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EDITORIAL

Future Directions for *AJCEH*

This issue of *AJCEH* presents numerous significant contributions by practitioners of clinical hypnosis to ASH members and to our subscribers, including libraries. They will enrich this field certainly in Australia but also, if they are able to reach beyond this audience, in our East Asian region or indeed the world. It will be apparent to our long-term readers that both the content and the regularity of journal editions have changed dramatically in recent years. It must be acknowledged that contributions by academics, particularly of experimental hypnosis research, have dwindled to almost a full stop. For some time now the flow of clinically based articles needed to reach an issue target of 35,000 words has taken much closer to one year than to the projected six monthly issues. Though some will disagree I believe honest scrutiny of the *International Journal of Clinical and Experimental Hypnosis*, the premier journal in our field, and of comparable national journals such as *Contemporary Hypnosis* (published by the British Society for Experimental and Clinical Hypnosis) over the same time frame shows similar trends.

In order to address these problems we need to understand some of the driving factors. The Australian government undertakes a regular assessment of the research outputs of disciplines within each university, Excellence in Research for Australia (ERA), which awards them a rank from 1 to 5. These rankings are used to determine the government's block-funding to support research in each university. For better or worse the intention and effect is to cull research in those disciplines that cannot maintain a ranking of 3 or better (this is the declared policy of my own institution). Research output is assessed for quality and journals are assigned quality rating based principally on citation index (average frequency of citation of published articles). Journals are ranked into categories for ERA purposes and publications in those of the lowest rank (which includes *AJCEH*) are not neutral; they actually lower the discipline's ERA ranking. Thus university administrators actively discourage publication in such journals. Universities are financially better off if their academics do not publish at all (that is not to produce such research outputs) rather than publish in such journals. Mechanisms similar to the ERA exist in most nations throughout the OECD.

For university-based hypnosis researchers a vicious cycle is in play. If they publish in hypnosis journals their research will not be supported because of the low (*IJCEH*) or nonexistent (*AJCEH*) rankings. It is very difficult to get

hypnosis research published in other highly ranked journals. If they do not publish in hypnosis journals then the quantity and quality of publications in those journals will contract and their reach and thus impact will go into free fall. For example, has anyone seen or heard of an article published in *Contemporary Hypnosis* (a journal I hold in esteem) in the last five or even 10 years? This is not because the journal has ceased publishing but its accessibility and sphere of influence has (in my estimation) shrunk from a major international contributor to an in-house journal for BSECH members (a direct parallel to *AJCEH*).

But cycles may also be virtuous. Historically professional societies sold control of their professional journals to commercial publishing houses in the 1940s and 1950s, which then ran them as a highly profitable business on a subscriber pays business model. Professional societies and their members provided the written articles, editorial and peer review while publishers very often took not only the profits but copyright ownership as well. With the development of the internet journals could be distributed electronically (a further saving) while the content was locked up behind expensive pay walls that only the largest universities could afford, effectively removing access to academic outputs from the reach of most end users. Open access publishing delivering material online free to the end user developed as a revolt amongst academic, professional and community users, and public funding bodies are now insisting that funded research outputs are published in open access journals. Major publishers have responded by buying up successful open access journals and switching to an author-pays business model that sees top journals charge authors over \$3,000 for single journal article made available in open access format. Sensing opportunity, literally hundreds of new independent commercial publishing ventures have tried to establish themselves as open access outlets undercutting the major publishers (with a mere \$500 author charge). Almost all of these ventures will disappear within a few issues and it would be a desperate or foolhardy author who accepts such spam email submission invitations.

The early success stories of open access publishing show that publications must be backed by existing professional societies with ties to related academic disciplines. Established journals of legitimate academic societies (such as *AJCEH* and the *ASH*) with a credible editorial board and peer review process currently possess a potential competitive advantage in the open access publishing environment. To realize this potential (which will only exist for a limited time) such journals must be able to make accepted material rapidly

available to a worldwide audience of end users beyond the professional society membership. For example, publication could be continuous (rather than in parts), distributed to members and other subscribers by group email and released free online following a six-month embargo. To be effective for ERA (or similar) purposes, each published item would need to be given appropriate meta-tags in order to be identified by and recognized by the major academic indexing systems (e.g., Scopus, Thompson's Web of Science, Google scholar). This process is skilled and labour intensive and is a major additional overhead cost in open source publishing, as is maintenance of hardware and software required to provide a suitable electronic publishing platform. At this point such services are already provided by university libraries which must meta-tag and maintain electronic repositories for published outputs of university staff, in effect making each library an e-publisher.

The current situation is ripe for the formation of strategic alliances between specific university library systems (or networks) and established professional bodies and their journal publications providing rapid, quality, peer reviewed professional articles in a not-for-profit framework. In the case of clinical and experimental hypnosis (and closely related content) such an outlet would quickly grow to become one of the journals of choice for professionals and academics worldwide and provide ASH members with a high impact outlet for their personal, professional and research development. ASH has already adopted open online access following a six-month embargo, a period of access limited to subscribers. However, much more can be done. The future of the journal is an issue that must be the subject of ongoing thought and discussion by ASH members, the ASH executive and the publications officer over the coming year and I welcome the contributions of all members to this debate.

Graham A. Jamieson
8 August 2013

THE GIFTS AND VULNERABILITIES OF THE HIGHLY HYPNOTIZABLE: RELEVANCE FOR THERAPY

Wendy-Louise Walker
Retired Clinical and Forensic Psychologist

This paper discusses the gifts and vulnerabilities of highly hypnotizable clients. It also explores the relevance for therapy of those in this category and the differences between those who are damaged (e.g., traumatized) and those who are not damaged.

Keywords: hypnosis, hypnotizability, highly hypnotizable, suggestibility.

Firstly a quick consideration of the factors on which this paper is based. It is relevant to consider hypnosis as both a state and a process, the ritual and interpersonal transaction of expectancies and beliefs.

