer et al. inasmuch as the self-esteem improvement occurred over a one-week interval in this study. The result that 29.9% of participants in the ES and 34.4% in the PR showed increase in self-esteem is an important finding suggesting that these protocols can be effective for some individuals. Given results reported earlier, it seems that while the high hypnotisables may benefit more from ES, the lows are more likely to benefit from PR.

Changes in Depression as a Function of

Table 2: Progressive Relaxation Vs. Ego-Strengthening and Change in Self-Esteem

	SSES change		
Condition	Decrease	No change	Improvement
PR	11 (11.5%)	52 (54.2%)	33 (34.4%)
ES	14 (12%)	68 (58.1%)	35 (29.9%)

Experimental Conditions and Hypnotisability

A purpose of this study was to examine if participants' depression scores (BDI-II) improved as a result of the intervention and if the improvement in scores was related to hypnotisability scores.

Analysis of Covariance The MCSD index was significantly correlated with the BDI-II pre scores (r = -.357, p < .001, n = 96), BDI-II post scores (r = -.254, p < -.014, n = 96), and BDI-II change scores (r = -.213, p < .038, n = 96) in the PR condition. In the ES condition, the following results were obtained: BDI-II pre scores (r = -.197, p < .034, n = 117); BDI-II post scores (r = .228, p < .014, n = 117); and the correlation with the BDI-II change scores was not significant (r = .101, p > .10, n = 117). These findings are similar to those obtained with the self-esteem change scores. Given this pattern of correlations, the MCSD scores were used as a covariate to evaluate the relationship between change in BDI-II scores, hypnotisability, and conditions, and their interactions.

The ANCOVA design was a 2 (between) × 3 (between) × 2 (within) with the between factors of condition (PR and ES) and hypnotisability (low, medium, and high). The within factor was the effect of intervention (i.e., pre vs. post).

The analysis of covariance results showed that the main effect of intervention (pre vs. post scores) was significant F (1,206) = 4.53, p < .05. The hypnotisability × intervention (pre vs. post) interaction was not significant (F (2,206) = 1.42, p > .10). The experimental condition × intervention (pre vs. post) interaction was marginally significant (F (1,206) = 3.51, p < .063). The three way interaction between the intervention (pre vs. post), hypnotisability, and experimental condition (F [2,206] < 1.0) was not significant.

Furthermore, the main effect of hypnotisability was not significant (F [2,206] < 1.0). The main effect of experimental condition was also not significant (F [1,206]< 1.0). The hypnotisability × experimental condition interaction was significant (F [2,206] = 3.11, p < .05), but it was of no interest in this study (since it combines pre- and post-test scores).

Table 3 shows that across both experimental conditions participants' depression scores decreased (from pre to post) significantly. Furthermore, there was a greater decrease in depression scores in the PR condition, relative to the ES condition. Although caution is needed to interpret this interaction, because of the marginal significance, a question of interest is why PR was somewhat more effective in reducing depression than the ES procedure used in this study.

McCloskey, Kumar, Pekala (1999) had found that sadness scores (as measured by the PCI) were lowered following the administration of the HGSHS:A. They speculated that the task-oriented suggestions of the HGSHS:A may have helped the students to divert their mind from their usual sad ruminations. It is possible that the more active nature of the PR procedure, relative to the ES intervention, may have helped reduce depression through diverting their minds from sad ruminations. This is an interesting finding given its obvious clinical application and warrants further investigation.

The above results did not change when the MCSD was not used as a covariate, that is, the result pertaining to the within subjects factor was

Table 3: Means for the Experimental Condition × Effect of Intervention Interaction

		BDI mean scores	
	n	Pre	Post
PR	96	11.64	9.87
ES	117	10.86	10.26
Overall		11.25	10.06

significant even when the MCSD was not used as a covariate (F [1, 207] = 14.07, $p < .001$). Using the covariate did not affect the other results.

Correlations of the Objective and Subjective Hypnotisability Measures with Changes in Depression The relationships between hypnotisability and improvement in BDI-II scores in each of the two experimental conditions were also examined by computing the correlations between change in BDI-II scores (pre – post) and the HGSHS:A scores, with and without partialling out the MCSD scores. In the PR condition the partial correlation between HGSHS:A and BDI-II change scores was .126, $p > .10$. In the ES condition, the same correlation was .161, $p < .10$. The zero-order correlations for the PR and ES conditions were .057, $p > .10$, $n = 90$ and .168, $p < .09$, $n = 108$.

Correlations were also computed between the subjective hypnotisability (pHGS) scores and BDI-II change scores. During intervention, the pHGS scores correlated .136, $p > .10$, $n = 84$ with the BDI-II change scores. The pHGS scores, obtained in reference to the HSGHS:A, correlated .101 $p > .10$, $n = 82$ (these correlations were only computed on participants who completed the PCI reliably).

Additional correlations were computed to see if change in self-esteem scores were correlated with change in depression scores. For the PR condition,

this correlation (with the MCSD partialled out) was .343, $p < .002$; the zero-order correlation was .373, $p < .001$, $n = 90$. For the ES condition, the partial correlation was .317, $p < .001$ and the zero-order correlation was .314, $p < .001$, $n = 108$. Thus the change in self-esteem scores were correlated with change in depression scores in both the PR and ES conditions, suggesting that there was a tendency of the same participants to show changes on both variables.

Frequency of Change in Depression Scores The frequency distribution of the BDI-II scores were examined to see the frequency of students who showed a decrease, no change, or an increase in the BDI-II scores were a function of the experimental conditions (PR vs. ES). To identify the cut-off scores, the standard error of the difference scores (pre-test minus post-test scores) was computed across both conditions. The standard error of the difference scores was found to be 3.41. The cut-off scores were then determined using the criterion of $\pm$ 1 (SEM), the students were divided into three groups, no change (0 $\pm$ 4), decreased depression (5 and above), and increased depression (– 5 and below).

The computed chi-square of .911, $p > .10$, for Table 4 suggested no significant association between condition and change in the BDI-II scores. Approximately 15% of the participants showed a decrease in depression, 7% showed an increase, and 78% showed no change across both the PR and ES conditions. Given that the participants in this study came from a non-clinical population, the depression scores tended to be quite low, and consequently an improvement in 15% of at least 5 points may be regarded as an encouraging finding.

Change in Self-Esteem and Depression as a Function of

Table 4: Progressive Relaxation v. Ego-Strengthening and Change in Depression

	BDI-II change (pre – post)		
Condition	Increase	No change	Decrease
PR ($n = 96$)	5 (5.2%)	76 (79.2%)	15 (15.6%)
ES ($n = 117$)	10 (8.5%)	90 (76.9%)	17 (14.5%)

Therapeutic Reactance and Experimental Conditions

We were interested in examining if a 4-way interaction existed between hypnotisability, reactance, condition, and effect of intervention (pre- vs. post-test). However, the analysis was not feasible due to the small numbers of participants in some of the cells. Thus, a 3-way analysis of covariance was done to evaluate the relationship between reactance, condition, and effect of intervention (post vs. pre) and changes in self-esteem. For this analysis, the MCSD served as a covariate. Three reactance groups—low, medium, and high—were formed by examining the frequency distribution of the TRS scores across all subjects. The cut-off scores corresponding to the low, medium, and high reactant groups were as follows: low = 63 or less (at or below the 25th percentile), medium = 64–74 (between the 26th and 75th percentile), and high = 75 and above (76th percentile and above). The analysis revealed no results of interest, and consequently they are not described in detail here. Similar analyses for the BDI-II revealed no results of interest and consequently are not described further here. Furthermore, the correlations between the TRS and SSES change scores and BDI-II change scores in the ES and PR conditions varied between -.045 and .151 ($p > .10$).

GENERAL DISCUSSION

This study replicated and extended Spencer et al.'s (unpublished) finding of the improvement in state self-esteem scores due to an ego-strengthening intervention, both in terms of average improvement as well as the percentage of subjects (29.9%) showing a change of about +1 SEM (difference scores). However, unexpectedly, an improvement in the self-esteem scores was also observed in the PR condition and the difference between the PR and ES conditions was not significant. These results were obtained over a one-week period after the intervention, whereas in the Spencer et al.'s study the pre-test was given in week one and the post-test was given in week two immediately after the ES intervention. Furthermore, the subjects who showed the greatest improvement were those students who scored low on the SSES pre-test scores. The initially high scoring students maintained their scores over the one-week period. These results suggest that ES and PR may serve both improvement and maintenance functions. These results could not be simply attributed to demand characteristics of the experiment, since a majority of participants in either condition showed no change in the self-esteem scores.

An interesting result was the marginally significant interaction between

hypnotisability (HGSHS:A), condition (PR vs. ES), and effects of intervention (pre vs. post scores). This interaction suggested that while the high hypnotisable participants benefited more from ego-strengthening, the lows benefited more from progressive relaxation. These results suggest that alternative methods such as progressive relaxation may be more suitable for individuals who are not easily hypnotised. An interesting question (see Pekala & Forbes, 1988) that could be raised is: Did the low hypnotisable subjects become hypnotised in PR but not in ES condition, and was the reverse was true for the high hypnotisables? This explanation can possibly be ruled out since in an analysis with pHGS scores (subjective levels of trance achieved during the intervention), the experimental condition × hypnotisability (low, medium, and high categorisation based on the HGSHS:A) was not significant. There does not appear to be a straightforward explanation as to why the high hypnotisable participants responded better with hypnosis and why the lows responded better with the PR.

Hypnotisability as measured with the pHGS (in reference to the intervention) was unrelated to changes in the state self-esteem scores. These results are partially inconsistent with those obtained by Spencer et al. (unpublished) and inconsistent with those of Pekala and Kumar (2000b). The latter study found a significant correlation between the pHGS score, obtained in reference to the ES protocol used in their study, and change in the state self-esteem scores ($r = .44, p < .01$), and the correlation approached significance at approximately a two-week follow-up. Perhaps the inconsistency between this study and Pekala and Kumar's (2000) study may be accounted for by the fact that the latter study used a 7-point scale with the PCI (instead of the 5-point scale used in this study) and tested smaller groups. It is likely that the hypnotic protocol may be more effective with small groups.

The results with respect to depression were similar to those reported for self-esteem, at least, in some respects. The BDI-II scores decreased significantly across both the PR and ES conditions. Approximately 15% of participants in both conditions reported a decrease in depression by at least 1 SEM (difference scores) from no change. Additionally, it was noted that depression scores decreased slightly more (marginally significant) in the PR condition than in the ES condition. It is possible that the active nature of the progressive relaxation, relative to ego-strengthening, intervention may have helped divert individuals from their sad ruminations in the progressive relaxation condition (see McCloskey, Kumar, & Pekala, 1999). The correlations between change in the SSES scores and the BDI-scores in the PR and ES conditions were

positive and significant, and they were of equal magnitude. Thus, there was some evidence of transfer effects of both PR and ES efforts on improvement in depression (see Stanton, 1997).

The analyses in regard to the relationship between level of hypnotisability, as measured by both the objective and subjective methods, and changes in depression produced largely null findings. This may be due to the low variability of the BDI-II scores given that the study used a non-clinical group of participants. It would be interesting to replicate this study with a clinically depressed group of participants. Finally, change in either self-esteem or depression scores were unrelated to resistance to therapy (TRS) scores.

In summary, the main findings were that over a one-week period, both progressive relaxation (34.4%) and ego-strengthening hypnosis (29.9%) were effective in improving self-esteem. For depression, improvement was observed for 15.6% of the participants in the PR condition and 14.5% in the ES conditions. Hypnotisability as measured by the HGSHS:A scores were weakly correlated with changes in self-esteem in both the ES ($r = .193$, $p < .039$) and PR ($r = -.239$, $p < .019$) conditions, suggesting that that in the PR condition, the low hypnotisable participants were more likely to show an improvement in self-esteem, but in the ES condition, the high hypnotisable participants were more likely to show an improvement. Analysis of variance supported the aforementioned correlational findings. The PCI-based hypnotisability measures were uncorrelated with changes in self-esteem. Furthermore, neither the objective (HGSHS:A) nor the subjective measures were correlated with change in depression measures.

Although the results of this study are weak in providing support for the usefulness of assessing hypnotisability, they may be viewed as encouraging, inasmuch as the high hypnotisable participants reported more positive change in self-esteem in the ES condition and low hypnotisable participants reported more positive change in the PR condition. Possible limitations of this study include using non-clinical subjects and implementing interventions in large groups. Hypnotic assessment and interventions may be more useful in clinical populations and better results may be obtained if interventions are done in small groups or individually. Another possible improvement for a future study would be to provide more than one session of the ego-strengthening intervention. A single session of ego-strengthening may be beneficial for some people, but more sessions are likely to be more effective in bringing about a change. It would also be interesting to test if those participants who do

experience changes in self-esteem and/or depression, maintain that change over a period longer than one week.

References

Barber, J. (2001). Freedom from smoking: Integrating hypnotic methods and rapid smoking to facilitate smoking cessation. *International Journal of Clinical and Experimental Hypnosis, 49,* 257–266.

Beck, A. T., Rush, A. J., Shaw, B. E., & Emery, G. (1979). *Cognitive therapy and depression.* New York: The Guilford Press.

Bennett, C. (1994). Treatment of an adolescent boy with eating difficulties using hypnotherapy and systematic desensitisation. *Contemporary Hypnosis, 11,* 33–36.

Calnan, R. D. (1977). Hypnotherapeutic ego strengthening. *Australian Journal of Clinical Hypnosis, 5,* 105–118.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24,* 349–354.

Daniel, S. (1999). The healthy patient: Empowering women in their encounters with the health care system. *American Journal of Clinical Hypnosis, 42,* 108–115.

Darken, R. (1992). Hypnosis in the treatment of survivors of sexual abuse. Australian *Journal of Clinical and Experimental Hypnosis, 20,* 105 – 109.

Dowd, T. E., Milne, C. R., & Wise, S. L. (1991). The Therapeutic Reactance Scale: A measure of psychological resistance. *Journal of Counseling and Development, 69*, 541–545.

Hammond, D. C. (1990). *Handbook of hypnotic suggestions and metaphors.* New York: W. W. Norton.

Hartland, J. (1965). The value of "ego-strengthening" procedures prior to direct symptoms removal under hypnosis. *American Journal of Clinical Hypnosis, 8,* 89–93.

Hartland, J. (1971). Further observations on the use of "ego-strengthening" techniques. *American Journal of Clinical Hypnosis, 14,* 1–8.

Heatherton, T. F., & Polivy, J. (1991). Development and validation of a scale for measuring state self-esteem. *Journal of Personality and Social Psychology 60,* 895–910.

Hornyak, L. (1999). Empowerment through giving symptoms voice. *American Journal of Clinical Hypnosis, 42,* 132–139.

Jorgensen, R. S., Gelling, P. D., & Kliner, L. (1992). Patterns of social desirability and anger in young men with a parental history of hypertension: Association with cardiovascular activity. *Health Psychology, 11,* 403–412.

Kirsch, I., Council, J. R., & Wickless C. (1990). Subjective scoring for the Harvard Group Scale of Hypnotic Susceptibility, Form A. *International Journal of Clinical and Experimental Hypnosis, 38,* 112–124.

Linden, J. (1999). Discussion of symposium: Enhancing healing: The contributions of hypnosis to women's heath care. *American Journal of Clinical Hypnosis, 42,* 140–145.

McCloskey, M. S., Kumar, V. K., & Pekala, R.J. (1999). State and trait depression, physical and social anhedonia, hypnotisability and subjective experiences during hypnosis. *American Journal of Clinical Hypnosis, 41,* 231–252.

McNeal, S., & Frederick, C. (1993). Inner strength and other techniques for Ego Strengthening. *American Journal of Clinical Hypnosis, 35,* 170–178.

Mjoseth, J. (1997, May). Hypnosis allies are urging insurers to raise coverage. *APA Monitor,* p.22.

Moss, G. J., & Oakley, D. A. (1997). Stuttering modification using hypnosis: An experimental single-case study. *Contemporary Hypnosis 14,* 126–131.

Mutter, K. L. (1999). Empowering strategies: The physician's point of view. *American Journal of Clinical Hypnosis, 42,* 116–121.

Pekala, R. J. (undated, unpublished). *Progressive relaxation protocol.* Coatesville, PA: Coatesville VA Medical Center.

Pekala, R. J. (undated, unpublished). *A self-hypnosis protocol.* Coatesville, PA: Coatesville VA Medical Center.

Pekala, R. J. (1982). *The phenomenology of consciousness inventory.* Thorndale, PA: Psychophenomenological Concepts. (Now published by Mid-Atlantic, see Pekala, 1991b).

Pekala, R. J. (1991a). *Quantifying Consciousness: An empirical approach.* New York: Putnam.

Pekala, R. J. (1991b). *The phenomenology of consciousness inventory.* West Chester, PA: The Mid-Atlantic Educational Institute.

Pekala, R. J. (1995a). A short unobtrusive hypnotic assessment procedure for assessing hypnotisability level: I. Development and Research. *American Journal of Clinical Hypnosis, 37,* 271–282.

Pekala, R. J. (1995b). A short unobtrusive hypnotic assessment procedure for assessing hypnotisability level: 2. Clinical case reports. *American Journal of Clinical Hypnosis, 37,* 284–293.

Pekala, R. J., & Forbes, E. (1988). Hypnoidal effects associated with several stress management techniques. *Australian Journal of Clinical and Experimental Hypnosis, 16,* 121–132.

Pekala, R. J., & Kumar, V. K. (1984). Predicting hypnotic susceptibility by a self-report phenomenological state instrument. *American Journal of Clinical Hypnosis, 27,* 115–121.

Pekala, R. J., & Kumar, V. K. (1987). Predicting hypnotic susceptibility by a self-report phenomenological state instrument. *American Journal of Clinical hypnosis, 30,* 57–65.

Pekala, R. J., & Kumar, V. K. (1999). *Ego-strengthening protocol.* Coatesville, PA: Coatesville VA Medical Center.

Pekala, R. J., & Kumar, V. K. (2000a). Operationalising "trance" I: Rationale and research using a psychophenomenological approach. *American Journal of Clinical Hypnosis, 43,* 107–135.

Pekala, R. J., & Kumar, V. K. (2000b, February). *A psychophenomenological approach to operationalising "trance:" Assessment of subjective hypnotisability.* Paper presented at the annual meeting of the American Society of Clinical Hypnosis.