Who is hypnotized? Are most people hypnotized to some extent? Or as Gordon Hammer used to assert when I was a student, are only the top part of the distribution actually hypnotized at all? If that is the case then is it only with these gifted subjects that the state of consciousness is an important determinant of what is done and experienced in the hypnotic transaction? In the moderately hypnotizable should one pay more attention to the context, expectancies and atypical interpersonal transactions, making oneself receptive to suggestion, achieving relaxation, etc., which are effecting change? These factors are also powerful determinants, I think, of change (either positive or negative) in that small group of highly hypnotizable subjects, but when considering this group it is difficult to deny that (a) there are major and complex shifts in consciousness and (b) the highly hypnotizable are simply different. That view is supported by the research and writings of the Spiegels, the Hilgards and one's own work and self-observations.

Hypnotizability appears to be more like an ability than like a personality trait.

This paper was originally prepared by Dr Wendy-Louise Walker as a training presentation for a group of ASH students in May 2008. It has subsequently been edited by her for publication. Correspondence regarding this paper should be sent to Wendy-Louise Walker, 20 Blackheath Street, Leura, NSW 2780, Australia.

The problem of differentiating causality from correlation in the relationships between hypnotizability and other behaviours needs to be considered. There is almost certainly a genetic factor in hypnotizability. More relevant for therapy might be not what causes hypnotizability but what learning and experiences foster or inhibit the development of this ability. The role of abuse in childhood is almost certain to exaggerate or to make pathological the capacity for dissociation and double tracking (c.f., compartmentalization) with which the highly hypnotizable are born.

The fact of generally little or nil correlation with stable personality factors suggests that we might not do best by categorizing personality according to hypnotizability. Maybe the level of hypnotizability sets a tendency to adopt certain cognitive or defensive styles but these interact with other major personality traits. Despite the poor coverage in the literature and stereotypes such as those set out by the Spiegels, highly hypnotizable people do not all seem to be alike. The work here on absorption and loss of the sense of self in this experience should be mentioned. All highly hypnotizable people are not set in a stereotyped sameness and one gets a very different picture from a relatively well-functioning population—seen mostly in the laboratory situation, where an in-depth interview is generally not carried out—than from the population seen in the clinical situation.

My medical student Michelle Rottenstein repeated Josephine Hilgard's interviews with 20 mostly non-student highly hypnotizable subjects, screened for psychiatric disability and only one (and not the best) reported being the recipient of harsh punishment. All 20, however, reported using dissociation when very upset as children. This suggests to me that there is a lot of stereotyped thinking about the highly hypnotizable.

Unhelpful concepts in the clinical literature:

- How often we hear how clever the therapist is, not how gifted the subject is!
- Some people like to show off at the expense of hypnotic virtuosi.
- The highly hypnotizable are called names like “fantasy addict” with all the negative connotations.
- Dissociation is linked with MPD, dissociation disorders, and automatism in the McNaughton rules for the insanity defence (e.g., in the case of murder).
- Recent scales of dissociation do not differentiate normal and abnormal dissociation. This, in my view, is a most serious flaw.

I believe these are some of the salient points:

- The distribution of high hypnotizability remains similar to reports from the early times of hypnosis (e.g., Abbe Faria estimated one in five were excellent subjects).
- Hypnotizability is more a cognitive style than a personality trait.
- The highly hypnotizable are probably “stimulus hungry”
- Studies of hypnotizability suggest normal distribution with discontinuity at the top end.

First consider the highly hypnotizable population and relate this to therapy, a process of fostering skills of living effectively and productively. However, let us start with the normal individual first and then move to the pathological. For the highly hypnotizable, the hypnotic ritual accentuates a process that goes on all the time. With focus of attention as the access key and suggestions as the driving program, the highly hypnotizable go in and out of altered states of awareness, and switch hemispheres quite readily; they do not need a “crisis”; they do not need to have been abused. The undamaged highly hypnotizable keep themselves to themselves; they may occupy all sorts of jobs but tend to gravitate to the arts; when they are actors, I suspect they go for method acting rather than, say, Lawrence Olivier’s carefully constructed performances.

Extending E. R. Hilgard’s concept of a partial lifting of the background controls of consciousness, looser controls lead to greater flexibility, which I believe leads both to creativity and to increased error. The highly hypnotizable are a group for whom background controls are very readily lifted; indeed they often spontaneously shift this control. I concede that when highly hypnotizable people are damaged, upset or drunk, they can appear very strange, but are clearly differentiated from schizophrenics and saints. With damaged highly hypnotizable clients, teach them to understand, harness, value and utilize their gifts, and to recognize the vulnerabilities associated with these gifts—we get nothing for nothing (the gift comes at a price).

DISSOCIATION PRONENESS

What do we mean by dissociation? The term has a number of meanings which overlap. I use it predominantly to denote the double tracking of consciousness. It is not a disease process but something that some people (one or two in 20) do easily, habitually and to very good effect.

Double tracking: This is par for the course for the highly hypnotizable, engaging two competent sets of cognitive processes, with self-awareness and executive awareness flitting back and forth. This is not ideal for total recall, since memory access is easier with material that was in the central focus of conscious attention. Advantage: great flexibility, rarely get bored, can get a lot done. Disadvantage: memory gaps, especially when tired. However, the second track can often be accessed by entering other information, especially sensory information.

Splitting affect from cognition: There may also be dissociation in the meaning of splitting of affective components of cognition and memory. Highly hypnotizable people can use this as a conscious mechanism in an emergency. When it is unconscious and extensive it is a defence mechanism. Advantage: excellent for crisis, can put terror aside, ride with the demands, carry on "as if in a trance." For the non-damaged highly hypnotizable there is no problem: They need to process the feelings soon after the event, just postpone a little, meet the practicalities first and then weep. For the damaged, this is done automatically, non-volitionally, then it splits off feelings from perceptions and cognitions; if this is in a major way, life becomes unreal, bleak, two-dimensional, and they may be misdiagnosed as schizophrenic!

There can be a splitting off of whole systems. Dissociation may also refer to the splitting off of relatively sizeable chunks of consciousness (systems of cognitions, motivations and patterns of affect) separated by walls of amnesia. There is major loss of control, with MPD and fugue states as the extreme. The damaged highly hypnotizable tend to use dissociation in a maladaptive way, as a defence, rather than repression. These major maladaptive dissociations may very likely be initiated and fostered in childhood.

Highly hypnotizable people, even those without damaged personalities, have more of a sense of multiplicity, they have looser controls of consciousness. Multiple personality is of course the abnormal extreme. An important goal with highly hypnotizable patients, who come for help because they have been damaged, is fostering a sense of flexible unity in the personality, of accepting the different facets.

My own research data strongly suggest that the spontaneous emergence of primary process thought in the waking state is more frequent among the highly hypnotizable than the low hypnotizable and also that primary process thought is more frequent in hypnosis compared with the waking state.

IMAGINATIVE INVOLVEMENT AND SPONTANEOUS HYPNOSIS-LIKE EXPERIENCES IN EVERYDAY LIFE

Non-damaged highly hypnotizable people report this area of experience with pleasure and commonly produce it on purpose and guard against it when it is likely to seem inappropriate. Damaged patients have less ability to shift consciousness and have a sense of loss of control of consciousness in everyday life and a fear of this. My own work on imaginative involvement suggests that it can be a great refuge and a source of rich and growth-provoking experience. Equally vividly it can create a sense of doom. For example, if a husband is late home and the thought that he might be dead emerges, the highly hypnotizable can experience trains of imagery and affect which are quite commonly self-propelling. The flexibility and vivid loss of self in imagined experience with access to vivid emotional responses accessible to the highly hypnotizable are great for problem solving, magical, but need to be kept on leash.

For the undamaged highly hypnotizable this is the quality-of-life dimension. They automatically use this for stress management (lost in nature, sparrows in rain puddles, off with music). They use it for problems-solving (e.g., rehearsal), for recreation. They read novels and poetry and extend their life experience and spirituality. Sometimes things just “pop into their heads,” like the poem that came into my head whilst listening to a presentation at Darwin last September!

The damaged highly hypnotizable tend to underutilize this dimension as a source of entertainment, wonder and joy. Also, it is their major source of unharnessed, negative and overwhelming suffering. The goal then is to teach them controls and limits. The negative future is created and reacted to and negative suggestions are amplified imaginatively into complex vistas of creative suffering, with ensuing wear and tear on the body. The greatest gift of being highly hypnotizable becomes shut off because it can generate such suffering. For therapy: Teach about the area, teach how to use self-direction, self-talk to direct these processes, controlled involvement.

SUGGESTIBILITY

Both damaged and undamaged highly hypnotizable people are highly suggestible, both in the sense of compliance with suggestion and in terms of incorporating suggestion into the self-concept. The undamaged highly hypnotizable learn to protect themselves against undue invasion quite early in childhood. The damaged highly hypnotizable are confused and tortured

by this dimension and continue the suffering with self-talk, which acts as suggestion. Teach the damaged highly hypnotizable about their qualities, teach them to have imagined “force fields” around them, teach them to evaluate suggestions before responding or incorporating; teach them to use self-talk in a positive and creative way. Education is a powerful modality in therapy and is very necessary for the highly hypnotizable. Teach further limiting and harnessing of their great gifts.

INTERACTING WITH THE HYPNOTIST

There are differences here according to transference and reality components of the relationship and according to whether it is taking place in the context of therapy or research. The highly hypnotizable can be very concrete in receiving instructions but they may not always be compliant. Even in research, with the weakening of executive control in hypnosis one may find spontaneous regression or abreaction. This occurs infrequently in research because of the contract. Interpersonal relationships are greatly intensified when we use hypnosis in therapy, especially with the highly hypnotizable. The relationship needs to be kept safe and proper limit setting needs to be set out.

HIGH HYPNOTIZABILITY AND MEMORY

Memory, is there anything different? Further research is needed here. Spiegel suggests that the highly hypnotizable have very good memory but they are probably prone to amnesia gaps. Good subjects are often skilful at alternative accessing of memory stores, for example by using sensory imagery rather than words to access memory. Many of the memory problems of damaged highly hypnotizable patients are probably dissociative rather than repressive. Note the hidden observer phenomenon and also the phenomenon of automatic writing. I personally slam the notion of talking with the unconscious like Dr Doolittle talking with the animals.

IMPLICATIONS FOR TREATMENT

Here I emphasize the notion of, first of all, fostering a sense of control and unity at the central core of personality. Use hypnotic techniques in the beginning to foster this sense. Teach the subject what it feels like going in and out of hypnosis and to defend against trancelike consciousness in inappropriate situations by voluntary barriers. Emphasize in and out of hypnosis the joys of

having a creative and flexible mind but emphasize also that we get nothing for nothing. Anxiety proneness and the sense of the mind slipping out of gear are liabilities that accompany the gift. For self-hypnosis, use ritual such as listening to a piece of beautiful music with trance directed by that music and the direct suggestion with such beautiful music that no negative or discordant experience is possible. With highly hypnotizable clients it is also very easy to transfer fragments of the hypnotic state into waking habits emphasizing absorption in delightful, positive or constructive experience.

Highly hypnotizable people are unpredictable to hypnotize; they require sensitivity and attention; “routine” hypnosis is not suitable. Get constant feedback about what is being experienced and learn to use language appropriately. The damaged highly hypnotizable person needs structure and clear definition of the hypnotic experience. Their needs are somewhat different from less hypnotizable people, and from my 40-plus years experience with them, “indirect” methods are often quite noxious to them.

IN CONCLUSION

Your highly hypnotizable subjects and patients will teach you a great deal about hypnosis if you give them the chance.