Pekala, R. J., & Nagler, R. (1989). The assessment of hypnoidal states: Rationale and application. *American Journal of Clinical Hypnosis, 31,* 231–236.

Phillips, M. (2001). Potential contributions of hypnosis to ego-strengthening. *American Journal of Clinical Hypnosis, 43,* 247–262.

Phillips, M., & Frederick, C. (1995). *Healing the divided self: Clinical and Ericksonian hypnotherapy for posttraumatic dissociative conditions.* New York: W. W. Norton.

Piccione, C., Hilgard, E., & Zimbardo, P. (1989). On the degree of stability of measured hypnotisability over a 25–year period. *Journal of Personality and Social Psychology, 56,* 289–295.

Rosenberg, M. (1986). Self-concept from middle childhood through adolescence. In J. Suls & A. G. Greenwald (Eds.), *Psychological perspectives on self* (Vol. 3, pp. 107–135). Hillsdale, NJ: Erlbaum.

Shor, R. E., & Orne, E. C. (1962). *The Harvard group scale of hypnotic susceptibility.* Palo Alto, CA: Consulting Psychologists Press.

Spencer, J. T., Kumar, V. K., Pekala, R. J., & Conte, A. (unpublished manuscript). *Hypnotisability assessment prior to and in reference to an intervention: An exploratory study.* Department of Psychology, West Chester University of Pennsylvania, West Chester, PA.

Stanton, H. E. (1979). Increasing internal control through hypnotic ego-enhancement. *Australian Journal of Clinical and Experimental Hypnosis, 7,* 219–223.

Stanton, H. (1989). Ego-enhancement: A five-step approach. *American Journal of Clinical Hypnosis, 31,* 193–198.

Stanton, H. E. (1990). Using ego-enhancement to increase assertiveness. *British Journal of Experimental and Clinical Hypnosis, 7,* 133–137.

Stanton, H. E. (1993). Ego-enhancement for positive change. *Australian Journal of Clinical and Experimental Hypnosis, 21,* 59–64.

Stanton, H. E. (1997). Gurdjieff and ego-enhancement: A powerful alliance. *American Journal of Clinical Hypnosis, 40,* 376–384.

Vanderlinden, J., & Vandereycken, W. (1994). The (limited) possibilities of hypnotherapy in the treatment of obesity. *American Journal of Clinical Hypnosis, 36,* 248–257.

Wickramasekera, I. E. (1988). *Clinical behavioral medicine: Some concepts and procedures.* New York: Plenum.

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Is the Use of Hypnosis During Childbirth Preparation Associated with Beneficial Obstetric and Psychological Outcomes?

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The literature review is based upon the question: is the use of hypnosis during childbirth associated with beneficial obstetric and psychological outcomes? The paper examines the clinical and research literature addressing the use of hypnosis in childbirth. While anecdotal reports, self-reports, and clinical usage do suggest hypnosis can be beneficial, more rigorous research is required to provide definitive answers to the question.

Literature supporting the use of hypnosis for effective childbirth preparation is extensive, with authors reporting that women benefit in terms of obstetric outcomes (e.g., ability to cope with pain, shorter labour duration, rapid recovery rate), higher rates of uncomplicated delivery (e.g., spontaneous vaginal delivery), and more success establishing lactation (Brann & Guzvica, 1987; Davenport-Slack, 1975; Harmon, Hynan, & Tyre, 1990; Jenkins & Pritchard, 1993; Mairs, 1995; Marriot, 1981; McCarthy, 1998; Robertson, 1981; Sauer & Oster, 1997; Schauble, Werner, Rai, & Martin, 1998; Walker, 2000; Werner, Schauble, & Knudson, 1982). In recent times a few studies have begun to assess whether women experience psychological benefits from hypnosis used before or during childbirth (Brann & Guzvica, 1987; Harmon et al., 1990; Mairs, 1995; Venn, 1987).

Reviewing the hypnosis literature for childbirth preparation is complicated in that the data are based upon a range of anecdotal reports based on personal experiences (Dillenburger & Keenan, 1996; Moon & Moon, 1984; Weishaar,

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1986); suggestions for hypnosis models (Marriot, 1981; Oster, 1994; Schauble et al., 1998; South, 1988); literature reviews (Davenport-Slack, 1975; Spiegel, 1983; Werner et al., 1982); and case studies (Robertson, 1981). These outweigh scientific research studies with sound methodological practices. This literature review will critically review recent research, which investigates obstetric and/or psychological outcomes as measures of the benefits of hypnosis. To begin, studies using only obstetric outcomes will be reviewed followed by those investigating both obstetric and psychological outcomes. Finally, research investigating psychological outcomes as the main focus for study will be reviewed. A summary of areas for methodological improvement on existing research will be provided, followed by final comments and overall conclusions, in response to the question: Is the use of hypnosis for childbirth preparation associated with beneficial obstetric and psychological outcomes?

RESEARCH INVESTIGATING OBSTETRIC OUTCOMES

Jenkins and Pritchard (1993) have completed one of the largest studies investigating obstetric outcomes (amount of medication, duration of first and second stages of labour). Eight hundred and sixty-two women participated in the study between 1984 and 1989. Participants were divided into primigravida women and secundigravida women as follows: 126 women having their first baby were matched with 300 age controls, and 136 women having their second baby were matched with 300 age controls. Women attending antenatal clinics at the Aberdare General Hospital (Maternity Unit) were invited to participate in a hypnotherapy service. Jenkins and Pritchard gathered demographic data to determine any differences between groups prior to intervention. These included age, height, marital status, and smoking prevalence. Women who required medical intervention (Caesarean section, ventouse, or forceps) were excluded from the study.

The hypnosis intervention involved six 30-minute sessions with a trained hypnotherapist. Techniques of auto-relaxation and auto-analgesia were the main focus of sessions, with the aim of teaching participants self-hypnosis for use during childbirth. Participants in the control attended the antenatal clinic only. It is not clear exactly what the antenatal clinic services entailed.

Statistically significant results were reported for both (primigravida and secundigravida) hypnotised groups when compared with controls for "no analgesia required," "no Pethidine required," and "stage one labour duration," with differences for the primigravida women being greater. Jenkins and

Pritchard took this data to confirm earlier studies undertaken in the 1960s, demonstrating similar benefits.

Results for "stage two labour duration" were more complex. Differences between hypnotised primigravida participants and control participants were statistically significant ($p < 0.0001$), however the researchers concluded that, in practical terms, the difference of 13 minutes was not meaningful. No significant difference was shown for secundigravida participants. To explain these results, Jenkins and Pritchard (1993) arrived at the conclusion that childbirth involves psychological as well as mechanical factors. They claimed that by helping psychological factors in stage one, the labour duration was decreased. However, in the case of stage two, they claimed that no evidence of decrease in labour duration signifies that mechanical factors are greater and psychological factors are less prominent.

Obstetric data were included in the form of infant's birth weight, and delivery results (prevalence of tears, physical trauma, or requirement for episiotomy). Significant differences were shown between hypnotised primigravida participants (greater birth weight) and controls, but not between hypnotised secundigravida participants and controls. No significant differences were found for delivery results. One explanation provided was that social class may have explained the differences in birth weight. However, reliable means of measuring this were not undertaken. A lack of significant differences for delivery results might support the theory that psychological processes play less of a role in second stage labour results (that is, labour duration and delivery result).

A number of methodological problems have been identified with this study. Hypnotic susceptibility was not measured, making it difficult to qualify whether findings were affected by participants' hypnotisability. Self-selection by participants resulted in differences between the hypnosis and control group (no treatment). On average, women in the hypnosis group were four years older, which also reduced the number of single women in the group. It is possible that these differences between groups prior to intervention resulted in a confounding effect. Furthermore, it is possible that women who volunteered for hypnosis were different from their control counterparts. The fact that the dropout rate for the hypnosis group was so high was not fully explained. It would be worthwhile to investigate whether the dropout rate would have been as high had the intervention involved fewer sessions, and had hypnotic susceptibility been measured (were low hypnotisables withdrawing?).

The idea of hypnosis having a positive effect on "emotional factors" was alluded to, but not directly measured in this study. To comment with confidence the study could have included measures of such factors (e.g., anxiety) before, during and after childbirth.

RESEARCH INVESTIGATING OBSTETRIC AND PSYCHOLOGICAL OUTCOMES

Harmon et al. (1990) measured obstetric outcomes for 60 nulliparous women. Participants were also assessed for emotional adjustment using the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1940, cited in Harmon et al., 1990), and subjective pain ratings using the McGill Pain Questionnaire (MPQ; Melzack, 1975, cited in Harmon et al., 1990). In addition, in order to assess analgesic effects of each treatment, an ischaemic pain task (IPT) was used to measure pain thresholds during the treatment phase (Smith, Egbert, Markowitz, Mosteller, & Beecher, 1966 cited in Harmon et al, 1990.

Harmon et al. (1990) improved on the research methods of previous studies by randomly allocating participants to intervention conditions based on the measurement of hypnotic susceptibility. Thus, using a factorial design, low, and high hypnotisability groups were assigned to either the hypnosis or relaxation group interventions (n = 15, per group). Both interventions were provided in combination with usual childbirth classes in a six-session group format. Participants in the hypnosis groups received one "live" session with a clinical psychologist (session one). This session was taped, and played at the beginning of each childbirth education class (sessions two to six). The relaxation group did not receive a live session. Participants were given a tape recording of *Practice for Childbirth* (Bing, 1973, cited in Harmon et al., 1990) instructing use of progressive muscular relaxation, which was played at the beginning of each childbirth education session (sessions one to six).

Participants in both interventions were asked to play the tape recordings daily. In terms of obstetric outcomes, a significant finding of an interaction between treatment condition (hypnosis) and hypnotic susceptibility for pain reporting. Significant main effects were also shown for stage one labour duration, medication usage, infant's Apgar scores, and delivery type (more spontaneous births), in favour of participants receiving hypnosis.

In terms of psychological outcomes, Harmon et al.'s (1990) most significant finding was an interaction between treatment condition (in favour of hypnosis)

and hypnotic susceptibility for depression scores on the MMPI: Highly susceptible women receiving hypnosis had significantly lower depression scores than all other groups put together. The explanation given was that a suggestion of maternal wellbeing and enjoyment of the birth process were present in the hypnosis intervention but not in the relaxation training. This occurrence supports neo-dissociation theory (Hilgard, 1977, cited in Harmon et al., 1990) which states that only highly susceptible participants should be able to benefit from hypnosis. Contrary to this, no other interactions between treatment condition and dependent variables were detected.

There were a number of methodological problems with this study. One was the lack of a control group, although it was claimed that the relaxation group acted as a control condition. It is also the case that participants may be equally hypnotised by the relaxation intervention, and providing a no-treatment control would eliminate such concerns. A second problem was that due to the small sample size ($n = 60$) it is unlikely that this study had sufficient statistical power. According to Cohen (1992), insufficient statistical power makes it more likely that a significant effect will be detected when it is there (type 2 error).

Furthermore, the quality of interventions in the study was limited in two ways. First, only one "live" session of hypnosis was provided, and all other sessions involved listening to a recording of the "live" session. No live sessions was provided for the relaxation training at all. Thus the content of these interventions was limited in comparison to other hypnosis interventions involving two (Sauer & Oster, 1997), four (McCarthy, 1998), or six "live" sessions (Oster, 1994; Schauble et al., 1998). Second, both types of intervention were provided on a group basis. While this may be a cost-effective method, Oster and Sauer (2000) suggest that providing individual sessions allows more flexibility in catering for individuals' needs.

Several other studies have also measured a combination of obstetric and psychological outcomes, although these studies are of limited empirical value due to substantial methodological flaws. For example, Brann and Guzvica (1987) measured childbirth satisfaction as well as obstetric outcomes (blood pressure, blood loss, spontaneous birth, amount of analgesia, labour duration, birth weight of baby, Apgar scores, number of women breast-feeding). Ninety-six women attending general practice chose between hypnosis or relaxation training for childbirth preparation. The hypnosis intervention involved one individual session followed by group classes at each medical check-up. Playing a tape recording of the first session provided subsequent hypnosis. Participants were able to purchase a tape recording for use between sessions. The relaxation

class involved four group classes at the hospital. Thus, while this study appears to have improved the quality of intervention by providing an individual session, it was only one session, and relying on tape recordings as the main source of interventions compromised quality.

Methodological problems in this study included not controlling for parity, hypnotisability, or maternal age. Participants were not randomly assigned to treatment conditions and a control group was not utilised. Insufficient statistical analyses were undertaken to determine whether groups were significantly different on dependent measures. The hypnosis group showed shorter stage one labour duration, slightly less usage of medication, and more women breast-feeding at six weeks postpartum. Stage two labour duration was slightly longer for hypnosis participants. It was suggested that hypnotic relaxation may have acted as disincentive to push. In the case of childbirth satisfaction, participants rated their satisfaction on a linear scale of 0 to 10, where, 0 was a "horrible experience" and 10 was "wonderful." Only basic descriptive statistics were provided in the form of means and standard deviations. Although hypnosis groups showed higher childbirth satisfaction, it is unclear whether group differences were statistically significant. Use of more sophisticated statistical analyses would have given more credibility to the results.

Venn (1987) measured a number of obstetric measures (use of medication, duration of labour, self-ratings of pain, and nurse's ratings of patient's pain) and one psychological measure (childbirth satisfaction). Comparison was made between three childbirth preparation groups: Lamaze only (e.g., relaxation and controlled breathing), hypnosis only, and Lamaze combined with hypnosis.

Dependent measures included amount of medication, labour duration, self-ratings of pain, nurse's rating of pain, and birth satisfaction. Pain and birth satisfaction were incorporated into a postpartum questionnaire, which asked participants to rate 28 variables on a 10-point scale. Items ranged from comfort during labour, to feelings of control and satisfaction during labour, and how useful participants found treatment interventions.

A major problem with this study was that participants self selected their chosen treatment, with relatively few (n = 17) choosing hypnosis only. Self-selection caused disproportionate numbers in each group, with 80 in the Lamaze-only group, and 25 in the combined group. Again, the inadequate sample size is likely to have resulted in type 2 errors, no control group was utilised and variables such as age and parity were not controlled. Only one significant difference was identified, with women in the Lamaze-only

condition, reporting higher satisfaction with item 15 on the postpartum questionnaire ("How did it feel to use Lamaze during your delivery?") than the Lamaze plus hypnosis condition. Results from hypnotic susceptibility ratings did not correlate highly with either treatment condition.

RESEARCH INVESTIGATING PSYCHOLOGICAL MEASURES AS THE MAIN FOCUS OF STUDY

A number of authors have suggested that obstetric measures (e.g., labour duration, medication usage, mode of delivery) are unilateral in understanding pain (e.g. Hilgard & Hilgard, 1994). With the advent of the gate theory of pain, the idea that psychological factors are involved in pain perception is gradually becoming more accepted.

Mairs (1995) aimed to measure differences in experiences of pain, associated with anxiety levels. Specifically, the study focused on measures of self-ratings for anxiety and pain for hypnosis group training ($n = 28$) and a no treatment control group ($n = 27$). Volunteers were recruited after the researcher provided an information session at hospital antenatal classes, and participants chose either hypnosis or no-treatment. Participants who underwent Caesarean section were removed for post-measures (six in the hypnosis group and one for the control group). Hypnosis training involved four one-hour sessions, with content including progressive relaxation, imagery and suggestions appropriate to the different stages of labour. A pre-birth questionnaire elicited women's anxiety and anticipated pain ratings. A post-birth questionnaire was administered 2–14 days following childbirth, to determine participants' perceived experience of pain and anxiety during the birth.

Comparison for both pre-birth measures showed no significant differences between groups prior to intervention provision. Comparison for post-birth measures showed significant differences between groups for both anxiety and pain ratings, in favour of hypnosis training. No differences were shown for medication usage or labour duration. Potential confounding variables including age, medication usage, and labour duration were statistically analysed, without any differences being noted. Mairs (1995) argued these data confirm hypnosis as a useful coping method. It was suggested that hypnosis contributed to women's self-confidence during birth, and consequently lowered pain perception during childbirth. The author noted that hypnosis did have some limitations for women whose labour was induced artificially. It is not clear, however, which participants this affected and future research should remove

induced participants from post-birth data, to avoid this procedure confounding data. A number of common methodological problems existing in the hypnosis literature were repeated in this study: Participants were asked to self-select type of treatment, hypnotic susceptibility was not assessed, and small group sample sizes were utilised increasing the possibility of type 2 errors. Future research may improve upon this study by accounting for these problems. A further area for development is the use of psychometric testing which has been validated for use with the child-bearing population.

METHODOLOGICAL IMPROVEMENTS FOR FUTURE RESEARCH

As this review illustrates, further investigation is needed to determine whether hypnosis has a beneficial effect on women's physical and psychological wellbeing before, during, and following childbirth. Further research could extend on previous studies in several ways:

Standardising Hypnotic Interventions

Further research is required to evaluate the essential components of hypnotic intervention for the average child-bearing woman. This would include determining the optimal number of sessions required, whether sessions should be individual or group, be complemented with recorded sessions, whether recorded sessions are adequate when compared with "live sessions" with a trained professional. Furthermore, evaluation of the content of a number of different "hypnosis models" should be made, and consideration given to whether hypnosis models are flexible enough to use with any individual.

Controlling for Confounding Variables

In particular, parity, age, and socioeconomic status have been shown to have an impact on childbirth outcomes, and should be controlled for in research studies.

Standardising Dependent Measures

Some agreement as to how dependent measures are to be measured would be helpful in understanding and comparing research studies. For example, labour duration has been measured subjectively by the child-bearing woman, from 8 cm dilation, in stages or from beginning to end.

Three Levels of Treatment Conditions (i.e., Non-Treatment Control Group)

A common problem with the research studies in this review was use of only two treatment groups. Usually the decision has been to use a hypnosis group and another form of treatment (Lamaze/antenatal class/relaxation training) or a hypnosis group and a no-treatment control. The main criticism is that statistical differences can be attributed to demand characteristics, or the difference is simply due to having contact with a therapist. Having three types of treatment condition would overcome such criticisms.

Hypnotic Susceptibility

According to neo-dissociation theory (Hilgard & Hilgard, 1994), a participant's level of hypnotic susceptibility would have a direct relationship on their level of experience of hypnosis. It is important to ascertain that treatment groups have a comparable level of hypnotic susceptibility prior to intervention, to avoid any confounding effects.