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TEACHING HYPNOTICALLY RESPONSIVE CLIENTS SELF-MANAGEMENT OF NEGATIVE EMOTIONS USING SELF-TALK, IMAGINATION, AND EMOTION

Wendy-Louise Walker
Retired Clinical and Forensic Psychologist

These case notes are based on a presentation Dr Walker gave to ASH members in 2009 and were recently edited by her.

Keywords: hypnotherapy, PTSD, conversion disorder, CBT.

In developing our repertoire of hypnotic treatment modalities, I think that we often ignore the power of getting the client involved in self-management, of active and enjoyable involvement in the process of therapy, not just passive receiving. There is a treasure trove of techniques that have the grace of handing over considerable responsibility and power to the client, teaching him/her to use the gifts of hypnotic responsiveness to manage his/her own imaginative, suggestible, creative mind. I think that educating the client is a very important component of therapy. With the highly hypnotizable, we have high *suggestibility* both in the sense of doing what one is told or taking into our self-concept suggestions made by the therapist. We have both great capacity for *imaginative involvement* and considerable *dissociation proneness*, and these can be used to learn patterns of self-management.

1. Self-talk. A great deal of the suffering of my clients has come from negative self-talk, acting on their own suggestibility, for example, repeatedly saying: “Oh my God, I am hopeless, a failure, worthless ... Oh my God, I cannot cope, I cannot cope, I cannot cope ...” To deal with this: identify it and change the script. The highly hypnotizable do not just respond to suggestion from others, they also respond to their own repeated self-talk.

In collaboration with the client, we can change this. A happy spin-off is a sense of increased autonomy: One is changing one's self, not just being manipulated by the powerful therapist.

2. As well as getting the client to shift to positive self-talk, it can be very helpful to attach this with breathing—that is, “breathe in peace and joy... breathe out fear and pain”—and this can become like a peaceful, positive mantra. The notion of letting go as one breathes out is quite powerful, as is the notion of breathing in positive, joyous feelings. The repetition is quite peaceful. Set out below are some names of emotions as examples to begin your planning with the client: Breathe in positive, breathe out negative. Enjoy the rhythm of the self-talk, it blots out nasty self-doubts.

A MENU OF LOVELY FEELINGS TO BREATHE IN

Use words like: “peace,” “enthusiasm,” “harmony,” “joy,” “serenity,” “love,” “contentment,” “happiness,” “resilience,” “optimism,” “courage,” “cheerfulness,” “faith,” “wonder,” “reverence” ... *in setting this up you might like to get the client, in hypnosis, to experience the emotions you are going to suggest and make it stronger with suggestion. Remember how easy it is to produce suggested emotions in hypnosis. Link this to the waking state, suggesting how with practice this technique will get more powerful.*

A MENU OF FEELINGS TO BE DISCARDED, FOR BREATHING OUT

Feelings like: guilt, anger, fear, pessimism, self-doubt, worry, stress, over sensitivity, apathy, agitation, misery, negativity, depression, hate, anger, jealousy, helplessness, hopelessness, bitterness, remorse, cowardice, irritation ...

For each occasion pick a pair of words, one positive to breathe in, one negative to breathe out. Set up a rhythm. *Rehearse in hypnosis, building in that the self-suggestions will get more powerful with practice, thus starting to form new neural pathways.*

REMEMBER the power of LOVE, REVERENCE, etc. Remember St Francis; it is better to love than to be loved.

USING PRAYER FOR SELF-CALMING AND COMFORT

For those who have religious faith and who find it acceptable, we can use prayer for self-calming and comforting (e.g., The Lord's Prayer). Practise it in

hypnosis, suggest feeling the comfort, warmth, love, safety of being protected, and bridge this across to ordinary life with suggestion. Or for those from the Catholic background, what about Hail Mary?

ATTACH FEELINGS OF PEACE, LOVE, REVERENCE, JOY ETC.

Attach these to a small object one can carry in one's pocket or handbag and hold in one's hand as a symbol of the feelings. For me it would be a tiny statue of a whippet or imagining a bird held lovingly in one's cupped hands. It could be a small photo in one's pocket to take out and beam love to (one would have it appropriately protected, of course). This can be conditioned to produce the feelings when one focuses on the object held (or imagined) in one's hand in the ordinary waking state and it can be used to drive away self-doubt, bitterness, fear, etc.

A STORY I HAVE NEVER TOLD BEFORE, TERROR OF DEATH DELETED

A long-term patient of mine had a difficult and complex but much loved and respected mother. She was terrified of dying and of the process of dying, although she was a devout Catholic and was not worried about being tossed off to hell. I made a loving script for her son to say to her (he had every intention of being there to hold her hand as she died and I had told the nursing home staff to have him there, which they did). Before the time of her death came, he got informed consent along the lines: "Mum, I have talked with Wendy-Louise about your fear of the process of dying and she has written out words that will help you connect with dearest Mary, Mother of God, and asked me to get your permission to use these gentle words when the time comes." The mother (who had met me on a number of occasions) loved the suggestion and asked her son to thank me. "Mum, tell me when you think we are getting close to the step into eternity, and I will help you go gently and happily." (Reportedly, on the day she died, the mother indicated by gesture that she was terrified and that she was going.) The son then said my script which was that she felt like a small child, alone and afraid, but then the Mother of God appeared, calm, beautiful, loving, powerful and peaceful, and the old lady (feeling like a little child) reached her hands to Mary, who took her small hands in her graceful white hands and drew the child across to where she was standing, a sense of joy, of going home to her loving mother ... According to my client, his mother simply breathed out and quietly slipped

into death with a peaceful and even happy expression on her face. He said it was a most beautiful experience and left him calm, accepting and peaceful. His mother had been painfully ill for some time and was in her eighties and her son saw it as a great gift that the dear, bossy old woman died with dignity and a sense of peace and love.

THE PLACE OF HYPNOSIS IN PSYCHIATRY PART 5: TREATMENT OF SPECIFIC PHOBIAS—ANIMAL AND SITUATIONAL SUBTYPES

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Part 5 of this series concentrates on the practical use of hypnosis as an adjunct to therapy in the treatment of specific phobias, focusing on animal and situational subtypes. The author evaluates the effectiveness of a range of interventions which have been shown to have been valuable in treatment. The report shows how hypnosis may be employed effectively in conjunction with behavioural approaches, including cognitive restructuring and systematic desensitization, psychodynamic psychotherapy, and dental treatment. There are a surprisingly large number of advertisements in the media which claim that phobias can be treated quickly using behavioural therapy; however, although in vitro desensitization and imaginal exposure have been employed successfully by clinicians, when the source of the phobic anxiety is in early childhood further psychological investigation is often required. This study discusses the implications of using a number of hypnotic techniques which have been employed in clinical practice.

Keywords: specific phobia, animal phobia, situational phobia, desensitization, integrative psychotherapy.

INTRODUCTION

Specific phobias have been treated using psychodynamic psychotherapy (Seligman, 1995), but the treatments of choice have been systematic desensitization with or without hypnosis (Craske, Mohlman, Yi, Glover, & Valeri, 1995; Emmelkamp, Bouman, & Scholing, 1989; Kraft, 1994), EMDR (De Jongh, Ten Broeke, & Renssen, 1999) and Virtual Reality Exposure Therapy (VRET) (Carlin, Hoffman, & Weghorst, 1997; Côté & Bouchard,

2008; Garcia-Palacios, Hoffman, Carlin, Furness, & Botella, 2002). DSM IV (American Psychiatric Association, 1994) states that the, “essential feature of specific phobia is [a] marked and persistent fear of clearly discernible, circumscribed objects or situations.” Specific phobia is also accompanied by one or more of the following features: an anxiety response, uncontrollable fear, avoidance reaction and an interference of one’s daily routine, including occupational and social functioning—and, as with agoraphobia, individuals usually experience one or more panic symptoms (Kraft, 2011). In almost all cases, specific phobia is related, in some way, to a fear of losing control (Kraft & Kraft, 2004; Kraft & Kraft, 2010), and sometimes patients fear having a panic attack or being embarrassed in public (Arntz, Lavy, Van den Berg, & Van Rijsoort, 1993). Some phobic patients fear, or anticipate fear, that they will come in harm’s way: for instance, being scratched by a cat (cat phobia) or hit by a car (driving phobia). However, many adults come to realize that their fear is irrational—for example, the arachnophobic who is unable to say the word “spider” or read a children’s book on spiders; alternatively, the phobia has symbolic value and is a manifestation of a deeply rooted trauma in early childhood or a traumatic incident later in life.

This report focuses its attention on two of the subtypes within the specific phobia category—animal phobias and situational phobias. The following table does not represent a complete list of studies which have used hypnosis to treat these conditions, but it nevertheless provides the reader with examples of both subtypes. An extensive search of the literature using MEDLINE, PsychInfo and EMBASE (in the first instance 1980–2010; and then 1930–80) has revealed a number of case studies and clinical trials that have used hypnotherapy in treatment—some comparative studies have also been included here for further reading.

Table 1: Specific Phobias Treated With Hypnosis

Animal type		
Phobia type	Author(s)	Treatment strategy/experimental design
Phobia of cats and dogs	Spiegel (1960)	Posthypnotic seed
Bird phobia	Scott (1970)	Relaxation; age regression; abreaction; theatre visualization and systematic desensitization
Bird phobia	Brann (2012)	Safe place imagery; “reason room” technique; use of older, wiser self-dialogue

Fear of dead birds	Van der Hart (1981)	Safe place imagery; gestalt dialogue
Mouse phobia	Kraft and Kraft (2010)	Systematic desensitization in vitro and in vivo; special place imagery; playfulness
Dog phobia	Schneck (1952)	Hypnoanalysis; visualization; ego strengthening; in vivo exposure
Dog phobia	Kraft and Burnfield (1967)	Systematic desensitization in vitro and in vivo
Snake phobia	O'Brien, Cooley, Ciotti, and Henniger (1981)	Systematic desensitization and posthypnotic dream suggestion vs desensitization only
Snake phobia	Milne (1988)	Age regression ¹ in hypnosis
Spider phobia	Horowitz (1970)	Hypnosis. Relaxation vs fear arousal; suggestion vs no treatment
Spider phobia	Brown, Summers, Coffman, Riddell, and Poulsen (1996)	Reframing in hypnosis
Spider phobia	Brann (2012)	Cognitive reasoning in hypnosis; use of empathic metaphor
Wasp phobia	Brough, Yorkston, and Stafford-Clark (1965)	Systematic desensitization in hypnosis
Worm phobia	Brann (2012)	“Reason room” technique; psychotherapy
Slug phobia	Gustavson and Weight (1981)	Dream interpretation; age regression directed imagery; theatre technique
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Situational type		
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Phobia type	Author(s)	Treatment strategy/experimental design
Dental phobia	Golan (1971)	Mastery imagery and suggestions
Dental phobia	Bills (1993)	Self-hypnosis; visualization; affect bridge
Dental phobia	Moore, Abrahamsen, and Brodsgaard (1996)	Hypnosis vs group therapy and individual desensitization
Dental phobia	Gow (2006a)	“Needle desensitization” (McGoldrick, 2001, see Gow, 2006a) and hypnosis; special place imagery; calm mantra; glove anaesthesia (Gow, 2002)
Dental phobia	Gow (2006b)	Hypnosis education; special place imagery; calm mantra; “tell/show/do” technique; implied causative communication, clenched fist technique, use of gate control theory (Melzack & Wall, 1965)

¹ Throughout this study the author refers to the term “age regression”; however, it is important to note that this technique should be used with care and he advises that, in most cases in clinical practice, some form of dissociative mechanism should be put in place before accessing previous traumatic experiences.