Random Assignment of Participants

Ideally, random assignment of participants would overcome the problems associated with hypnotic research to date, which has heavily relied on "convenience samples" and volunteers.

Adequate Sample Size

Sufficient sample size for the type of research design being used is critical. Without sufficient statistical power the probability of making a type 2 error is increased (Cohen, 1992).

Psychometric Testing Suited to Child-Bearing Women

Finally, the sophistication of outcome measures requires improvement. For example, it is recommended that the Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987) is used in preference to other depression scales for child-bearing women.

CONCLUSION

Existing literature indicates personal successes, and beneficial outcomes in the use of hypnosis for childbirth preparation. In an attempt to answer the question of whether hypnosis is superior to relaxation training, other forms of childbirth preparation or receiving no treatment condition, a number of studies have investigated dependent measures in two categories: obstetric outcomes and psychological outcomes. Results have varied between studies, with unqualified consensus on whether labour duration, medication usage or mode of delivery is in fact benefited by use of hypnosis as some of the studies suggest. Studies investigating psychological outcomes including depression, anxiety and childbirth satisfaction show favourable outcomes, however this research is in its infancy and requires further studies, with methodological improvements to support findings.

References

Brann, L. R., & Guzvica, S.A. (1987). Comparison of hypnosis with conventional relaxation for antenatal and intrapartum use: A feasibility study in general practice. *Journal of the Royal College of General Practitioners, 37,* 437–440.

Cohen, J. (1992). A power primer, *Psychological Bulletin, 112,* 155–159.

Cox, J. L., Holden, L. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh postnatal depression scale. *British Journal of Psychiatry, 150,* 782–786.

Davenport-Slack, B. (1975). A comparative evaluation of obstetrical hypnosis and antenatal childbirth training. *International Journal of Clinical and Experimental Hypnosis, 23,* 266–281.

Dillenburger, K., & Keenan, M. (1996). Obstetric hypnosis: An experience. *Contemporary Hypnosis, 13,* 202–204.

Harmon, T. M., Hynan, M. T., & Tyre, T. E. (1990). Improved obstetric outcomes using hypnotic analgesia and skill mastery combined with childbirth education. *Journal of Consulting and Clinical Psychology, 58,* 525–530.

Hilgard, E. R., & Hilgard, J. R. (1994). *Hypnosis in the relief of pain* (rev. ed.). New York: Brunner/Mazel.

Jenkins, M. W., & Pritchard, M. H. (1993). Hypnosis: Practical applications and theoretical considerations in normal labour. *British Journal of Obstetrics and Gynaecology, 100,* 221–222.

Mairs, D. A. E. (1995). Hypnosis and pain in childbirth. *Contemporary Hypnosis, 12,* 111–118.

Marriot, J. A. (1981). Hypnosis and the relief of pain. *Australian Journal of Clinical Hypnotherapy, 2,* 117–121.

McCarthy, P. (1998). Hypnosis in obstetrics. *Australian Journal of Clinical and Experimental Hypnosis, 26,* 35–42.

Moon, T., & Moon, H. (1984). Hypnosis and childbirth: Self-report and comment. *British Journal of Experimental and Clinical Hypnosis, 1,* 49–52.

Oster. M. I. (1994). Psychological preparation for labour and delivery using hypnosis. *American Journal of Clinical Hypnosis, 37,* 12–21.

Oster, M. I., & Sauer, C. P. (2000). Hypnotic methods for preparing for childbirth. In L. M. Hornyak & J. P. Green (Eds.), *Healing from within: The use of hypnosis in women's health care* (pp. 161–190). Washington, DC: American Psychological Association.

Robertson, A. W. (1981). Hypnosis in obstetrics: A model for the integration of hypnosis in prenatal clinics. *Australian Journal of Clinical Hypnotherapy, 2,* 65–69.

Sauer, C., & Oster, M. I. (1997). Obstetric hypnosis: Two case studies. *Australian Journal of Clinical and Experimental Hypnosis, 25,* 74–79.

Schauble, P. G., Werner, W. E. F., Rai, S. H., & Martin, A. (1998). Childbirth preparation through hypnosis: The hypnoreflexogenous protocol. *American Journal of Clinical Hypnosis, 40,* 273–283.

South. T. L. (1988). Hypnosis in childbirth: A case study in anesthesia. In S. R. Lankton, & J. K. Zel (Eds.), *Treatment of special populations with Ericksonian approaches* (pp. 16–24). Ericksonian Monographs, 3. New York: Brunner/Mazel.

Spiegel, D. (1983). Hypnosis with medical/surgical patients. *General Hospital Psychiatry, 5,* 265–277.

Venn, J. (1987). Hypnosis and Lamaze method: An exploratory study: A brief communication. *International Journal of Clinical and Experimental Hypnosis, 35,* 79–82.

Walker, W.-L. (2000). Improvised self-hypnosis for childbirth. *Australian Journal of Clinical and Experimental Hypnosis, 28,* 100–102.

Weishaaar, B. B. (1986). A comparison of Lamaze and hypnosis in the management of labor. *American Journal of Clinical Hypnosis, 28,* 214–217.

Werner, W. E., Schauble, P. G., & Knudson, M. S. (1982). An argument for revival of hypnosis in obstetrics. *American Journal of Clinical Hypnosis, 24,* 149–171.

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Hypnosis in Childbirth

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The client in this case report self-referred for the use of hypnosis during childbirth. The current pregnancy had been uneventful except for intermittent problems with elevated blood pressure. The client was seen for four sessions prior to a successful delivery using hypnosis. This paper describes in detail the preparation for childbirth using hypnotic techniques, an abreaction that occurred during this time, and the use of hypnosis to control blood pressure.

Ms Suzie Smith, during attendance at a professional meeting, approached the authors (a psychologist and a psychiatrist) about the use of hypnosis in childbirth. She was seven and a half months pregnant and stated that she wanted her baby to be delivered as naturally as possible. Suzie's only previous experience with hypnosis was the extraction of a tooth some years previously. Although no formal assessment had been undertaken, she was at that time reported to be highly hypnotisable.

History

Suzie was a 40-year-old divorced woman, mother of two daughters, 21 and 18 years, from the first of two marriages, who presented at seven and a half months pregnant with her third child. Two terminations of pregnancy had occurred in the interval between the current pregnancy and the birth of her 18-year-old. Suzie stated that, despite her initial ambivalence about re-experiencing motherhood at her age, she was now pleased about the pregnancy. Although she was aware of the changes a baby would bring to her life, she was excited to be having another child.

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The pregnancy to date had been uneventful aside from occasional elevations of blood pressure (BP). Suzie was planning to work until two weeks before the birth, and reported no undue signs of sleeplessness, appetite loss, anxiety, or mood disturbance. She was seen for four sessions prior to the birth and between sessions used an audiotape that was updated at each visit.

Initial Assessment

Both authors were present at the first session, during which time the second author ascertained that Suzie's previous obstetrical history and current medical condition posed no contraindications to the use of hypnosis. Despite Spiegel's (1983) recommendation that patients commence instruction and practice in self-hypnosis at mid-pregnancy, Suzie's commitment and her earlier successful experience with hypnosis appeared to augur well for a positive outcome. Indeed, Walker (1988) reported the successful use of hypnosis in childbirth in a client who, until a few hours earlier, had anticipated a Caesarean birth and consequently had not attended antenatal classes nor made any preparations for a natural birth.

As the second author would be unavailable on Suzie's due date it was agreed that Suzie and the first author would work together. She was asked to consult with her doctor and hospital to obtain their approval for the use of hypnosis and for me to be present at the birth.

Although Suzie had been hypnotised before and the application of standardised scales of hypnotisability in clinical settings is controversial (e.g., Frankel, 1982; Sacerdote, 1982) the Stanford Hypnotic Clinical Scale (SHSC) was administered. Suzie scored five out of five.

This first session ended with a brief progressive relaxation induction following the guidelines of Stone and Burrows (1980) who recommended suggestions of physical relaxation and the relief of pain below the waist. In trance it was suggested to Suzie that she was going numb from the waist down and she would feel no pain in that area; sensation was permitted to return to the region and Suzie was counted out of trance. She stated that she had felt completely numb from the waist down and was now fully relaxed: "Better than I have felt for a long time!" Suzie was asked to bring a tape to the next appointment a week later.

Session 2

The induction components of this session were taped and Suzie was requested to practise with the tape and other techniques introduced throughout this session, each day. Trance was induced using a progressive relaxation technique. Suzie stated that this approach was especially welcome as she had been "rushing to get here" and she appeared slightly anxious and flustered. After using the staircase descent as a deepening technique Suzie commented that she was "ten" (out of 10) on relaxation.

Suzie was then asked to think of a colour, any colour, and allow it to fill her mind and body. She was told that, as the colour flowed through her body, she would become more and more relaxed, feel really good about herself and her life. She would anticipate the birth of her baby with great joy and she would have a sense of control over her body and know that she would only feel the sensations of birth and not the pain.

Suzie chose a pale apricot colour, and stated she was able to imagine it and the accompanying feelings of wellbeing flooding through her body. She was asked to focus on the colour and those good feelings for a moment. A few seconds later, she became noticeably uncomfortable and appeared to be perspiring. When asked what she was feeling, she replied that she was hot, very hot, getting so hot she could hardly bear it. She was given the suggestion that she was beginning to feel cool, a slight breeze was coming up and it was just strong enough to refresh her and make her feel comfortable. After some seconds she seemed to relax into the recliner chair and responded that she was now cool and relaxed. Suzie believed it was the apricot colour that had caused the problem for she had focused on this colour which had caused her to think of warmth, and heat, and hot. She was still in trance, quite relaxed, and it was agreed to change the colour to a refreshing and cool blue. She had no problems with the substitution of colour, nor did the reaction re-occur.

More self-esteem enhancing suggestions were given, then Suzie was instructed to make her body go numb from the waist down so that she would feel no discomfort at all (Stone & Burrows, 1980). She was able to achieve this objective within seconds. Suzie was assured that she would still be aware of sensations, she would always be able to distinguish between sharp and dull sensations, and she would be able to identify these to the doctors if required. She was also assured that she would be able to monitor any instructions given to her during childbirth, but at no time would there be any sharp pain. Suzie agreed to test this by allowing herself to be pinched on her thighs and calves—

she was aware of a "slight flutter" but nothing more. A further non-invasive and ethical demonstration that she was in control over her sense of pain was agreed upon. I gave her a gentle tap, and then a much sharper one, on the calf with an open hand. Suzie was able to differentiate between the light and sharp strokes but did not feel either was uncomfortable. The same procedure was applied to her upper arm, with a similar result.

Following positive reinforcement of her ability to control pain and to think positively about herself in such a situation, Suzie was counted out of trance from five to one. As noticed during the previous week, Suzie was slow to come fully out of trance, and she dreamily commented: "beautiful, most wonderful feeling."

In the remaining minutes, Suzie was taught two more rapid inductions: focusing on a spot on the ceiling (Spiegel & Spiegel, 1988) and a breathing technique: "Inhale'Re,' Exhale'Lax'" and as you "Re-Lax" you become more and more relaxed, deeper and deeper in trance. As both of these demonstrations followed a deep trance state, Suzie went into trance very quickly. These plunge phenomena (Spiegel & Spiegel, 1988) were not only successful in deepening the trance state on each occasion but also assured Suzie that she could go into trance, by herself, very quickly.

The tape was edited of the "apricot scene," Suzie was encouraged to practise daily, and a further appointment was made for two weeks hence.

Session 3

This session involved a discussion on the use of hypnotic imagery and its function in helping one separate from pain and altering the perception of, and possibly actual, time from the first contraction until birth (Weishaar, 1986). Elton, Burrows, and Stanley (1980) utilised a "secret room" to help patients overcome pain; others, such as Spiegel (1983) and Stone and Burrows (1980), suggested the therapist work with the patient in advance to ascertain what imagery the patient associates with the feeling of total relaxation. When prompted for a place, Suzie thought immediately of a place called "Mythical Land"—a deserted beach scene some miles from Melbourne. When asked what it looked like, she replied:

> You come up over a hill and there's the ocean, little river … quite a wide set of sand dunes covered in low heath; ocean front beach, beautiful, rough, turbulent but calming … water is blue green, definitely a green, some white from the caps …

T: What does it sound like?

S: Noise … loud … noise of water.

T: What does it feel like?

S: Feeling of the place … strong feeling … a cleansing place … It's a winter place … grey overcast sky, misty colours, love rain, love mist, walking in the rain with decent overcoat … with a hat you can take off and put on again … feel … like my hair flowing in the winds …

Trance was induced using progressive relaxation, then I suggested to Suzie that she was at Mythical Land. She was just coming up over the hill and in a moment the ocean would be in front of her … maybe it was a misty, rainy day … as she walked down the beach she felt really good … felt herself going deeper and deeper into trance. Suzie was given time to work with this imagery and was asked to use an ideomotor signal, that is to raise her "Yes" finger when she was feeling very content, very relaxed. The wide smile of pleasure on her face could have served just as well for the signal.

Suzie was then given the suggestion that she could go to Mythical Land whenever she felt she wanted to, whenever she wanted to "Re-lax," whenever she wanted to numb her body from the waist down, she was in control. She was told that now there would be a series of sensations, no pain, on her calves and she was to utilise her techniques so that they would remain sensations only. The previously described tap/slap technique was implemented and Suzie remained with a smile on her face, only acknowledging the difference between flutter and slightly harder.

Suggestions to reinforce Suzie's competency and self-esteem were given and she was then counted out of trance from ten to one. Another time was set with Suzie being encouraged to continue practising self-hypnosis.

Session 4

This session was two weeks after the third. Suzie was now only one or two weeks off her due date but she was feeling very confident and relaxed. She was not using self-hypnosis every day as she was busy getting the baby's room ready and doing last-minute things at home.

Again, Suzie had "rushed in." Trance was induced using an abbreviated progressive relaxation technique, that is, the focus was on relaxing the legs, arms, torso, etc., rather than concentrating upon more separate parts of the

body. It concluded with emphasis on her breathing "Re-lax," think of Mythical Land, think of the waves, the wind, the ocean, the calmness.

Suggestions followed the basic pattern of the previous session but added in the word "torso" (Suzie's word)—"Numb your torso"—to indicate her abdomen and back, that is, the areas most affected by pain in childbirth. Suggestions concentrated on feeling good, and utilising the strength of the waves, wind and calm feeling of Mythical Land to cope with contractions and know that she was not experiencing sharp pain although aware of the sensations.

On termination of the trance, Suzie was encouraged to practise, attend her next appointment in a week's time, and to telephone if she was admitted to hospital.

During this session, Suzie was asked how her doctor felt about her progress to date. She replied that he was concerned about her slightly elevated blood pressure. A reading at this time showed her BP was 135/80, but that was after the hypnotic induction. Unfortunately no pre-measure was available.

The Hospital

Suzie did not attend her next appointment but rang four days later (a Friday at 2.30 p.m.) to say she was in hospital. This was a second admission, the first was overnight three days before because of elevated BP (155/95). The current admission followed onset of contractions at 10.00 p.m. the previous night and staff again wanted to monitor her BP. At the time of her telephone call, the contractions were 12–15 minutes apart, and she felt was coping well: "No, I don't need you at the moment, you have work to do, come in when it gets closer to the delivery."

I arrived at the hospital at about 7 p.m. Suzie, seated on a bedside chair, was looking considerably drawn and stated, "I'm coping okay, but I really am glad to see you." Almost immediately she moved into a squatting position on the floor as another contraction began. Squatting beside her, the brief command to "Re-lax, re-lax" was said in time with her breathing, and as she focused on these words she began to move into trance state: "You're at Mythical Land … see the ocean and the waves … feel the calm … you're at Mythical Land … Re-lax."

Suzie advised that she coped much better with this contraction than with earlier ones. The next few minutes were spent analysing what she had imaged and what had helped her. The image of a wave washing over her was her

dominant image and so it was suggested to Suzie that as this wave washed over her, it would bring a numbness that would take away the sharpness of the pain. The sensations would stay, she would be able to follow any instructions and be able to differentiate between the various sensations in her body, but there would be no sharp pain and she would be relaxed.

A combination of "Waves" and "Re-lax" and "you're at Mythical Land" was used to assist her through the next hour and a half of contractions. During one of these early contractions and the suggestion that she was at Mythical Land on the beach enjoying the feeling and the place, Suzie began to smile quite broadly. Upon my asking what was making her so happy, where was she, Suzie replied that she was having a picnic at Mythical Land on the sand "no, not actually a picnic … there was this shaft of light and it was beautiful." After each contraction, when Suzie was opening her eyes quite naturally and talking (see Fuller, 1986), she was asked if the shaft of light had any special significance to her. She replied, "No." It was then suggested to her that it might mean that her child would be born soon and this was the shaft of light he might see as he came down the birth canal. She smiled, and agreed with the metaphor.

Suzie's contractions were now coming about every three minutes. At this time, the nursing staff examined her to ascertain the position of the baby's head and checked her BP (160/100). Ward staff decided she should go to the delivery ward on the floor below. Suzie declined a wheelchair and walked to the delivery room, arriving there at approximately 9 p.m. She continued to cope very well with the contractions and staff commented that this was the quietest room in the delivery suite; they were amazed that she was so relaxed even during the contractions.

As the baby's head was coming down and the staff had difficulty hearing the foetal heart beat, they asked to place a monitor clip on the baby's head. Suzie agreed and this was inserted. The initial readings made while Suzie was attempting to move herself from the bed down onto the floor to assume a squatting position—her preferred position—showed that the baby was in some distress. His heart-beat was around 80–100 instead of 120–160 and the curve was also rather flat. Concerned that the baby was not getting enough oxygen, staff advised Suzie to lie on the bed on her left side, even though she was more comfortable on the floor. Suzie agreed and the indicators returned to normal ranges.

Suzie coped with all the contractions through stage one labour. Just as she was entering stage two labour, the nurse monitoring her blood pressure announced that it was now elevated at 160/100; checks were made between

the next two contractions and yielded readings of 150/95 and 160/100. Staff had already indicated that this was of great concern and one of the midwives asked if something could be done about Suzie's BP. It was suggested she might see a thermometer, a clock face, a ladder, or whatever other image she felt would be appropriate for her (just so long as there was a facility to move downwards or to turn it off).

"As you focus on that image you are also focusing on and controlling your blood pressure … and as you look at that image and the levels begin to go down, down and down … they do not have to drop radically, just come down slowly and comfortably … as it slowly decreases so too will your blood pressure … down and down, comfortable feeling good, until it is at a level normal for you."

After the next contraction her BP was 120/70.

As stage two was coming to an end, Suzie suddenly expressed concern that she had some back pain. I explained to her that this was the baby descending and she could use the waves to wash away the pain in her "torso" as well as her front, "Re-lax," and she again settled. Now, the baby's head was showing. Suzie was coping beautifully. She had the light at Mythical Land, she was using the waves, the waves, the waves, and now the baby's head was out and the midwife was asking her not to push (in order to avoid a tear) and, for the first time, Suzie said: "The pain!" Using the waves, she worked with the pain and pushed her baby out—the midwife immediately placed her son on her breast and Suzie's arms went around him although she did not appear to see him … "Re-lax, it's over, Re-lax."

A full minute or so went past and Suzie, who was now looking in the direction of her son but still not really seeing him, said: "Has the baby been born?" "Yes, it's over, he's a beautiful boy, it's over and you're here with him, you are now out of trance and you are here with him." These remarks seemed to rouse her from the trance state that had deepened considerably during the final numbing wave, the wave that had not only deepened the trance but also enabled her to push the baby out. It was 11.23 p.m.

Baby began to suckle within a couple of minutes and the midwives waited patiently for this to have an effect on the expulsion of the placenta. For the first midwife, despite 16 earlier deliveries, this was the first time she had seen a drug-free delivery and hence a naturally delivered placenta.

Suzie did not need an episiotomy; staff complimented her on her calmness and some two hours later, baby's tests and checks complete, herself showered and refreshed. Suzie carried her baby in her arms as she walked back to the ward (refer Martin, 1983).

Suzie's teenage daughter was very excited although somewhat anxious for her mother and about the process of childbirth in general. Much of her time during the labour was spent in talking with John, the baby's father. As he had a blood phobia—he had fainted two days before at the sight of his own blood coming from a slight cut—Suzie had wished for, but not expected, him to stay throughout the delivery. She was delighted to have him there and he approached to hold her and his son as soon as the placenta had been expelled.

Discussion

Suzie was a highly hypnotisable subject whose relatively uncomplicated pregnancy, labour, and delivery provided an excellent introduction to the experience of using hypnosis with women in childbirth. Hypnosis certainly contributed to Suzie's confidence in her ability to cope with labour. It also reduced her anxiety and fear of pain (Lowe, 1987; Stone & Burrows, 1980), and enabled her to deliver her child "drug free," and generally facilitated a calm and relaxed atmosphere not only for Suzie and family but also for the staff. Staff commented upon the ease of Suzie's delivery and were impressed by her calmness throughout.

This experience also reinforced my own convictions on the utility of hypnosis in such diverse areas as pain management, anxiety reduction, control over BP, and in general terms, the powerful mind–body connection (Rossi & Cheek, 1990).

An interesting aside to this case occurred four weeks later when all parties involved were present at an after-hours meeting and Suzie, in a separate room, was trying to settle a tired and whiny baby. In order to allow her some respite, I took the baby from her, placed him over a shoulder and walked around the darkened room saying, "Re-lax." He settled immediately! There is no evidence to suggest that he may have learned this suggestion in utero. His mother reports that he has subsequently settled for her too when she used this approach.

Conclusion

This paper has provided a detailed description of the use of hypnosis leading up to, and during, childbirth. The patient in this case was highly hypnotisable and it is strongly recommended that anyone wishing to utilise these techniques ascertain the mother's level of hypnotisability. The importance of using the patient's own imagery has also been demonstrated in this case study. The clinical experience of the therapist in these circumstances is also important and this was demonstrated during the abreaction to the colour apricot and in the use of hypnotic suggestions to reduce the patient's blood pressure during the birth.

References

Elton, D., Burrows, G. D., & Stanley, G. V. (1980). Chronic pain and hypnosis. In G.D. Burrows & L. Dennerstein (Eds.), *Handbook of hypnosis and psychosomatic medicine* (pp. 269–291). Amsterdam: Elsevier/North-Holland.

Frankel, F. H. (1982). Hypnosis and hypnotisability scales: A reply. *International Journal of Clinical and Experimental Hypnosis, 30,* 377–392.

Fuller, A. K. (1986). A method for developing suggestions from the literature. *American Journal of Clinical Hypnosis, 29,* 47–52.

Lowe, N. K. (1987). Individual variation in childbirth pain. [Special issue] Maternal development during reproduction. *Journal of Psychosomatic Obstetrics and Gynaecology, 7,* 183–192.

Martin, J. (1983). Hypnosis gains legitimacy, respect, in diverse clinical specialties. *Journal of American Medical Association, 249,* 319–321.

Rossi, E. L., & Cheek, D. B. (1990). *Mind–body therapy.* New York: Norton.

Sacerdote, P. (1982). A nonstatistical dissertation about hypnotisability scales and clinical goals: Comparison with individualised induction and deepening procedures. *International Journal of Clinical and Experimental Hypnosis, 30,* 354–376.

Spiegel, D. (1983). Hypnosis with medical/surgical patients. *General Hospital Psychiatry, 5,* 265–277.

Spiegel, H., & Spiegel, D. (1988). Induction techniques. In G. D. Burrows & L. Dennerstein (Eds.), *Handbook of hypnosis and psychosomatic medicine* (pp. 133–147). Amsterdam: Elsevier/North-Holland

Stone, P., & Burrows, G. D. (1980). Hypnosis and obstetrics. In G. D. Burrows & L. Dennerstein, (Eds.), *Handbook of hypnosis and psychosomatic medicine* (pp. 307–325). Amsterdam: Elsevier/North-Holland.

Walker, W.-L. (1988). Improvised self-hypnosis for childbirth. *Australian Journal of Clinical and Experimental Hypnosis, 16,* 163–165.

Weishaar, B. B. (1986). A comparison of Lamaze and hypnosis in the management of labor. *American Journal of Clinical Hypnosis, 28,* 214–217.

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Hypnosis and Client Resistance

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This case demonstrates the use of hypnosis to complement cognitive–behavioural therapy. Although the principal treatment used was cognitive therapy, supplemented with insight-oriented therapy to explore the underlying causes for the problems being treated, hypnosis provided a useful and successful addition to therapy. Hypnosis facilitated a more rapid therapeutic response after the cognitive approaches stalled due to patient resistance in initiating and maintaining changes in behaviour patterns.

INTRODUCTION

Peter is a 33-year-old university student, receiving Austudy benefits. He is single, living on his own in a private rental unit. He had no children and had never been in a long-term relationship and was referred to me by his general practitioner for treatment of a recurrent depressive disorder in the context of recurrent relationship break-ups. Peter was keen to explore the underlying reasons for the pattern of failures in his relationships.

Presenting Complaints

Peter told me that he had recently become depressed again, following another break-up in a relationship of six months standing, which had occurred five months previously. He told me he tended to attract women who "cannot commit," that he always felt he had to "emotionally prop up" his partners and then felt betrayed when they left him, feeling they had "conned" or "duped" him. He stated that his partners always said they were looking for long-term relationships, but they would then end the relationship suddenly, totally unexpectedly as far as he was concerned, and he felt they were obviously only

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interested in "a fling," much to his grievance. Peter said he never saw the end of his relationships coming, and he always felt cheated and confused when it happened. He believed the women he had been in relationships with were not open or honest, and he felt the reason for their behaviour was because they all "had problems with their fathers" which were transferred onto him. The longest relationship he had been in was for 18 months, and they had lived together for nine of these months.

On specific questioning, Peter gave a history of a number of mild to moderate symptoms of depression. These included depressed mood which was worse in the evening, early morning wakening, fluctuating appetite, impaired concentration and energy levels, low interest and motivation levels, social withdrawal and reduced affective reactivity. He tended to ruminate excessively on the reasons for his relationship failures, trying to understand what went wrong with each of them. However, by the time of my assessment most of these symptoms had responded favourably to an antidepressant, prescribed by his general practitioner. He denied having any suicidal ideation at any time.

Peter blamed his weight for all his problems, stating that the one period in his life in his mid-twenties when he successfully lost weight, he did not seem to have any problems attracting women, but this period only lasted one to two years. He believed women were not attracted to him, nor did they stay with him, because they saw him as being overweight.

Family and Social History

Peter had not previously seen a psychiatrist or a psychologist and there was no significant medical history. He had been prescribed an antidepressant, moclobemide 600 mg per day, by his general practitioner, but was taking no other medication. He did not smoke tobacco and denied using any illicit recreational drugs, except marijuana on a very occasional basis. Peter did admit to drinking heavily, consuming around six stubbies of beer most evenings, which had been a long-standing pattern for him.

Peter's father was a 63-year-old retired electrician, who divorced Peter's mother when Peter was 13 years old, and subsequently remarried. Peter described his father as a "nice" man, with whom he was reasonably close but he also described him as weak, reserved, and not overly affectionate. Peter also felt his father tended to be selfish and "unsharing." Peter's mother is 57 years old but he has had no contact with her since he was 17 years old, not even knowing her current whereabouts. She was described as always having

"nervous breakdowns," being stressed, tearful and highly strung. She had recurrent hospitalisations when Peter was around four to five years old. He was never close to his mother, whom he described as being volatile, angry, and verbally aggressive. Peter's only sister was 32 years old and lived in Western Australia. Peter described her as "tough" and "street smart," and he had little contact with her. Peter did not get on with his father's second wife who picked on him and was very demanding and punitive towards Peter. He had four stepsisters, by his father's second wife, but he was never close to any of them, believing none of them were interested in getting to know him. Apart from his mother's hospital admissions for anxiety and depression, there was no other family psychiatric history.

Peter was born in Adelaide, with unremarkable neonatal development and no history of physical or sexual abuse. His childhood memories were of his parents fighting, but otherwise he felt that overall his childhood was positive. At school he maintained good grades, until his parents separated, when he became depressed and his school performance declined until he left school two years later, when he was 15 years old. He maintained a good social circle at school, with interests in sports and the school choir, and was regarded as a "model student." However Peter was overweight as a child, and he remembered "knowing girls would not like him," and he never felt included in activities by females, but rather he was "accepted" by them because he was thoughtful and caring.

When his parents separated, Peter initially lived with his father, while his sister lived with their mother. When he was 15 years old Peter had to live with his mother after his father's remarriage, because of his stepmother's intolerance of having Peter at home and her favouritism for her daughters. However, Peter never felt accepted by his mother and sister, his mother constantly verbally abusing him with frequent threats to throw him out. This was in contrast to the very positive relationship between his mother and his sister. When he turned 17, Peter's mother "ran off" with another man, leaving her son who then moved into a youth shelter, while his sister followed their mother. Peter has had no further contact with his mother. He described feeling abandoned not only by his mother, but also his sister, stepmother, and stepsisters.

After leaving school, Peter worked in a factory for two years, then obtained work as a youth worker for two years and then as a nurse assistant for eight years. He was then successful in obtaining acceptance to university, where he has been for the preceding three years.

Peter described five significant relationships in his life, that had lasted from six to 18 months. He was unaware of any particular pattern in his selection of partners, the various women being different in their personalities and lifestyles. However, while discussing these relationships Peter recognised a pattern of him becoming emotionally dependent on his partner who he thought may have been "frightened off" by his dependency. All his partners apparently left suddenly and with little warning. Occasionally Peter heard from others about problems his partners had in their relationship with him, but he was unaware of these himself. He was left feeling "used" and abandoned when they left and stated he was now fearful of initiating any new relationships, feeling he would be unable to bear any further cycles of bonding and subsequent rejection. He had attended various courses on relationship building, but did not find these particularly helpful.

Peter described his premorbid personality as being gregarious, confident, with a good sense of humour. He enjoyed many social activities and stated he had a good social circle. However, he felt he had to do all the organising and arranging if he was going to be included in any social activities, and felt he tended to be on the periphery as all his friends were in relationships.

Mental State Examination

Peter presented as a tall, stout, large-framed man who was not obese, but was moderately overweight, neatly and casually dressed and groomed. He appeared relaxed, with a friendly disposition, and made good eye contact and interacted in a positive and pleasant manner. His conversation was appropriate with no formal thought disorder or delusions. He tended to be preoccupied with trying to understand why he could never maintain a relationship, and why he was so "unacceptable" as a partner, and how he could lose weight, believing this to be the key to his problem. His affect was reactive and his cognition was intact, and I rated his intelligence in the upper average range. His insight was fair in that he could discuss his problems in an intelligent and thoughtful manner, but then would retreat to simplistic explanations, such as his weight, for these problems. Rapport was good in that he could engage in a friendly and pleasant manner, and it was easy to discuss issues with him.

DIAGNOSTIC FORMULATION

Based on DSM-IV criteria (American Psychiatric Association, 1994) I diagnosed Peter as suffering from a Major Depressive Disorder, Recurrent, in Partial Remission. The resolution of depressive symptoms followed the prescription of antidepressant medication. On the personality axis, I diagnosed Peter as having characteristics consistent with dependent personality traits, with his focused need to be in a relationship, to the point where he failed to appreciate developing difficulties within the relationship, but he did not fulfil the criteria for a personality disorder. However, there were ongoing relationship issues, with a recurrent pattern of relationships in which Peter acknowledged becoming dependent on his partners, and then feeling rejected by them when they left. I believed this to be related to his early life experiences, when he was repeatedly rejected by important females in his life. His need for acceptance by females made him quickly dependent on potential partners, ignoring any difficulties within relationships, and possibly sabotaging relationships so as to repeat the cycle of rejection, followed by his sense of abandonment by his partner when the relationship terminated. He tended to blame his partners for the failure in relationships and saw himself as having to emotionally prop up his partners. I believed this reflected Peter transferring his anger and emotional needs from his primary female caregivers onto his current partners. However he also had an underlying belief of not being acceptable to females, but attributed this to his weight which prevented females from finding him acceptable, further fuelling his cycle of failed relationships and recurrent depression.

INITIAL MANAGEMENT

I maintained Peter on antidepressants as he had a positive response to these when prescribed by his general practitioner. I undertook a cognitive–behavioural approach complemented by insight-oriented psychotherapy when appropriate. The underlying themes explored were Peter's assumption that all women would neglect and eventually reject him, repeating the pattern established in his early childhood and adolescent experiences. As a result of these expectations Peter tended to avoid potentially affectionate and supportive relationships, particularly by focusing on unfavourable qualities of himself that he believed made him unacceptable to women but which he felt powerless to change. He also tended to choose women as partners who were similar to his mother, only to repeat the emotional trauma when they failed to provide the

emotional support he sought.

Therapy explored Peter's sensitivity to any sense of non-acceptance or misunderstanding, and his underlying sense of not being good enough. This resulted in him perceiving a constant sense of demand and expectation from others, which he needed to fulfil, creating a performance anxiety over never being able to satisfy these expectations, particularly sexually. Peter learned to expect to disappoint others and then to be rejected. He tended to ignore or discount any successes or positive interactions with females, dismissing these as "game playing" and doubting their motives. His sensitivity to any criticism resulted in him withdrawing from relationships, but then perceiving the females as having abandoned him. The females he did have relationships with were assertive and all made the first move, but were rather histrionic and superficial, with histories of numerous affairs. Peter tended to glamorise the relationships of others, such as his friends, believing they all had positive long-term relationships, when obviously they did not when examined in any detail. Therapy explored the underlying cognitive schema Peter had about relationships, his sense of self worth, the expectations of others and his need to fulfil these. He was encouraged to pursue friendships with female friends, and discuss his interactions with them, when his cognitive beliefs would be challenged. During therapy Peter discussed how three women, who did not have the histrionic traits of his previous partners, had propositioned him at different times, and on each occasion it was Peter who rejected the female. Exploring the reasons for this highlighted Peter's suspicion of their motives, his own fear of commitment and his performance anxieties.

Therapy also addressed Peter's weight issue, looking at his diet, means of controlling his tendency to binge eat and drink excessively, as well as helping him to increase his physical exercise. He was verbally very committed to undertaking these changes, agreeing to engage in various activities including keeping diaries of food intake, maintaining charts, changing daily routines, investigating exercise options as well as exploring the underlying emotional issues related to his behaviour patterns. These latter issues included his tendency to drink then binge eat at times of loneliness, when he had an intense sense of "missing out" and need for nurturing. Therapy explored his need to be "unacceptable" due to his fear of relationships, which he perceived as "potential disasters" and best avoided. He allowed himself to become involved with women if they took the initiative in an unambiguous and forceful manner, which he interpreted as being indicative of a long-term involvement, only to be traumatised when it proved to be for a short-term affair.

However, my behavioural–cognitive approach was hindered by Peter's conviction that his weight was a real deterrent to any women really accepting him. Most of the attempts to help him with his diet, take regular exercise, and control his drinking were only effective for short periods, after which he would revert to his previously established patterns. In view of this, I decided to incorporate hypnosis into his treatment to see if it could resolve this barrier and facilitate therapy.

SUITABILITY FOR HYPNOTIC PROCEDURES

I felt hypnosis might be useful for Peter as it has been successfully used to supplement cognitive behavioural therapy (Clark & Jackson, 1983) and has been advocated in the treatment of depressive disorders (Yapko, 1992).

Peter was very positive about using hypnosis, he engaged well with me, and I felt comfortable working with him. He was insightful, psychologically orientated and resourceful. Though he had a history of significant depressive symptoms, these had responded to antidepressant medication, with resolution of most of the main symptoms, and Peter denied having any suicidal ideation at any time. I believed hypnosis would complement the cognitive therapy being used and would hasten the attainment of treatment goals.

HYPNOTIC PROCEDURE

Peter had no previous experience with hypnosis, but was very positive about using hypnosis in therapy. I outlined a simple structure of the conscious and subconscious mind, with the role of hypnosis being to be able to communicate more directly with the subconscious mind and explained this would allow exploration of any subconscious reasons for his difficulty in reducing his weight, and also to reinforce his conscious goals of obtaining his desired weight. I discussed "safe place" imagery with him, and he decided for him this was sitting on a particular stretch of a beach not frequented by many people.