Dental phobia	Wilson (2006)	Hypnosis and systematic desensitization
Dental phobia	Rauch and Panek (2008)	Hypnosis and analgesia (anchoring); control of bleeding and gag reflex
Cancer phobia	O'Donnell (1978)	Implosion techniques
School phobia	Lawlor (1976)	Uncovering; strategic family support
School phobia	Valente (1990)	Hypnosis and mastering self-esteem
School phobia	Brown et al. (1996)	Hypnosis and use of metaphors and imagery
School phobia	Hudson (2009)	Hypnosis and solution-focused techniques
Claustrophobia	Kraft (1973)	Systematic desensitization and in vivo exposure
Claustrophobia	Velloso, Duprat, Martins, and Scoppetta (2010)	Management of claustrophobia in MRI examinations; use of safe place
Claustrophobia	Brann (2012)	Use of protective bubble (Alden, 1995)
Contamination phobia	Scrignar (1981)	Systematic desensitization; flooding; cognitive restructuring
Flying phobia	Deyoub and Epstein (1977)	Use of anchoring words; dissociation, positive mental rehearsal
Flying phobia	Bakal (1981)	Behaviour modification in hypnosis
Flying phobia	Spiegel, Frischolz, Maruffi, and Spiegel (1981)	Hypnosis and problem restructuring (systematic follow-up data)
Flying phobia	Milne (1988)	Systematic desensitization; bonding with baby
Flying phobia	Brann (2012)	Special place imagery; retrograde desensitization; calmness anchoring
Flying phobia (aeroplane phobia)	Volpe and Nash (2012)	Supportive psychotherapy; exposure therapy in hypnosis; anxiety management
Exam phobia (severe test anxiety)	Spies (1979)	Systematic desensitization. Biofeedback vs hypnosis vs no treatment
Fear of public speaking	Schoenberger (1996)	Hypnosis with cognitive behavioural work
Fear of eating	Spiegel (1960)	Hypnoanalysis; an uncovering of the symbolic nature of the phobia
Fear of eating	Culbert, Kajander, and Reaney (1996)	Hypnosis and self-management techniques
Penetration phobia	Frutiger (1981)	Dilation exercises; psychotherapy and systematic desensitization; masturbation leading to coitus
Hospital phobia	Waxman (1978)	Age regression; systematic desensitization in vitro; self-hypnosis

Driving phobia	Morgan (2001)	Systematic desensitization; psychodynamic psychotherapy; special place imagery
Driving phobia	Kraft and Kraft (2004)	Systematic desensitization in vitro and in vivo; psychodynamic psychotherapy
Driving phobia	Williamson (2004)	Special place imagery; unconscious search; self-hypnosis; use of metaphor; covert conditioning; cinema technique
Driving phobia	Hill and Bannon-Ryder (2005)	In vivo desensitization; visualization; special place imagery
Bus driving phobia	Kraft and Burnfield (1967)	Systematic desensitization in vitro and in vivo; social support
Traffic phobia	Kraft & Al-Issa (1965)	Systematic desensitization especially to noise
Wedding phobia	Kraft (1970)	Systematic desensitization in vitro using emotional imagery

Case studies which have used hypnosis in treatment tend to fall into two discrete categories: (a) studies which involve an investigation and uncovering of insights into the source of the phobic disorder, and (b) studies which work on behavioural lines, focusing more on coping strategies, use of systematic desensitization and emotive imagery. However, there are some studies that use a combination of these approaches. This report outlines treatment programs and techniques which have been shown to be effective in treatment and examines their use in clinical practice.

ANIMAL TYPE

Animal phobias have been treated by a range of approaches from traditional systematic desensitization (Marks, 1969; Pagoto, Kozak, Spates, & Spring, 2006) to virtual reality exposure therapy (VRET) (Carlin et al., 1997); however, surprisingly few papers have explained how hypnosis can be used in the treatment of this subtype. Generally, the source of an animal or insect phobia is in childhood (American Psychiatric Association, 1994) and, despite the number of advertisements on the internet claiming that phobic anxiety is easy to treat, often the fear is part of a more complex and deep-rooted problem (Brann, 2012). Nevertheless, there are examples in the literature which have shown that animal phobia can be treated successfully using eye movement desensitizing and reprocessing (EMDR) (De Jongh et al., 1999; Ten Broeke & De Jongh, 1993; Young, 1994); systematic desensitization (Marks, Gelder, & Edwards, 1968; Pagoto et al., 2006); cognitive therapy (Choy, Fyer, & Lipsitz, 2007); in vivo exposure therapy (Emmelkamp et al., 1989); VRET

(Carlin et al., 1997; Côté and Bouchard, 2008); and hypnosis (Spiegel, 1960) without the need for a psychotherapeutic investigation.

A possible reason for the lack of recent reports may be due to the fact that individuals suffering from animal phobia have not had an impact on the number of hospital admissions (Brann, 2012); nevertheless, animal phobia can have a deleterious effect on an individuals' sense of wellbeing. Some patients develop elaborate avoidance behaviours and this often reduces mobility and effects quality of life.

The following section looks at how hypnosis has been employed in the treatment of animal phobia. In some instances, a psychodynamic investigation of the problem was required; whereas, on other occasions, therapists were able to reduce or completely eliminate the phobic anxiety with systematic desensitization only, or by using a multi-modal approach. In the examples that follow, hypnosis is used as an adjunct to therapy.