Hypnotic induction was achieved using eye fixation with distraction method (Hartland, 1971) with arm levitation and then progressive relaxation. On the first induction no arm levitation occurred but Peter reported, after the session, a marked sense of lightness, and subsequent sessions resulted in a moderate levitation, while more emphasis was placed on the sensation of lightness. The first session consisted of relaxation, using Peter's safe place and instructions in self-hypnosis (by taking deep breaths, counting backward from five to one, and going to his safe place). This allowed Peter to become familiar

and comfortable with the hypnotic procedure. After several sessions I tried using Chiasson's technique (Hammond, 1992), which appeared to produce a deeper and quicker trance, so this was continued for all future inductions.

The next session focused on ego-strengthening suggestions, aimed at improving his confidence and motivation in achieving his goals, and feeling more confident in social situations generally. Management plans discussed before hypnosis were reinforced, along with his ability to keep his goals in mind whenever he felt tempted to abandon them. In the following session I used the technique of Peter imagining the image of himself that he would like to be in a mirror, with all the characteristics and qualities he desired. He was encouraged to use the period when he successfully lost weight in his mid-twenties as a role model, as he described this time as being very positive for him. He was then encouraged to visualise himself merging with this image. This technique had a very favourable response for Peter, so was repeated in the next three sessions, extending the image of himself being confident in social interactions with females and feeling positive about himself and his achievements. This was then modified for Peter to imagine himself, as he would like to be in the future, on a movie screen, and then again merging with the image on the screen. Another metaphor used was Peter imagining himself like a symphony orchestra, where his life was integrated and coordinated with his goals, and all parts of him were working in unison and in harmony together. Peter then asked for the therapy to extend to helping him with motivation for his academic studies, as he felt happy with the progress he was making using these approaches with his weight control programs, and this was done during the next two sessions of hypnosis.

Overall, Peter reported a number of successes using these techniques, with an increasing commitment to a regular exercise program, sticking with a balanced and sensible diet and reducing his alcohol intake, to the point where he was only drinking two to three times per week. However, his tendency to binge eat after drinking a few beers when alone at home on the weekends, when he would feel lonely and "left out," was still occurring. Following this revelation, hypnosis was used to attempt to find an alternative solution for Peter to deal with his emotions at these times, using an "affect bridge" and the technique described by Barnett (1981).

Once in trance, ideomotor signals were established, using the index finger and thumb for "yes" and "no" replies, and the little finger for "not wanting to answer." Peter was asked to go to the time when he tends to drink and binge on weekends, to focus on the feelings associated with this and to then increase

the intensity of these feelings tenfold. He was then asked to go back to the first time he had ever had these feelings, but he indicated he could not find any particular time. (Peter later reported that there was no particular time or event, but his feelings developed over an extended period when he was significantly overweight as a child.) He was then asked to find that part of himself that had the feelings, to which he gave an affirmative response. I asked him to use all his adult knowledge and understanding to find a solution to this situation and communicate this to the deeper part of himself. Peter indicated positively about finding an appropriate solution, and being able to communicate this with his deeper unconscious self. I asked if the solution was acceptable to this deeper part of him, and again he responded by lifting the "yes" finger. I asked if this deeper part of him now felt reassured and again he responded positively. Finally I emphasised a sense of the different parts of him working together to attain his goals. At the end of this session Peter expressed intrigue with the technique and was very buoyant leaving the session.

The final session to date was used to repeat the above method, but no further issues surfaced and the rest of the session was used on further ego-strengthening, emphasising and reinforcing his successes, as well as his sense of mastery and empowerment to achieve his goals. I focused also on further support for finding a suitable balance in his pattern of eating and drinking, along with balancing this with a suitable exercise program.

REVIEW OF MANAGEMENT AND OUTCOME

Peter's progress using cognitive therapy alone was very inconsistent, with him finding it hard to implement many of the activities discussed during therapy, even though these were regarded as being high priority for Peter. His course prior to introducing hypnosis fluctuated considerably, and his mood tended to fluctuate in tandem. However, with the introduction of hypnosis Peter was able to start and continue a considerable number of initiatives, although with some inconsistencies at first. He started taking regular exercise, changed his eating and drinking patterns, and altered his social patterns with female co-workers in a new job. He reported "not feeling daunted by the task of losing weight" any more, that he was "just doing it," and it was no longer a "success/ failure situation," and he commented that this was the first time he had lost weight without being on a "starvation" diet. By the end of the sessions reported herein, Peter had lost five kilograms.

Other developments for Peter included obtaining work, and socialising more, including holding a party for himself for the first time and starting to

initiate contact with women, rather than waiting for them to approach him. His sister had also moved to his home city after the failure of her relationship and Peter found that he was able to develop a better relationship with her than he had had in the past. Although Peter had yet to be successful in developing an intimate relationship with a female, this was no longer an intense focus for him and he was more relaxed about finding a partner, while enjoying the company of his sister and other female friends.

FINAL COMMENTS

I found this a very instructive case. Although I enjoyed using the cognitive–behavioural therapeutic approach with Peter, and this was having positive results initially, the difficulty he had in implementing and maintaining changes in his behavioural patterns slowed progress considerably. Hypnosis was a very effective therapeutic tool to deal with these issues, without having to abandon the underlying therapeutic approach. The rapid response to hypnotic suggestions also gave the patient a very positive incentive to undertake further activities, and certainly bolstered his self-esteem and confidence, giving him a sense of empowerment in being able to attain the goals he sought for himself. I believe this significantly contributed to his brighter mood and his more optimistic outlook for success, including interactions with women. Prior to introducing hypnosis into therapy, Peter was tending to use his difficulties in maintaining positive developments to reinforce his negative cognitions about his abilities and self-worth. Although I believe the cognitive–behavioural approach would have been successful on its own, the introduction of hypnosis allowed for some rapid changes, which in themselves provided beneficial therapeutic interventions.

References

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC. Author.

Barnett, E. A. (1981). *Analytical hypnotherapy: Principles and practice.* Ontario: Junica.

Clark, J. & Jackson, J. (1983). *Hypnosis and behavior therapy.* New York: Springer.

Hammond, D.C. (1992). *Hypnotic induction and suggestion: An introductory manual*. Chicago: The American Society of Clinical Hypnosis.

Hartland, J. (1971). *Medical and dental hypnosis and its clinical applications* (2nd ed). London: Baillière Tindall.

Yapko, M. (1992). *Hypnosis and the treatment of depressions.* New York: Brunner/Mazel.

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Hypnosis and Chronic Pain

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This case study describes the use of hypnosis as an adjunct to the treatment of chronic pain, and helping the patient develop more effective coping skills.

PRESENTING PROBLEM

Colleen was a 44-year-old woman who attended initially asking if I would agree to be her treating doctor for a "worker's compensation injury," as the doctor who had been assessing her was retiring.

She had suffered a painful frozen right shoulder for 18 months and was limited in her ability to function both at home and in the office, where she worked as a receptionist and wages manager. At the first consultation she was working two hours per week at the office and doing 15-minute stints at the computer at home, adding up to five hours per week.

Colleen stated that she had first experienced discomfort in both shoulders following a recreational bicycle ride in August 1998. She had been improving, with a decrease in her usual activities. However, on her return to work she had a very busy day as two other employees were absent, and it was at this point that she developed more severe pain and restriction in her right shoulder.

At this initial assessment, Colleen was noted to have symptoms and signs consistent with frozen shoulder, a condition of unknown aetiology characterised by gradual onset of stiffness and pain on movement of the shoulder joint, with limitation of movement and little documented response to physiotherapy, cortisone injections, or manipulation (in fact, physiotherapy or any attempt to exercise the joint makes the symptoms worse). In most cases the symptoms persist for about two years, before spontaneously resolving (Watson & Sonnabend, 2000).

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The diagnosis was discussed with Colleen, who stated that even though she knew it would improve, she would like to continue with the acupuncture treatment she was receiving from another practitioner, and to try hypnosis to see if it would also help to decrease the ache she experienced in her arm and make her more comfortable. Colleen knew from previous attendance at the practice that I used hypnosis for certain cases and she was keen to try.

SOCIAL HISTORY

Colleen was born in Sydney of Australian parents. She was an only child, but as her grandmother had been one of 12 children, she grew up experiencing a great deal of contact with her family and attended school with some of her cousins.

Colleen's father is well, although not able to drive due to failing eyesight. Colleen keeps in regular contact, phoning him at least twice per week, and she stated she gets on very well with him. She also described being close to her mother, who died of lymphoma a few weeks before Colleen developed her painful shoulders following her bicycle ride.

Colleen described her childhood and adolescence as very average and happy and that, throughout her life, she has always had friends with whom she has been able to socialise and who have provided help when she needed it. Colleen stated that she used the phone daily to contact her friends, as she found driving too painful.

ACADEMIC HISTORY

Colleen attended the local public primary school and was then admitted into a small, innovative high school which attempted to promote the arts, drama, and sporting achievements by attracting teachers and students with special interests. She found this a satisfying experience and maintains she was friends with the teachers as a result of the supportive environment.

Business college followed high school, and she was asked to stay on as a teacher and given training to do so.

MARITAL HISTORY

Colleen met her husband through her work in the business college, as he was the brother of a co-worker, and she married in 1976. The marriage was not successful, however, and she left her husband in 1988, finalising the divorce in

the following year. She stated that her husband's emotionally abusive behaviour was the reason for the split and mentioned that the divorce was amicable, as they had not involved lawyers and their two sons were free to visit both parents as they wished.

Colleen does not have a partner at present, but states that this is not a problem. She has two sons, born in 1981 and 1983, who still live with her. The older son is undertaking studies in accounting at TAFE and the younger has an apprenticeship. Both were described as doing well, and being helpful with the household chores Colleen is unable to do.

EMPLOYMENT HISTORY

Colleen worked full-time until the birth of her first child, and then commenced part-time employment, performing the paperwork for her husband's business and occasionally typing reports at home. She considered herself a stay-at-home mother even though she worked from home.

When she separated from her husband, she remained at home on a single parent's pension for six months and then commenced work with an accountant for three days per week, during school hours, progressing to five days. She remained at this job for six years, then left when she felt her employer was not treating her well.

Colleen was then approached to work at a real estate agency, a job she enjoyed, but left due to problems in her relationship with her employer. Her next place of employment folded one year after she had joined it, and it was then (in January 1997) that she commenced work at the real estate agency where she is currently employed.

Colleen stated that she enjoyed the exciting life of being in the office, the interesting people ("they're salespeople, very outgoing and extroverted"). She also enjoyed playing with the computer systems, and prior to her problem had set up a desktop publishing program for the agency. Colleen also mentioned the intricacy of trust accounting, and the challenge of troubleshooting the arrangements of showing houses, talking to lawyers and solving problems.

The negative aspects of her job were the pressure of deadlines (once monthly) and the fact that no other employee was trained to help her. Mundane tasks, such as filing, were also unpleasant.

HOBBIES

Colleen took up horse-riding following her divorce, as she had always wanted to do it and she "didn't want to sit at home and pine when the children were with their father." She had been unable to ride with her painful shoulder. Skiing was also mentioned as she had found great comfort in being able to hire a lodge in the Snowy Mountains with friends following her divorce, and have a joint holiday with "the girls" and their children (fathers had stayed at home). Again, the task of driving that distance was now impossible due to pain.

Colleen added that she enjoyed reading and computers, but that she had never taken up painting again after her husband had "systematically put me down." She thought painting would be too difficult to attempt with her problem.

MEDICAL HISTORY

Colleen had had a difficult first labour with a third degree tear which took six months to heal after the birth of her first child, and so elected to have a Caesarean section for the second birth. She had had arthroscopies in both knees in 1997, and had recovered well from surgery.

Colleen had never experienced anxiety or depression, and related that, although she had shed tears during her marriage break-up, she had been mainly angry and disappointed and had never had anhedonia, insomnia, or suicidal ideation.

TREATMENT APPROACHES – ROLE FOR HYPNOSIS IN THIS CASE

One of the most successful uses of hypnosis has been in pain management (Hartland, 1989; Holroyd, 1996) and it is also an excellent way of teaching relaxation techniques for stress management.

I also considered that there may have been issues of conflict at work or home that the patient had not discussed, as she had not initially mentioned pain relief as one of her aims (see treatment goals). There appears to be a positive correlation between disability and the level of dissatisfaction with relationships or the workplace—or, as Madrid and Barnes put it, "The disease process is often linked to the frustration of an emotion" (Madrid & Barnes, 1998, p. 134).

TREATMENT GOALS

Colleen wanted to use hypnosis as a way of relaxing and also mentioned that the acupuncturist she was now seeing was treating her for more than her shoulder, as he felt her mother's death was implicated in her present symptomatology. She felt that she may reach a resolution of her grieving through hypnosis, and I agreed that hypnosis would be useful to help her deal with emotional issues that were important to her.

Colleen had been asked to write a list of goals which she wanted to achieve. "Emotional and financial security" were at the top of the list; she wanted to work just enough to be comfortable financially, and to have time to devote to her hobbies, which would equate to two or three days per week at the real estate agency.

Interestingly, Colleen mentioned these aims initially, and only on specific questioning did she agree that a diminution of her shoulder pain and stiffness might be useful.

Colleen then stated that she wanted to feel less pain and be more able to do things she had previously been able to do, although she felt she did not want to return to her previous level of work.

ASSESSMENT OF SUITABILITY FOR HYPNOSIS

Colleen was assessed as an intelligent woman who was not depressed or anxious and had significant insight into the limitations of hypnosis, and a keen interest to try a self-help measure.

When assessed using the "teapot test" (McCarthy, 1999) she showed good visual, auditory, and gustatory capacity for positive hallucination, and stated she felt very relaxed.

PREPARATION FOR HYPNOSIS

The benefits and limits of hypnosis were discussed, namely that hypnosis could be a useful adjunct to achieving muscle relaxation, as well as mental relaxation and wellbeing which would be useful in helping to deal with the limitations to normal life which she was experiencing. She was advised that it was not a magic cure, and that she would benefit more by practising at home daily with the relaxation tape I would make for her. She was also instructed in the role of the hypnotist as a guide, and that she would be in control and would be able to communicate freely as she wished.

SESSION I

Following an initial short discussion on how she had been the previous week, induction was commenced using Ericksonian suggestions for progressive muscle relaxation—"I don't know which of your feet will start to feel relaxed, the right or the left … etc… ."

She was guided along a river in her imagination to a special place, and asked to describe a door through which she could pass into an even better, calmer and more fulfilling place. She was asked to place any discomfort or unwanted feelings in a container by the door, and then to enter and close the door behind her. She spent time in her special place, and was then guided to return as she came, bringing back the good feelings and only taking out of the container what she feel she would need, at which she smiled and decided to "leave them just where they were." She was then counted out gently over the count of five.

SESSION 2

At this session, the concept of psychoneuroimmunology was explained (cf. Madrid & Bames, 1998).

Induction consisted of suggestions for physical relaxation as before, and the mental image of her special place, utilising the sensory modalities to promote involvement. She was also reminded of how she had achieved many goals in the past, and encouraged to see her learning of techniques in hypnosis as another way to achieve her goals.

Colleen was then asked to consider the various suggestions as detailed in the work of Madrid and Barnes (1998). She showed positive ideomotor response with the right index finger when she was asked to become aware of the "healing glow from the pineal and pituitary glands, and from the adrenal gland releasing cortisol."

A tape was made of the session so that she could practise the feeling of letting her healing hormones being released, as practice has shown to improve outcome in chronic pain (Holroyd, 1996). She was also advised that she could recall the feelings of relaxation and calm by listening to music and going in her mind to her special place.

SESSION 3

Colleen had practised her tape daily, and felt she derived benefit from it, especially as she saw herself walking through the snow in her favourite place. She stated that she was able to do more, go to the shops, and walk more comfortably.

She commented on the visit she had had from an occupational therapist from the work cover insurance company and the fear she had that she would be assessed as being a malingerer.

At the start of the session, the concept of the time line and the image of herself in the future was explained.

Trance was induced as before, and she was taken in her imagination to her special place. Based on brief hypnotherapy principles (Howsam, 2000), she was asked to allow the healing light of the universe to flow through her from the top of her head to her toes. She was then asked to focus on the subconscious processes of which her body was capable: healing, intuition, and to allow the healing chemicals to flow and do their work.

Colleen was then asked to allow herself to float up above her time line (James & Woodsmall, 1988), and to see an image of herself in the future, doing what she wanted to be doing, interacting in positive ways.

Colleen's face showed some distress at the suggestion that she could see herself in the future. On questioning as to what was happening for her, she stated that she had, in fact, seen her mother and that perhaps that meant that she would not be allowed to feel good. As a tape was being made of the session, I asked Colleen if she wanted to talk more about this or concentrate on the good feelings for the tape. She decided to allow herself to talk about this at a later time and the session then proceeded.

She visualised the symbol of her future as a gold and silver pyramid and was encouraged to consider the meaning that the pyramid has to many in terms of energy, success, mystery, and healing (many people sit in pyramid-shaped tents and other constructions when meditating to "focus the energy").

Colleen was then given the suggestion that she would be able to listen to the tape daily and to see herself in the future doing the different things that she had in mind, and that her subconscious mind would be able to work out the meaning of her initial visualisation of her mother during her dreams.

SESSION 4

Colleen reported that as she had listened to the tape daily, she had noticed a shift in the direction of her time line—the future had initially extended in front, and was now to her left. She stated that she felt much improved in herself, and was no longer getting cramps in her shoulders during routine activities during the day.

Colleen felt that her sadness in the previous session had been more for herself, and that she had tried therefore to see more positive things, describing "warmth towards self, sharing, giving the children hugs, walking in the mountains, riding my horse, and skiing" as the images she had chosen.

When asked to describe how she saw herself in her career future, she stated that she enjoyed the challenge of doing accounts and perhaps working freelance for others. She saw herself working a 20-hour week. She then mentioned that there were some problems with other staff at work, but "nothing I can't handle"—she had managed to deal successfully in her past with "an unpleasant boss" and felt that she could be assertive if she needed to be.

The hypnosis session focused on her special place, healing light and body chemicals, and then asking her to recall her skills from previous experiences to deal with present and future situations.

The time line was again used to visualise the future self-image, with her behaviour at work, with friends and family, and an increasing awareness of the skills she would require to achieve those goals. She was "invited to be surprised at the results!"

SESSION 5

At this session, Colleen was feeling much better, "as if a screw in my shoulder that had been tight had been loosened at least three turns." She stated that she wanted to increase her work hours to two days of three hours each at the office, as well as the five hours she was doing at home.

Colleen also discussed making her plans more concrete, and noted that her car was not comfortable for driving long distances. She mentioned that her son was buying a car and that they might swap sometimes, or she might buy another, more comfortable car soon.

During the session, she visualised walking through a quiet field, feeling energised and peaceful. She was again taken through the steps of healing chemicals being released, and visualised herself in the future, driving

comfortably and having new experiences and behaviours more consistent with her goals.

SESSION 6

Colleen stated that she had enjoyed increasing her working hours, and had coped well with some "interesting" situations—namely, the fact that her youngest son's new car had been "written off' when he swerved to miss a turning car and crashed into the gutter barely three hours after picking it up. She described not feeling as overwhelmed as she would have expected to be, and was pleased with this.

Colleen was asked to describe her feelings about her mother's death, and whether she would like to spend this session working in this area. She replied that apart from the one time when she had seen her mother as her future self, and had interpreted that to mean that life was finite, and therefore to be enjoyed, she had not had unpleasant thoughts associated with her mother. She mentioned that when she first met me I had given her some general strategies to cope with her grief, and that she had found them most helpful.

It was agreed that as she was doing well, and making positive changes, this would be the last regular session, with a view to returning in one month for review. It was decided that a new tape could be produced during this session, incorporating a focus on self-protection.

Trance was induced as before, and the agreed image of a gentle cliff path with well-defined edges was described. The concept of protection from overwork or demands of others was mentioned, with the suggestion that there would be increased awareness of situations when she was at risk, as well as the ability to say no when appropriate, and to ask for help.

Interestingly, as the fence which bordered the cliff path was being described, Colleen stated that she had felt herself go up to the fence and holding on to the top bar, vault over it to a ledge some twelve feet down on the other side, "landing like an Olympic gymnast with my arms up in the air!"The suggestion was made that the fence was for her protection, not to limit her life, and that protection was not the same as being fenced in.

DISCUSSION

Colleen's case highlights the use of hypnosis in the treatment of chronic pain, and as a way of helping the patient to make appropriate life choices where there appears to be a correlation between the development of a chronic pain

syndrome and other life issues. She reported improvements in her physical and mental wellbeing, and felt that she was well on the way to achieving her goals of "emotional and financial security," having defined them more clearly to herself.

Colleen felt the session tapes were a useful adjunct to her fortnightly appointments, and also expressed confidence in being able to recall a trance-like state for daily relaxation while listening to music, which she could use for the future.

References

Hartland, J. (1989). *Medical and dental hypnosis.* London: Bailliart Tindal.

Holroyd, J. (1996). Hypnosis treatment of clinical pain: Understanding why hypnosis is useful. *International Journal of Clinical and Experimental Hypnosis, 41,* 33–51.

Howsam, D. (2000, June). Brief hypnotherapy. Workshop for the NSW Branch of the Australian Society of Hypnosis, Sydney.

James, T., & Woodsmall, W. (1988). *Time line therapy and the basis of personality.* Los Angeles: Meta Publications.

Madrid, A. D., & Barnes, S v.d. H. (1998). A hypnotic protocol for eliciting physical changes through suggestions of biochemical responses. In B. Evans & G. Burrows (Eds.), *Hypnosis in Australia* (pp. 134–141). Heidelberg: Australian Society of Hypnosis.

McCarthy, P. (1999, September). Hypnosis in general practice. Workshop at the Australian Society of Hypnosis Conference, Sydney.

Watson, E. M., & Sonnabend, D. H. (2000). Shoulder problems: A guide to common disorders. *Medicine Today,* January*,* 22–30.

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Hypnosis in the Rebuilding of Self Following Marriage Breakdown

Colleen Wilson
Psychologist

This case demonstrates the use of hypnosis in rebuilding a sense of self-identity in a 48-year-old female following the breakdown of her marriage of 25 years. The case illustrates the benefits of hypnosis in managing anxiety surrounding the fears of facing a future without the security of the marriage which the client had relied on as her primary source of self-identity. The client had a history of child sexual abuse and her poor self-concept, her personal boundaries, and low self-esteem had resulted in a great deal of anger, which was dysfunctional for her intimate relationships.

PRESENTING PROBLEM

Therese came to counselling after an Apprehended Violence Order had been served on her by the courts on behalf of her husband. She had been violent following her husband's disclosure that he had been having an affair and wished to end the marriage to be with his new partner of three months. Therese had continued to pursue her husband with telephone calls and going to his place of work, where there were scenes involving verbal abuse. On occasions he would come to the house to see her and they continued to have a sexual relationship. She had frequent outbursts of anger with her adult daughters, husband, extended family, and over the years had found it difficult to sustain friendships. Therese recognised that managing her anger had always been a problem and the powerlessness she felt around the breakdown of her marriage had highlighted the extent of the problem. She found it difficult to let go of the marriage, while her husband would at times during the separation pursue a sexual relationship with her.

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HISTORY

Therese was the eldest child in a family of four, she had two younger brothers and a sister. Her father's drinking was a problem for the family; he drank daily and could become violent both physically and verbally towards her mother, who stayed in the relationship. Therese was sexually abused by her father on a regular basis from the age of 9 until she was 12. Her father also sexually abused two of Therese's daughters, now aged 23 and 21, when they were 10 and 8 years old. The abuse was disclosed by Therese's eldest daughter shortly after her father died. Following this disclosure, the younger daughter also disclosed the abuse. Forced to confront the abuse towards her and her daughters, Therese disclosed this to her mother. Angry, and guilty about her feelings of failure to protect her daughters, Therese believed her daughters had been safe when they stayed with their grandparents and that her mother would protect them. Therese showed no anger towards her mother. Her relationship with her mother was very important to her and she kept regular weekly contact throughout the 25 years of her marriage.

Therese's identity of herself was that of a wife and mother to her own daughters. She married when she was 18 years old, after finding she was pregnant with her eldest daughter. She had made a career of her mothering role and supported her husband in their business by doing the bookwork. Therese's relationship with her daughters was difficult. She desired a close mother–daughter relationship and invested heavily in her mothering role. However, as her daughters sought to establish their own identity they displayed considerable anger towards their mother, especially the younger daughter who was now 18 years old, completing her secondary education. This daughter had moved from the family home to live with her boyfriend. Therese was experiencing feelings of loss and rejection from this.

Her marriage had always been difficult. Her husband had worked long hours in his business, there was very little intimacy, and financial problems following the failure of some business investments.

Medical and Psychiatric History

Therese had a history of somatisation disorders. She would present to doctors with a wide range of vague symptoms such as headaches, sleeping problems, back pain, and nausea. She worried about her physical health. She was aware of her mood disturbance and explained much of her distress as resulting from pre-menstrual tension (PMT). She believed her anger and impulsive behaviour

were PMT-related. Following arguments she would then over-spend on shopping sprees to feel good. This would then cause further conflict in the couple relationship.

She displayed symptoms of social phobia and avoided social contact with others outside the immediate and extended family unit.

During adolescence she reported symptoms of bulimia, but had received no treatment.

Following the marriage breakdown she sought treatment from her doctor for her PMT and when she came for counselling was taking Zoloft for depression and Normison to assist with her sleeping. She was fearful of taking the medication and expressed a desire to terminate medication as soon as possible. She had thought of suicide but had no plans as to how she would take her life.

Clinical Summary

Therese was showing signs of an adjustment disorder with associated depression/anxiety following the breakdown of her marriage. The marriage had been emotionally abusive for both Therese and her husband. She was displaying the fear of abandonment typical of a borderline personality disorder. The anger she was carrying related to the childhood sexual abuse by her father and the subsequent abuse of her daughters. The "client's self-structure" (Kohut, 1977; Masterson, 1985) did not provide her with the ability to deal with the abuse in the marriage. Emotional insecurity in the married relationship had contributed to a fear of abandonment. The client had attempted to maintain a sense of self through her role as a wife and mother. The developmental cycle wherein her adult children no longer required her mothering, along with the marriage breakdown, had highlighted the fragile self. She had built up a well-defended personality but the demands for intimacy in the "empty nest" family life cycle stage (Hill & Rodgers, 1964) had proved difficult for the client to achieve. Schnarch (1991) maintains intimacy is a paradoxical phenomenon, wherein, for intimacy to be achieved, differentiation of the self is essential. This client had limited potential for an intimate relationship with a fragile self-identity.

TREATMENT

Treatment goals were set around Therese's goals of anger management and coping with the pain of separation. The following treatment plan was proposed:

1. To manage depression associated with the loss of the marriage.
2. To manage anxiety associated with her fears for the future.
3. To work through her anger and the hypothesis that this was based in childhood sexual abuse.
4. To develop a sense of identity separate to that of mothering, wife, and daughter roles.

First Stage of Therapy

The first stage of therapy focused on stabilising Therese's feelings of depression and anxiety. A cognitive–behavioural treatment (CBT) strategy was used here to begin to anchor the client with her thought patterns and self-structure. Since Therese was reporting thoughts of suicide and the self-structure was so fragile, hypnosis was not used at this stage of therapy.

Therese was seen weekly for four weeks, and then fortnightly for three months. She was given regular homework exercises of keeping a diary of her thought patterns and challenging beliefs with her "wise" mind. This stage of the therapy made extensive use of Linehan's (1993) psychosocial skills training program. During this stage Therese was taught progressive muscle relaxation techniques to help manage tension in the body.

At the end of this initial stabilisation stage, I contacted Therese's husband with the option of seeing the couple for relationship counselling. He agreed to attend a session without his wife, but refused further counselling for the marriage.

Despite Therese's ability to see more clearly the problems in the marriage and how dysfunctional the relationship had been for her, from time to time she pursued confrontational contact with her husband in the workplace and he sought to pursue sexual contact with her in her home. The client's mood at the end of stage one in counselling had stabilised and she was now more regular in her sleeping patterns, and no longer held thoughts of suicide.

Second Stage of Therapy

During the second stage of therapy Therese was offered the opportunity to extend her relaxation therapy into hypnosis, to address the negative self-beliefs which were feeding her anxiety and anger outbursts. Trust had been established in the counselling relationship and I was sufficiently assured suicide was no longer contemplated. I assessed Therese's suitability for hypnosis following her response to the progressive muscle relaxation exercise, which was eventually

extended to include "safe place" visualisation. She had a positive attitude towards hypnosis and was keen to work on her problems.

If the sense of self could be strengthened by the use of ego-enhancement in hypnosis, I felt that Therese's anxiety could be reduced and the anger would begin to dissipate, as she began to experience herself as more powerful and in control of her life.

The client was introduced to hypnosis to achieve her goals with management of her anger. She was assured the process would be paced at her level and was advised that she was in control of the session—at any time she could raise the index finger on her right hand if she chose to end the process.

Induction was achieved using eye closure, progressive muscle relaxation technique, and the safe place exercise we had been using for the three months. A second phase of induction provided the initial shift into hypnosis practice. An ideomotor item of arm levitation was used, as I was reasonably sure the client was willing to let herself go and experience the hypnosis process. I felt the arm levitation would help her shift from the relaxation process and convince her that something unusual was happening, something quite different to her experience in previous sessions.

Music was used to further enhance the deepening stage. Therese selected a joyous piece of music by Handel—chosen to bring a content of joy to her inner world, which so often had been contaminated by her negative cognitive process. Since her safe place was a spring garden scene, the music fitted perfectly with her joyous experience of colour and growth of the plants. Deepening was furthered using a scene of resting under a tree in the garden, with a fixed gaze absorption exercise where the client focused on the detailed texture of a leaf. A second ideomotor item was then introduced—a buzzing fly and the involuntary movement of using her hands to shoo the fly. A subsequent deepening process was then used to help her experience calm, peace, and harmony once the fly was gone.

Deepening continued using the visualisation of an object to represent the experience of strength. The client chose a dove, which rested upon her left shoulder. This was later used as part of a post-hypnotic suggestion.

The content of the hypnosis process focused on addressing various aspects of Therese's cognitive experience of self. Areas addressed were her body image; her social intelligence, personality, and spontaneity; and her ability to manage negative feelings, especially messages of fear of the future. Her capacity for productivity and creativity was especially focused on, as the client had a natural

gift of creating and making high quality craft items, which she sold at a local market.

The de-hypnotising stage was important for Therese. She had a capacity to easily dissociate and would become quite absorbed in her hypnotic experience. It was always important to allow her sufficient time to bring her awareness back to the here and now.

The debriefing stage was used as a way of re-anchoring Therese in her here-and-now world. She often made links with aspects of her personality, unknown to my experience of her. While previously she had used the power of her mind in a self-destructive way, she gradually began to use her vivid imagination to serve her more constructively.

Stage two was completed over a period of six sessions. At this point, Therese had a more positive experience of herself but was expressing the need to look further at how the negative self-concept had emerged. She wanted to know more about her childhood.

Third Stage of Therapy

During the third stage of counselling regression work was added, but with caution, and again it was emphasised to Therese that she was in control of the pace of the sessions and could use the signal of raising her index finger when she wished to stop the process.

Therese was asked to imagine her life as a storybook, in which the pages represented the years of her life. She could browse the book and choose to tell me about a page that was significant to her. As Therese got in touch with various painful episodes in her life I asked her wise, caring adult to comfort the hurt and fearful child in her past. She worked through some significant family life cycle events.

Probably the most significant issue for Therese was an intense anger she felt for her mother, following her mother's inability to protect her from the abuse of her father. Prior to this, she had always expressed an idealised image of her mother. Therese's mother had been the strong source of protection in her life. No doubt the pain of the client acknowledging her mother's shortcomings was too distressful for the child part of her. The fear of the child acknowledging her vulnerability and the anger towards her mother were processed, after which her anxiety and anger began to dissipate.

SUMMARY AND COMMENTS

Counselling with Therese took place over a period of 22 sessions. The counselling was paced to allow for her fragile sense of self to begin to develop and consolidate. There were periods of return to depression as she progressed through the various stages of counselling. On termination of the counselling process, Therese was advised that she could return at any time and she has made contact from time to time.

This case illustrates a blend of CBT techniques in the psychodynamic context of Therese's life story, wherein hypnosis proved a valuable asset to uncover material that helped to restructure a self-concept based on her strengths. Initially Therese was not sufficiently stable to risk the less structured process of a hypnosis session, but the relaxation skills learned in the early period provided the environment for a successful transition into hypnosis treatment.

While the sexual abuse by her father seemed to be the focus, hypnosis uncovered issues in the Therese's relationship with her mother, and seemed to provide the most beneficial insights. Therese now faces the future with a sense of control over her life.

References

Hill, R., & Rodgers, R. (1964). The developmental approach. In H. T. Christensen (Ed.), *Handbook of marriage and the family* (pp. 14–15). Chicago: Rand McNally

Kohut, H. (1977). *The restoration of the self.* New York: International Universities Press.

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder.* New York: Guilford Press.

Masterson, J. F. (1985). *The real self: A developmental self and object relations approach*. New York: Brunner/Mazel.

Schnarch, D. M. (I991). *Constructing the sexual crucible.* New York: Norton.

Australian Journal of Clinical and Experimental Hypnosis
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Hypnosis and Unresolved Grief

Delma Gordon
Psychologist

This study reports the use of hypnosis with a client who was seeking to resolve a number of relationship issues. What became clear early in treatment, however, was that he had unresolved grief and loss concerning the unexpected death of his father many years previously. These feelings had hindered his personal development for many years and were contributing to indecision regarding his present relationships. Hypnosis was effectively used to enable the client to go back to his father, conclude his unresolved grief, and use his new-found peace as a means of ego-strengthening.

INTRODUCTION

This client, who will be called Mike, was referred by a local doctor for therapy. He was being treated for mild depression and was taking a low dosage of Arapax. Mike had recently separated from a three-year relationship with Anne, who had an adult daughter. He also had a previous marriage of 18 years, which had resulted in three children, with whom he had very close relationships.

Mike reported having difficulty concluding the relationship with Anne because of the strong sexual attraction which existed between them. He had met another woman (Mimi) who was everything that he had ever wanted in a partner, having shared interests and her emotional stability. Anne was emotionally unstable and suffered severe mood swings. Mike wanted to free himself emotionally from Anne so he could consider a relationship with Mimi.

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FAMILY HISTORY

Mike was the eldest child of four children, each with a two-year separation between them. His parents were a strict, devotedly Catholic couple. The sudden death of his father in 1969, when Mike was 19 years old, shocked the family. Mike suppressed his grief and loss as the rest of the family were so grief-stricken that Mike "took over," as he expressed it.

Two years later he married Helen and they had three children. This marriage lasted 18 years and they separated in 1990. Both an aunt and uncle, to whom he was very close, died in 1992 and their son suicided in 1994. Mike's mother died in 1995.

Mike married Anne in 1995. This marriage lasted three years. During this time he experienced constant blame for whatever happened in the relationship. He experienced being excluded by Anne because of her very close relationship with her 23-year-old daughter Susan. Generally, Mike and Susan related well and this upset Anne. Anne had been seeing a psychiatrist for several years, a fact made known to Mike only after they had married. Anne used to telephone Mike at work and accuse him of having affairs, not giving her enough attention, and trying to turn her daughter Susan against her. Anne would phone five to ten times per day, then accuse Mike of not being available and of harassing her. Anne claimed that the psychiatrist said that she had no problems.

Until recently Mike had not been on any medication. He said he was a person who "kept busy" but also liked to relax and to attend concerts and dinners. He was currently suffering some prostate problems which were being attended to.

THERAPY

Session 1

This session was used to develop rapport and to clarify Mike's expectations, my role and the structure of therapy. A family history was gathered and genogram developed.

Session 2

We explored the effects of his medication and his current feelings. Mike admitted that having talked about the losses of family, with whom he had a very close relationship, put him in touch with feelings of grief. After exploring

his understanding of the grief process, it was evident that he had never given himself time to grieve. He had kept busy helping everyone else and now it was time for him to acknowledge the depth of the losses he had experienced.

Mike had taken a voluntary retirement package in 1998 and, although he was now financially secure in a viable joint business venture, he found that he missed the constant stimulation of his previous working environment in a large industrial company. In therapy, Mike was taken through the steps of his feelings of grief and loss. He immediately identified how he had become stuck in the bargaining stage of grief and had continued to function in this way over the years from 1969 to the present.