The present author treated a young man, Steven, with a life-long fear of spiders. His avoidance behaviour had worsened over the last 10 years and, when he came for treatment, he said that he even feared reading the newspaper in case he would unexpectedly come across a picture of a spider. In addition, for some years his phobia had had an impact on his choice of holiday destination. In the first session, Steven was encouraged to experience a special place in which he could feel like "his best self" (Callow, 2003), and this consisted of him experiencing all the emotions connected with finishing a marathon abroad. The graded desensitization on the first day of treatment consisted of the following—(a) saying the word "spider," (b) looking at a small spider in the corner of a room, (c) looking at a children's book of spiders or real dead spiders, (d) looking at a book on real spiders, (e) looking at a television program about spiders and (f) going to the zoo to look at spiders. We worked through each scenario together and, whenever he became anxious, he was returned to his special place for a boost of relaxation and confidence. These situations were rehearsed during the first two sessions and were reinforced with in vivo work which involved looking at the children's book, *The Itsy Bitsy Spider* (Trapani, 1993). In the third session, we added to the graded hierarchy and worked towards looking at exotic spiders in a biology book. After the hypnosis, the author placed a dead spider in the corner of the room and asked him to approach it to have a look. Steven also looked at pictures of real spiders: he turned over each picture, one by one, and graded them on an anxiety scale from zero to 10. He also practised touching plastic spiders and putting them in his hands. The process of desensitization—in vivo and in vitro—continued over the following four weeks and, eventually, Steven

was able to hold a dead spider in his hand. In the final session, Steven reported that he had gone camping and that something—he assumed it to have been a spider—unexpectedly crawled across his body, and this did not cause him any problems whatsoever.

An interesting approach to treatment is one reported by Brown et al. (1996) who, in the treatment of an 11-year-old girl with spider phobia, used systematic desensitization and an elaborate re-framing technique. The authors pointed out that children, in general, enjoy hypnosis because it helps them to fulfil their intrinsic need to gain mastery of themselves and of their environment: They can do this best through fantasy (Brown et al., 1996; Erickson, 1958). Before the induction, her therapist read a story about a fictional spider in a book called *Charlotte's Web* (White, 1980) in order to seed the idea of spiders being both non-threatening and human-like. Age regression did not reveal the source of the phobia and, therefore, the author gradually desensitized the girl to spiders by using characters from the story: She was asked to visualize Charlotte and her baby spiders all wearing pink clothes made out of her web. Charlotte was depicted as a caring mother and she soon became the heroine of the visualization. In the third session, further age regression revealed her first encounter with a large spider; the therapist reconstructed the experience and pointed out that it was probably Charlotte or a member of her family. The girl was able to perceive the scene as being a happy experience in which the spiders took on human-like qualities—nurturing and love. The girl made a remarkable recovery in four sessions.

Avoidance behaviour can become so severe that it can have a serious effect on mobility. Brough et al. (1965) reported a case of a 39-year-old woman with a severe wasp phobia. The patient was housebound during the summer, she had lost her job and had a non-existent social life. Unlike the Brown et al. study (1996), the treatment approach, which largely consisted of systematic desensitization and anchoring in hypnosis, did not make any attempt to re-frame the traumatic event, nor did it use positive or special place imagery; and, thus, the process, although successful, took a considerable amount of time—46 sessions.

It is, therefore, recommended that, if systematic desensitization is used with hypnosis, it should at least be combined with in vivo exposure, while positive imagery and cognitive restructuring techniques can increase the efficacy of the therapy still further. For instance, Kraft and Kraft (2010) reinforced the in vitro desensitization by encouraging the patient, a mouse phobic, to hold a toy mouse, to look at pictures of real mice and to work towards holding a

dead mouse in the palm of her hand. The in vivo work, therefore, enhanced the graded desensitization that was done in the hypnosis in that she was not only able to visualize her improvement but was also able to build on her newly acquired skills in real life. Further, by holding the toy mouse (Mini Mouse) in her arms, the feared object was re-framed as a playful, non-threatening object which supported and comforted her throughout the session.

It is helpful in therapy to help the patient to change his or her perception of the feared animal. Another example of this change of perception can be found in a case reported by Scott (1970), although a more thorough investigation of the source of the phobic anxiety was required during treatment. The patient was a 27-year-old woman with a life-long fear of birds, and the treatment consisted of general relaxation, ego-strengthening, age regression, in vitro desensitization, and auto-hypnosis. During the age regression, it was confirmed that she had been attacked by a hen as a young girl and, although she had had no conscious memory of this event at the start of treatment, her mother confirmed the story. She also recalled seeing a hen in a dark cupboard at home. This scene was abreacted each session, but further age regression, using a “speedometer technique” and theatre visualization, revealed how terrified she was when she saw the pantomime *Mother Goose*, aged three. It then became apparent that, throughout her early childhood, her elder sister, who had played a big part in her upbringing, was also terrified of birds and had transferred her fear onto the patient. Scott carefully worked through a detailed fear hierarchy, and he later encouraged her to associate positive feelings towards birds—such as looking after them and feeding them outside. The patient made a remarkable recovery and her positive feelings of nurturing birds continued after treatment; indeed, she began to feed birds in her back garden and fed ducks in the park.

Van der Hart (1981) also used a technique which encouraged his client to associate positive feelings towards the feared object—which in this case was a fear of dead birds. He did this by encouraging his client, Myra, to have an internal dialogue—akin to Gestalt therapy (Perls, 1969, 1973)—during hypnosis, and this helped her to effect a profound change with regard to her phobia. After induction, Myra was asked to elucidate a possible reason for her phobic anxiety, to which she replied that, perhaps, she was “like a bird” herself. After the initial in vitro exposure, which caused an abreaction, her therapist utilized her feelings of being connected with birds, again, in order to connect positive emotions to the feared object. He did this by suggesting that she imagine herself in a safe place—a park—and by giving her the opportunity

to fly. Indeed, she was encouraged to become a bird and to fly away. A conversation ensued between the bird and “Old Myra.” During this internal dialogue it became clear that the “Old Myra,” which represented herself as a young girl, began to trust the bird, and she told her that she was afraid that all birds would have an accident and would die. She also feared that all people would die, and this caused another abreaction. After a period of silence, Myra began to understand and resolve the differences between the two conflicting parts of herself: the “bird self” agreed to fly carefully and both Myra and the bird flew away together. Finally, Myra buried the dead bird, and with it all her feelings of impending doom; and, now as an integrated whole, she was able to tolerate dead birds without any difficulty.