Session 3

Mike was enthusiastic about returning to therapy as the grief process gave him a context which allowed him to understand the role he had taken up in his family and his other relationships. He was also in touch with his feelings regarding not having been able to say "goodbye" to his father who had died so suddenly. Mike had always been extremely close to his father and even though they had different views about religion this had never affected their relationship. I offered Mike the opportunity to have closure to his grief in relation to his father through hypnosis. Mike was very accepting of this as he had attended hypnosis for smoking some years earlier.

Session 4

I assessed the client's hypnotic capacity using the Stanford Hypnotic Clinical Scale (SHCS; Morgan & Hilgard, 1975) which identified that Mike responded well to a relaxation induction, ideomotor instructions (i.e., pulling hands apart/glue), strong visualisation, and ability to regress. He advised me that he "trusted" my voice and found it reassuring and easy to follow my directions. This indicated that a strong rapport existed. Mike scored low on amnesia and post-hypnotic suggestion.

I asked him if he would like the opportunity to meet with his father again, through hypnosis. I call this "hello again" work.

Session 5

As Mike enjoyed bushwalking, the bushwalk was used to deepen his hypnotic state: walking from this building down the path towards the bush, the path leading deeper into the rainforest; paying attention to detail which satisfied all

his senses, visual, olfactory, kinaesthetic, and auditory. Mike's breathing became barely evident, which indicated the depth of his hypnosis.

Therapeutic content Mike was instructed to go to a time when he and his father were sharing an enjoyable interaction and to take the time to talk with his father about anything and everything that was important to him that he felt was left unsaid. Mike would know when they had brought closure to their meeting, as his father would just fade and Mike would be left with an inner peace. Mike was to signal with the index finger of his right hand when his father had faded.

Bridging the waking state Before his father faded, they might like to give each other a symbol, which could become for Mike a symbol of peace, so that whenever he felt down or anxious he could hold it in his "mind's eye" and relax.

De-hypnotising Walking back through the bush stimulating all his senses, back down the path back into this room. Becoming aware of his body parts, the chair, etc. and opening his eyes.

Debriefing Mike found himself experiencing regression. He was sitting in his grandfather's lap then regressed to memories of his father. Feelings of love and warmth, no "unfinished business." Experienced his father saying, "Mike, it is not your place to have to do everything, you have done well." Mike experienced the interaction with his father as long, filled with many lovely memories, sadness, and pain at having not been able to say goodbye to him before he died. While feeling sad, Mike indicated an inner peace and calmness. He expressed feelings of great satisfaction regarding the hypnosis.

Session 6

Mike announced that he had allowed himself to cry between sessions and that it had felt like a cleansing and a release. He had a clear picture of what he needed to do with regard to his relationships. He had decided to move back closer to his children as he realised that although they had a close relationship he had been keeping them at a distance in case he should lose them. He felt that he now had a new direction for his life. He would continue on the Arapax and report to his doctor to ensure that he maintained his current level of functioning until he had consolidated the changes.

Summary

Mike telephone six months later to advise me that he had been pursued by Anne to continue their relationship. He had resisted and was feeling much stronger. He was also beginning to love himself and found he was not nearly as self-critical as previously. Mike had taken on responsibility at the age of 19 years and sacrificed his own needs. This role, script or pattern then became his for the next 29 years, leading to depression and relationship difficulties. Mike will continue to build at his own pace and I feel sure that if he ever required further therapy he would return.

In Retrospect

I would have liked to work further on Mike's self-esteem. Having completed his goal of therapy, he was satisfied and had numerous other relationships to develop before developing more of his own inner resources. As always, I trusted the client to know and satisfy their own needs not mine as a therapist. Although Mike did not score highly on the post-hypnotic suggestion items, the suggestions which I made while he was in his hypnotic state (i.e., a feeling of inner peace) and which he had maintained even six months later, indicate that he was responsive.

References

Morgan, A. H., & Hilgard, E. R. (1975). Stanford Hypnotic Clinical Scale and the revised Stanford Hypnotic Clinical Scale for Children. *American Journal of Clinical Hypnosis, 21,* 134–147.

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Hypnosis, Trauma, and Anxiety

Susan Barnard
Psychologist

This case report details the content of counselling sessions with a client who had experienced a history of trauma as a young child that was now strongly affecting his current emotions and lifestyle. Hypnotic interventions were strategically incorporated into an extensive period of counselling. I continue to see the client and hope this record gives a glimpse of the journey that we have taken so far.

> *"When a man seeks desperately to unite vision and will by whatever power is within him, how adversity is overcome."* (Keenan, 1993, p. xv)

PRESENTING PROBLEM

Paul self-referred to the counselling service at a tertiary institution, wanting to better manage his concentration difficulties and general anxiety. He is 41 years old, single with no current partner, living alone. Paul had received counselling and was currently seeing a psychiatrist for what he described as anxiety and attention deficit disorder. He was interested in looking at alternative solutions to that of "having faith in God," which was the current focus of his sessions with the psychiatrist.

The first few counselling sessions revealed that Paul had a heightened sensitivity/hypervigilance to criticism. This caused him to be continually on his guard and he became very stressed and highly anxious in situations where he clearly felt he had little control over the process or outcome. He frequently became very frustrated and experienced anger in situations where he felt misunderstood or unjustly accused. Paul found the external world very stressful and potentially untrustworthy.

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HISTORY

Paul's mother had eight children, from three different fathers. Paul was the fifth child. He had always believed that he had the same father as his older siblings. However, five years previously his older sister told him that this was not the case. His mother confirmed that he was the only child she had from a relationship with another man. She had been advised by the bishop of the church to give him the same surname as his older siblings. Paul presumed that this was to prevent any scandal within the church community. Although he has since been curious about his real father, he has chosen not to "go there" because there was "too much pain" involved.

All of the five older children spent some time in children's homes. Paul did not know the reasons for having been placed in an institution but knew he was put in when he was about 12 months old. He lived in a children's home in a Queensland country town to about age 11, when he was moved to another home in Brisbane where he remained until he was about 16 years old. His mother visited him occasionally in the home until he was about seven years of age.

Having grown up in institutions, Paul described himself as always having had emotional problems. He remembered verbal, physical, and sexual abuse from the nuns, older boys, and possibly an older man. Some of these memories were clear while others gradually continued to come into his conscious awareness. Paul remembered very fondly one nun when he was about two to three years of age who made him "feel very special." His memories of the first home were the ones that were most traumatic, causing him "emotional and psychological drain." He described everyday experiences in the home as oppressive, regimented, and restrictive. It was survival of the emotionally fittest, always having to be on one's guard.

Initially he did well at school and was accelerated in year 3. However, he later had concentration difficulties, experiencing problems staying on task and being organised. He was then put down a grade. At the tertiary level, Paul completed an Arts degree over five years and was currently studying for a second professional degree.

Paul remembered having had friends while growing up, joining in with sporting and other activities. He had a number of short-term intimate and close relationships. In the past ten years, however, he had chosen not to focus on this area in his life, placing his energies into other directions.

Paul cited his work experience, prior to starting university in 1994, as significant in understanding the difficulties he experiences today. He was a rig worker, working in a geographically isolated, male-dominated, hierarchical, violent, and bullying environment, not too dissimilar to those experienced in the first ten years of his life in the institution. Although he came to deal more effectively with it, he found it emotionally draining.

Paul reported no major health problems. For the past two years he had taken dexamphetamine tablets to control his hyperactivity and to help increase his concentration.

THERAPEUTIC GOALS AND USE OF HYPNOTIC PROCEDURES

It was apparent that Paul was dealing with issues relating to growing up in an abusive and punitive institution. The report of the counselling sessions illustrates how the direction of the therapy was primarily directed by him. This was necessary in order to allow Paul to develop a sense of control. For survivors of abuse who have issues triggered by everyday events, shifting their focus from the present to the past and then to the future sometimes occurs in a random fashion and may be necessary to help them cope with any accompanying distress. Therapeutic goals encompassed some of the following:

1. To enable Paul to experience deep relaxation and learn how to initiate this for himself through self-hypnosis.
2. To deal more calmly and rationally with frustrating situations.
3. To decrease his hypersensitivity to others' rejections through alternative interpretations.
4. To increase positive self-esteem, trust of self, and valuing of inner resources.
5. To develop assertiveness skills.
6. To develop confidence enabling him to begin therapeutically addressing some of his traumatic experiences, to develop new understandings, and to rescript them if necessary.
7. To continue to be future-focused despite his past.

There were six main reasons for introducing hypnosis with Paul:

1. Paul had used meditation in earlier years, which he had found helpful, and was highly motivated to try hypnosis.
2. By learning deep relaxation, Paul could get immediate relief for his anxiety

and cope better in frustrating situations. Research indicates that hypnosis is useful in the treatment of anxiety.

3. Given that Paul's child ego state had been given little nurturance when growing up, he would greatly benefit from some ego-strengthening. Hypnosis is an excellent tool to bypass the critical conscious mind and implant positive statements about self-worth. Hunter (1994) stated that a strong sense of self ego-strength is the core of confidence and self-esteem.
4. Given Paul's history, I theorised that many of his current anxiety problems were the products of earlier traumatic experiences and associated affect. Hypnosis has been used effectively to deal with unresolved emotions connected with past incidents (Wadsworth, 1995).
5. Paul frequently experienced memories of his traumatic past. It was likely that the incidence of such intrusive memories would increase as a result of focusing on them and their associated feelings in therapy. There was a risk that he could easily get stuck with the emotions, including anger, that these memories raise. Developing a future-oriented focus would therefore be essential for him. Yapko (2001) noted the importance of amplifying clients' strengths and shrinking pathologies by focusing on the future and moving towards specific goals.
6. Self-hypnosis would provide a useful tool for enabling Paul to strengthen and reinforce the skills and resources introduced in therapy.

TREATMENT PROGRAM

Sessions 1 to 6

Paul's first three counselling sessions concentrated on obtaining a history and resolving his immediate academic concerns (e.g., his decision to reduce his workload, his late completion of assignments, his frustrations with some aspects of the faculty, and exam stress).

During these counselling sessions some thought patterns started to emerge. It was apparent that he quickly became frustrated and angry when in difficult social settings. He said he often "went blank" when he felt he was being put down and was then unable to respond to the perpetrator. He had a very small social circle and described having had a number of "fall outs" with friends over the years. He thought that maybe he was lacking in social skills and social confidence.

From a cognitive perspective we examined some of his faulty thinking that was causing so much frustration. Paul agreed that the conclusions he had come

to about others "wanting to tread all over me and not being interested in me" may be interpretations and as such could be debated and alternative explanations considered.

We discussed the difference between non-assertive and aggressive responses, a non-assertive response being what I call the B4 Syndrome: "bottle, bottle, bottle, burst." Paul strongly identified with this. The assertive response was explained and strategies discussed. He watched the video *When I Say No I Feel Guilty.* We explored situations from the previous week in which he could have responded assertively, describing what he could have said and how he might have felt differently. This helped to introduce techniques of cognitive restructuring, visualisation and rescripting—tools that we would later use in hypnosis.

The following week Paul commented that he had assertively responded to a friend in a situation which could have led to an unsatisfactory outcome for him. He felt really good about having stood up for himself. I went on to discuss the assertive response to compliments and positive behaviour of others towards us. I encouraged Paul to take notice of such compliments and challenged him to accept these positive moments for what they were without undermining their value or intent, as he usually did. The ability to accept positive self-statements is important in building self-esteem.

At the fourth session Paul announced that his older brother (eight years his senior) had died. Paul had not spent much time with this brother and it was 20 years since he had last seen him. However, he felt connected to him in that he thought they were "emotionally similar" and that they had cared for each other. In exploring what this meant, Paul said that they had both been in a children's home, that his brother had served in Vietnam, and that they both had painful memories of the past. Paul hypothesised that in some way keeping their distance had allowed them to avoid stirring up this pain when possibly they were not yet ready. I validated his grief and the possibility that feeling this connection he may find past issues raised for him.

As it was exam time, supplementary exams were set in place for him.

The next two sessions indicated Paul's increasing readiness to address some of the trauma in the past. He discussed his recent thinking around the death of his brother. It occurred to him that two of his siblings (with similar childhood backgrounds) had died recently because of health-related issues. He wondered about the impact that their traumatic emotional history might have had on their lives and on his. He said he believed his improvement in life

depended on his ability to take responsibility for his future and to diminish the impact of his past.

This led into a week of global rumination on social and political injustices. While things had gone well over the previous week, Paul was feeling an unexplained agitation. Once again a cognitive approach was employed. Metaphors and stories were used to demonstrate indirectly the determination of cognitions over our feelings and behaviours. I mentioned such people as Nelson Mandela, Mother Theresa, and prisoners of war and concentration camps. I discussed an autobiography I had recently read of Brian Keenan, an Irishman, who had been kidnapped by fundamentalist Shi'ite militiamen and held hostage for four and a half years, his only contact being with his gaolers (Keenan, 1993). The question I asked Paul to contemplate this week was how these people survived, and not only survived but used these experiences to forge and shape their personal life philosophies and goals. This homework was to reinforce for him the power of thought, in particular choice of interpretation, over emotional and behavioural outcomes.

Session 7

In this session I explained how hypnosis was an excellent tool for assisting in relaxation and for focusing attention on whatever Paul chose, from ego-strengthening statements to control over his life and emotions. I emphasised the notion of the hidden observer and the control he would retain.

Session 8

An eye fixation and distraction induction was used, followed by focusing on breathing, suggesting further relaxation with each exhaled breath. To deepen the trance, Paul was guided through a progressive muscle relaxation procedure, moving from the toes, relaxing all major muscle groups, through up to his head and then through his fingers. There were sounds outside the room but these were simply integrated into the process and utilised to deepen his trance state. I acknowledged that everyday thoughts may intrude but that he could allow these to just come and go without being particularly bothered by them. During this deepening process, Paul's breathing became laboured and much louder, demonstrating increasing trance depth.

Paul demonstrated his depth of trance by responding to arm levitation suggestions. I invited him to open his eyes to observe his lifted arm, and then instructed him to once again close his eyes, suggesting he become even more

relaxed. Inviting him to witness his hypnotic response to suggestion reinforced for him his excellent hypnotic capacities and thereby assisted the building of positive expectancy as well as facilitating trance ratification.

Suggestions for the serenity place (Hammond, 1990) were incorporated. While in this place, he was encouraged to feel wonderfully calm and confident. Paul was guided along a path to "a special viewing area." Using these positive feelings an affect bridge, age progression, was suggested by directing him to view himself in the future on a screen. He was returned to his special, safe place, suggesting to him that at any time he wished to relax and return to this wonderful place he could do so. Termination consisted of guiding him through the usual cancellation statements towards his normal alert state by counting backwards from five to one. Paul enjoyed the deep state of relaxation and stated he felt wonderfully relaxed at the end of the session. He said he had felt very heavy while in trance.

Session 9

The previous hypnosis session had been taped and Paul had listened to it once and then employed self-hypnosis on a daily basis. He was enthusiastic about hypnosis and how it had helped him to relax and focus during the week. He was even putting himself into trance for 10 minutes during his daily bus trip.

Hypnosis was induced using Spiegel's eye-roll technique, followed by progressive muscle relaxation and descending a staircase for deepening. Paul's child ego state needed the support, encouragement, and acceptance to feel valued. I used Hartland's ego-strengthening script (Hammond, 1990). These suggestions initially examined the philosophy of human worth and goodness, conveyed the acceptance of both comfortable and uncomfortable human feelings, and implied that Paul should choose to retain whichever feelings he felt were serving a useful purpose. Positive affirmations of acceptance and love of self were repeated. Paul enjoyed the direct suggestions that were given and requested that I make an audiotape of these suggestions.

Session 10

At the commencement of the session, Paul said that he had not felt the same sense of self-consciousness that he usually experienced and wondered whether it could have had something to do with the hypnosis sessions and the tape he had been listening to.

During this session he chose to talk in detail about the abuse he had experienced growing up. He had never felt he had "fitted in." He discussed verbal and physical abuse by one specific older boy, inconsistent and punitive discipline by one particular nun, and sexual abuse by a group of older boys over a period of seven years. It was the first time that he had spoken to anyone about the sexual abuse. Paul had clearly given much time to introspection and demonstrated a good insight into the impact of these experiences on his life. This included his inability to relax completely around others, holding others out of his life, difficulty trusting others, difficulty relaxing around children, and his lack of self-confidence.

Hypnosis in this session focused on the option of choice that one has as an adult and the process of choosing. This belief in choice was an important step towards his altering current cognitions and behaviours, altering past understanding of past events, and becoming more future focused. I also wanted Paul to become more goal oriented and make immediate choices today that would lead towards his long-term goal/s.

Indirect suggestions of choice were introduced during induction wherein Paul was permissively invited to, for example, "choose to make yourself as comfortable as you wish … you can choose to relax as deeply in trance as you want … you can choose to notice which of your thoughts and visualisations are most soothing and relaxing …" These indirect suggestions contributed to the goal of building a response set discriminating options and choices.

We moved from his serenity place along a path, which then led into a number of different paths. It was suggested that one path in particular was particularly well trodden and that he could choose to go down that path without even thinking, but he was encouraged to ponder where the other paths might lead and how often in life it's important to "do something different … to change paths … to make a conscious decision to do this something different even if at first it may feel uncomfortable or difficult … you can choose one in particular that seems sensible to you … even if unfamiliar … you can consider it from a variety of options and angles … gathering as much information as you need to make a wise choice." Paul was reminded how he has in the past chosen new, unfamiliar paths that have led him to progress, grow, and move on in new directions. Once again he is considering making changes in his life and these changes may require him to take new paths.

Age progression was then used to explore the consequences of options and choices. He was encouraged to imagine in detail that it has been months since

he chose a new path and to notice "the consequences … what he likes better about himself … how it has made him feel … what it has allowed him to do that before he felt unable to do …"

In closing, post-hypnotic suggestions were given such as "you may be pleasantly surprised over the next few weeks about how you are starting to make different choices … choices according to what's best in the long run … and not what's easiest in the short run … and how pleased you will be when you notice these wise choices become your new automatic response …"

Paul was invited to bring the experience to a comfortable close, followed by a suggestion to reorient himself. He was very quiet and introspective after the session.

Session 11

At this session three weeks later, Paul was feeling somewhat stressed. The end of the academic year was close, assignments were due, and exams pending. Paul had also had an unexpected visitor who had disrupted his study plans and his computer had malfunctioned. He was managing this stress well, actively engaging in facilitating supports and "being philosophical" about things he had little influence over. He agreed that maybe he was choosing to think differently about the things that were causing stress and in this way was exerting more control and not feeling so anxious. Paul was pleasantly surprised that for the most part he had chosen over the three weeks not to smoke marijuana.

Session 12

Things were going well for Paul and he felt on top of things, but he was starting to get anxious about forthcoming exams. We discussed how elite sports people used visualisation as an effective mental rehearsal for competition-type situations, setting up positive expectancy. Paul was able to go into trance on his own. Further relaxation was suggested and ideomotor signals were set up, and he was guided through a visualisation of the exam situation and a desensitisation process. Here he practised reassociating feelings of relaxation and calmness whenever he started to panic and he visualised each step of the process with positive, successful outcomes.

Sessions 13 and 14

One of Paul's exams had not gone well. He had not understood the material during the semester and was not well prepared for the exam. In his other

exams, he was confident that he had passed. He had found the relaxation and positive mental rehearsal most useful.

Paul stated that he felt the hypnosis was going well, particularly on the "software" of his computer but hinted that he was concerned that the "hardware may be problematic and may need work." He said it was "fragmented." He said that the self-hypnosis that he was practising regularly was helping from day to day, but that if he could organise the "inner part" better he would better be able to cope long term. He was ready to explore some past events that were causing him to continue to undermine and devalue himself.

I briefly outlined ego state theory to him and discussed the potential use of hypnosis in revisiting past memories and using the adult ego state and its resources to reframe earlier experiences. He felt he needed time to think about "going there."

Session 15

Christmas came and went, and it was four months later when Paul returned for further counselling. He had part-time work in a new job, which made him feel good, more independent and had given him the means to socialise. He had asserted himself with a colleague and his manager in this new job and felt good about the outcome.

Paul had taken two major steps in "clearing up things in the past." He had spoken to his mother on the phone and now felt that he "understood more of the truth about the past," and had spoken to his sister about how he felt she had always spoken down to him.

It became evident that Paul was indeed starting to "clear out the attic" and that his increased self-confidence and assertiveness were aiding this process. He was anxious about difficulties he could foresee at work and about the new academic year. We discussed strategies to deal with his tendency to ruminate on potential problems, which meant he was not able to enjoy the full positive implications of the progress he had made. He had not yet learnt to trust himself to cope.

Sessions 16 and 17

These two sessions concentrated on discussing Paul's frustrations with academic faculty and part-time work disagreements. These situations demonstrated that at times of pressure he often lacked the confidence in

himself to act. However he noted that he was beginning to reframe his frustrations and to think about what he could contribute to bring about desired changes. He continued to find using self-hypnosis useful to relax himself.

Session 18

The aim of this "affect bridge" hypnosis session was twofold—to reconnect with inner resources so that Paul could begin to trust himself more, and to give him an experience of time regression for future psychoanalytic work. I hoped that by accessing a positive experience and emotion in the past, he would reduce his global negative thinking about the past. Paul was invited to put himself into hypnosis and relax deeply. I then asked him to imagine that he was on a train going back in time (this train would be used again later in reconnecting with unpleasant experiences), and to recall a time when he had felt particularly pleased and proud of himself, a time when he felt really good and confident. He was then asked to visualise in detail what was happening and how he was feeling. Suggestions along the line of Stein's "Clenched Fist Technique" (Hammond, 1990) were then given. Post-hypnotic suggestions were given that he could reconnect with these positive, confident feelings at any time he chose, maybe in a time of great stress and worry, by simply clenching his fist.

In discussion, Paul said that at first he had difficulty regressing to a positive feeling experience but eventually found himself thinking of when he played football. This was a time when he had felt really good about himself, confident of his skills and abilities. He remembered being able to survey the field, plan ahead, and then take appropriate action.

Session 19

Paul continued to use this visualisation and confidence in other contexts and felt optimistic and "on top on things." He commented that he was better able to put things into perspective and to choose what he wanted to put his energies into rather than expending energy in negative rumination. He was participating more in tutorials, setting realistic study targets, thinking and deciding more strategically. He felt that he had learnt a lot about himself in the past six to 12 months.

Session 20

Hypnosis in this session allowed Paul to regress and vividly recall a specific event in the past, to ventilate some of the feelings associated with the experience, comfort his inner child, and to develop insight and understanding of the event and rescript the event.

Paul commented to me that he was having frequent flashbacks or memories of the past and would like to revisit some of these. While using self-hypnosis Paul had accessed a memory of being physically abused. Prior to the incident he had experienced a great deal of trauma, but up to that point he had been able to cope with it. After this incident things had been different for him. What he wanted to explore in therapy was what had happened just prior to this incident that had caused him to act in a certain way, which had then resulted in physical punishment.

Trance was induced, then deepening suggestions and focusing suggestions were given. Ideomotor signals were used and permission gained from his unconscious to explore the issue. He was guided back using a train going backwards in time going past stations, each with a number that signalled an age. He could choose at any platform to stop and get off. I gained permission from the unconscious to go back and gave him permission to take his time on his journey and to choose when he wanted to get off.

Through ideomotor signals I established that Paul had regressed to eight years of age. Direct suggestions were given to him to walk down a path, along which he would see things that happened to an eight-year-old Paul. I asked him to describe what he looked like and what he was wearing. It was suggested that he take the adult, 41-year-old Paul, his protector, with him down the path. He was asked to tell me what was happening. Paul said he was still standing at the station not wanting to go anywhere: "I don't want to go." Direct suggestion was given to the eight-year-old Paul to get back on the train feeling very safe, knowing that at any time he wished to go backwards or forwards on the train he could. He was in control.

I encouraged him to notice that adult Paul was sitting right next to eight-year-old Paul, observing him, reassuring him that he could get off now if he wanted or he could come back another time, knowing whatever choice he made the adult Paul would be with him—safety was repeatedly emphasised. I suggested that they get off the train and the suggestion was given to go down the path, reassuring that any time they could go back up the path, returning to the platform and the train.

The metaphor of a video rewinding back to this specific incident was used and Paul was encouraged to visualise in detail the events leading up to the physical abuse incident. While telling what he was experiencing, he abreacted. The adult ego was instructed to comfort the eight-year-old child.

As a result of remembering what had gone on before the incident, Paul developed new insight and understanding. With this new understanding adult, he was told to explain things to the eight-year-old. Rescripting included such statements as "It was understandable for an eight-year-old to have been afraid," "I can trust myself," "Courage is good," "People don't have to rely on my fear to accept me. They would prefer me to be courageous, be myself." Eight-year-old Paul was then led by adult Paul back onto the train. I gave them permission to come back at any time. Because of his enthusiastic use of self-hypnosis, I gave Paul a post-hypnotic suggestion, reminding him that he would always take his adult part with him. He was invited to reorient, when he felt ready.

The session was concluded discussing and consolidating what new learning had occurred during hypnosis. Paul continued to ask why atrocities happen and we both concluded that maybe there will always be things that happen in the world that don't make sense—as Yapko (2001) says, sometimes we need to ask, "why ask why?" He admitted he has spent many years asking "why" and that in stressful situations where he had no control he preoccupied himself trying to find answers, consequently disempowering himself. It was suggested maybe all we can really trust is ourselves.

Session 21

The goal of this final session was to help Paul integrate all he had learnt and to remind him that he can continue to use these learnings, insights, and skills in the future. This was an adaptation of Yapko's (2001) prevention-focused script. Apart from allowing time in hypnosis to reflect on what one has learned and integrating this, the message was clearly also one of recognising the value of all one's "parts" and the importance of valuing of all these parts.

OUTCOME

I continue to help Paul develop resources and skills that he did not have the opportunity to develop while growing up. At one session, he reported he was going to defer his studies for six months to give time to other things in his life. He was pleasantly surprised that, compared to 12 months ago, when he might have been "worried sick" and "uptight," today he felt good about this decision.

He was planning to catch up with some family members, look at where he was placed in the job market, and allow himself time to put other aspects of himself into perspective.

COMMENTS IN RETROSPECT

Paul clearly had insight into his traumatic past and chose to address aspects of it when the timing was right. Part of his success in life had come about through his ability to compartmentalise aspects of his life. It was necessary for him from time to time to choose not to be "in therapy" or not to "address" his traumatic past. Hypnosis proved to be an invaluable tool in this therapy case, complementing what was discussed in therapy.

References

Hammond, D. C. (Ed.). (1990). *Handbook of hypnotic suggestions and metaphors.* New York: W. W. Norton.

Hunter, M. E. (1994). *Creative scripts for hypnotherapy.* New York: Brunner/Mazel.

Keenan, B. (1993). *An evil cradling.* London: Cox & Wyman Ltd.

Wadsworth, R. (1995). Hypnotic intervention in unresolved grief. *Australian Journal of Clinical and Experimental Hypnosis, 18,* 45–56.

Yapko, M. (2001). *Treating depression with hypnosis*. Philadelphia: Brunner-Routledge.

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Book Review

Sport Hypnosis

Donald R. Liggett

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$U.S.17.95.

In recent decades, professional sport has become a multi-billion dollar business, in which athletes of average ability can command formidable salaries, and the truly gifted few can earn salaries that are beyond belief. For instance, the average baseball player in North America (who is very average indeed) earns $US1.9 million a year to play 162 games over summer. Then, there is the case of Alex Rodriguez (a.k.a. "A-Rod"), a truly gifted shortstop, who early this year signed a contract with the Texas Rangers for $252 million over the next 10 years. A-Rod continues to perform up to expectation with both bat and glove, and probably has no need for hypnosis. The Rangers, however, are one of the worst teams in baseball, and no amount of hypnosis is likely to improve the pitching staff.

Few books have been written on sport hypnosis, and there exist very few sport psychologists who are trained in hypnotic procedures. Athletes have always sought an "edge," as Liggett points out, and when an athlete is scheduled to compete at a certain time on a given day, his/her first concern is to be "in the zone." That is, the athlete seeks a peak performance unimpeded by psychological factors such as anxiety. For this reason alone (although there are others), hypnosis offers a variety of techniques by which the athlete will learn to be both loose and focused on game day. At the same time, a 100 metre sprint is an altogether different proposition to running a mile or a marathon– the sprinter has no margin of error, while the longer distance runner has some. Similarly, for athletes who play such team sports as football, ice hockey, baseball, and cricket, a mistake or two is not necessarily fatal.

This book does not start off well. It begins with a history of hypnosis, which occupies a page and a bit. It makes an unconvincing attempt to link present hypnotic procedures to religious practices of ancient times. The reader learns,

for instance, that the author of Genesis reports (*sic!*) that God put Adam "into a deep sleep to take his rib to form Eve." Various temples of antiquity such as that at Delphi, are cited similarly as precursors of hypnosis–they may well be, but the evidence is too remote, and too fragmentary to warrant the certainty Liggett expresses.

From here, the author progresses to Anton Mesmer (*sic*) who "revived an interest in hypnosis" and to the Benjamin Franklin Commission's conclusion that Mesmer's claims were "fraudulent" with respect to animal magnetism. He omits to mention a fact that would have permitted him to set his stage more favourably—the Franklin Commission concluded not only that animal magnetism did not exist, and thus could have no beneficial effects (although Franklin knew better than this). It also concluded that the phenomenon could be understood better in terms of imagination, imitation, and touch, with the primary effect being attributed to the magnetised person's imagination.

There are other troubling lacunae. Like many clinicians of hypnosis, Liggett is opposed to formal evaluation of hypnotisability using a standardised scale. While there are valid arguments to support this position, he resorts to the old chestnut that it is a waste of an hour that can be spent more profitably. Actually, the real clinical concern is that if the client proves to be minimally responsive to hypnosis, s/he will not benefit from such an intervention. Further, it transpires that he has his own informal (and unstandardised) method for assessing hypnotisability.

The issue is more complicated, though; long before the development of standardised scales, Freud (1970) reported that he had clinical success with patients in "light" trance, and failure with "deep" trance patients. A century later, a little more is known, such as that success in controlling pain is more probable with the more hypnotisable client (Cedercreutz, 1978; Hilgard & Morgan, 1975), and that phobics tend to be above average in hypnotisability (Gerschman & Burrows, 1994). Further, hypnosis is most effective in the treatment of pain, dermatological conditions, and asthma, and least effective with smoking, weight loss, and alcohol excess (Wadden & Anderton, 1982).

Such an enlarged data base of clinical observations could make clinicians working with patients and/or athletes more effective. Screening for hypnotisability at the beginning of a clinical intervention may, indeed, be counterproductive, but it could yield much valuable data if conducted once treatment has advanced beyond the initial stages.

Liggett tends to equate hypnotisability with vivid imagery, and he reports that he has obtained considerable success with athletes in "light" trance. While

many clinicians share this viewpoint, the data suggest that there is a non-linear relationship between imagery and hypnotisability. If a person has vivid imagery, s/he may be highly hypnotisable; the person with poor imagery is most likely (but not inevitably) to be low hypnotisable (Perry, 1973). Such a finding may better account both for Liggett's successes with "light" trance athletes, and Freud's successes and failures with clinical patients.

An additional issue that deserves attention is Liggett's belief that hypnosis increases imaginal activity. He presents an experiment he conducted which appears to support this conclusion. While there is a counterbalancing of experimental and control conditions, an essential item of information is not reported. It is known (Zamansky, Scharf, & Brightbill, 1964) that experimental subjects "hold back" their responses in a control condition if they know ahead of time that they will be asked to participate in two conditions, one of which is hypnosis. At the same time, he may be on much firmer ground when he observes that hypnosis tends to be effective much more quickly than other psychologically based methods that have been used with athletes. An additional claim may be true, also. Liggett observes that having the athlete describe the psychological problem(s) associated with his/her performance while in hypnosis is also a time-saving procedure that facilitates faster diagnosis and remedy.

On the other hand, he shows a keen awareness of the experimental, clinical and conceptual literature that is relevant to athletic performance. He is impressive in presenting the views of Jacobson, Suinn, and Benson, all of whose work is relevant to helping athletes perform at their best. For instance, Jacobson emphasised the need to develop a muscle "sense" by learning how to recognise what tension feels like, and to then learn how to alleviate it. Likewise, Suinn's visual motor behavioral rehearsal (VMBR) is presented as a shortened, and more cerebral version of Jacobson's procedures. Then again, Herbert Benson's relaxation response emphasises relaxing the mind as a prelude to relaxing the body; it is a reversal of the Jacobson/Suinn focus on bodily relaxation preceding mental relaxation. In addition, Liggett outlines Lars-Eric Unestahl's notion of an ideal performance state (IPS) which emphasises the subjective experience that accompanies a highly successful athletic performance as opposed to a substandard one, and he cites some success data that support Unestahl's position. There is, though, a chicken – egg dilemma here—elite athletes inhabit a very narrow band of high ability; their success may be because they are so highly motivated that they are attracted to any technique that offers an "edge."

Most of these procedures were developed within the context of helping clinical patients to feel and to function better, but they are obviously applicable to the mental aspects of athletic performance. The same can be said of such empirically based formulations as the Yerkes/Dodson law. Formulated in 1908, it asserts that human performance is best when there is a moderate degree of arousal (defined broadly) than when arousal is either high or low. Liggett cites Yuri Hanin to refute this view—on the basis of empirical data, Hanin proposed an individual zone of optimal functioning (IZOF) for each individual athlete. He reported studies that show that about 40% of athletes function best at low anxiety levels, 30% at moderate levels, and the remaining 30% at high levels.

Liggett points out, correctly, that this replicated finding is bad news for the "rah-rah" athletic coach who attempts to elicit high levels of arousal by impassioned rhetoric. At the same time, he reproaches Hanin for not providing "more practical suggestions" for identifying each athlete's IZOF. This, however, is the whole point of Hanin's position; an athlete is best helped by learning to identify his or her individual zone.

Of clinical techniques, Liggett singles out Albert Ellis' rational emotive therapy, and John Hartland's ego-strengthening technique as highly helpful in some situations. Although the book is liberally sprinkled with brief case reports, the final five chapters give more extended accounts of how the various clinical procedures and empirical data he presents can be applied to individual instances. There is, of course, always a problem in demonstrating conclusively that hypnosis was responsible for a particular successful outcome, but it may be less acute in an athletic context–athletes know when they have performed well, and when they have not. What is less apparent is whether athletic success is invariably associated with being "in the zone."

In addition, many of the athletes are quoted as saying that hypnosis increased their confidence of success. This is a well-documented finding in the forensic setting, though a crime victim or witness with a hypnotically induced confident memory of what happened can hinder a police investigation. On the other hand, Hartland's ego-strengthening technique is predicated on the belief that a confident patient is more likely to rise to the challenge of altering his or her maladaptive behaviour.

Despite our criticisms, we recommend this book highly. Given the billions of dollars that sport generates currently, it is likely that many young people will be attracted to a life in sport psychology. This book will be an invaluable source of required reading for those who follow in Liggett's footsteps.

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References

Cedercreutz, C. (1978). Hypnotic treatment of 100 cases of migraine. In F. H. Frankel & H. Zamansky (Eds.), *Hypnosis at its bicentennial: Selected papers* (pp. 255–259). New York: Plenum.

Freud, S. (1970). Unpublished contribution for a medical dictionary. In M. Tinterow (Ed.), *Foundations of hypnosis: From Mesmer to Freud*. Springfield, IL: Charles C. Thomas.

Gerschman, J. A., & Burrows, G. D. (1994). Hypnotisability and dental phobic disorders. *Hypnos: Swedish Journal of Hypnosis in Psychotherapy and Psychosomatic Medicine, 21,* 224–231.

Hilgard, E. R., & Morgan, A. H. (1975). Heart rate and blood pressure in the study of laboratory pain in man under normal conditions and as influenced by hypnosis. *Acta Neurobiologiae Experimentalis, 35,* 741–759.

Perry, C. (1973). Imagery, fantasy and hypnotic susceptibility: A multidimensional approach. *Journal of Personality and Social Psychology, 26,* 192–204.

Wadden, T. A., & Anderton, C. H. (1982). The clinical uses of hypnosis. *Psychological Bulletin, 91,* 215–243.

Zamansky, H. S., Scharf, B., & Brightbill, R. (1964). The effect of expectancy for hypnosis on prehypnotic performance. *Journal of Personality, 32*, 236–248.

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Vol. 30, No. 1, 2002, 97

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