Positive reinforcement (Cautela, 1975; Rowen, 1981) and re-framing (Erickson, 1985; Williamson, 2008) are extremely important techniques in treatment because, as the therapy moves forward, patients are able to associate both relaxation and positive feelings with the feared stimulus. Positive associations can be evoked using an empathic metaphor (Williamson, 2012), and an example of this technique is reported by Brann (2012). In this vignette, the patient, Peter, who had a fear of spiders, was advised that he should not worry about the spider approaching him for two main reasons. First, he was several hundred times bigger than the spider and, second, the build-up of lactic acid in its stomach meant that it could not walk much further than the distance of its web. The therapist then spontaneously imagined a spider trying desperately to play the violin while trying to dance at the same time—this image was then recounted to the patient, who burst out laughing, and this immediately reduced his anxiety.

On occasions, it is necessary to spend some time in the therapy investigating any associations a patient might have with the feared animal: The best way to do this is in the psychotherapy or by way of age regression in hypnosis. In these instances, hypnosis can be used to help the patient to uncover repressed memories and come to terms with these situations: By understanding the significance of these associations, the patient can begin to reduce his anxiety. However, these associations are often symbolic and it is not always a repressed traumatic incident that is responsible for the phobia; on occasions, repression of the affect associated with the memory can lead to defence processes which, in turn, produce phobic behaviour. Gustavson and Weight (1981) pointed out that “straightforward” phobic anxiety can often be resolved by systematic desensitization but that more deeply entrenched phobias are likely to require, to a greater or lesser extent, a psychodynamic investigation. This premise is

supported by Schneck (1952), Basch (1974) and Brann (2012), the last of whom warned, “Beware the simple phobia!”

A case reported by Gustavson and Weight (1981) clearly illustrates how age regression can be used in treatment. The patient was a 21-year-old female with a long-standing fear of slugs; she had developed a number of avoidance behaviours and, like the spider phobic reported by the present author, had become panic-stricken at the thought of unexpectedly coming across a slug. In the first instance, the patient visualized scenes involving slugs, and this, interestingly, did not produce anxiety. The therapist, therefore, used hypnosis and asked her to have a dream about slugs in order to gain insight into the source of her phobia. The patient said that she saw a number of slugs in a “meeting” and, in the age regression that ensued, she recalled an episode as a young girl in which a boy was forced to eat a slug. The therapist rehearsed this scene and encouraged her to have an abreaction. Using a theatre technique, the patient was asked to observe the scene while he gave her suggestions of relaxation and reassurance. During this process, the patient commented that her friends laughed at her when she began to cry and she feared that she would also have to eat the slug. Gradually, she realized that slugs represented an innate fear of being isolated, alone and helpless; in the following session, she spoke of her continual resentment of her parents—the fact that their relationship was far from adequate and that this had led to her feeling lonely, depressed and rejected. Further, slugs represented many of these previously unaccepted feelings, and coming to terms with this realization was a turning point in the therapy.

It is often important in the psychotherapy to investigate the symbolic meaning of the feared animal; and this investigation can also be done in the hypnosis by asking accessing questions (Yapko, 2003) with regard to the meaning of the phobic anxiety. Further examples of symbolism include worms representing the penis (Brann, 2012) and dogs representing a vindictive superior officer in the army (Schneck, 1952). It is important to note, however, that symbolism often works on many levels.

Some authors (e.g., Degun-Mather, 2001; Walters & Oakley, 2006; Williamson, 2008) have shown how effective it is to use a technique in which the older, wiser self advises the other self of more appropriate ways of how to think and behave. An interesting example of this technique is a study reported by Milne (1988) who used implosive desensitization in the treatment of a 56-year-old woman with snake phobia. Using age regression, he returned her to a remembered trauma rather than attempting to uncover a repressed

situation. Before the hypnosis, the lady recounted a memory in which her father returned home drunk and woke her up by coming into her bedroom with a live snake. In the hypnosis, her older, wiser self comforted her and embraced her—this situation was rehearsed and the abreaction repeated until she became more comfortable with snakes in general. The “older, wiser self technique” has also been used effectively in the treatment of 25-year-old lady with bird phobia (Brann, 2012): here, the patient was encouraged to visit the “corridors of her mind” and to visit her “reason room” in which she would be able to establish the causes of her problem. The patient, Natalie, recalled a traumatic event, aged three or four, in which a cockerel flew towards her on a holiday. The therapist normalized this event while the older, wiser self comforted her during the process. She was also given the opportunity to delete this memory using her “internal computer” and this was combined with further desensitization. This treatment strategy emphasizes the fact that there is not always a symbolic meaning attached to the phobic stimulus; sometimes a frightening experience is rehearsed and, therefore, amplified over a period of time, and the patient’s perception of it is as if (s)he is still a child.

Spiegel (1960) reported the successful treatment of a 16-year-old girl with a fear of cats and dogs, and this was done in hypnosis by transferring her fear onto lions and bears. After disengagement, she had complete amnesia for the posthypnotic “seed” and experienced a shift in attitude towards both dogs and cats—indeed, she pointed out that she no longer feared domestic animals and only feared wild animals or more fearsome animals in the zoo. Within a few months, she had bought herself a pet dog and her substituted fear of wild animals had also subsided.

SITUATIONAL TYPE

The situational subtype refers to phobias which are “cued by a specific situation” (American Psychiatric Association, 1994), including: being entrapped in enclosed spaces, taking public transport, driving, flying, going to school and the fear of visiting a dentist or having dental treatment. Due to the fact that phobics tend to experience panic in the feared situation, this category is closely connected with panic disorder without agoraphobia (Kraft, 2012a). Within this subtype, there have been a number of cases that have reported the successful use of hypnosis, specifically in the treatment of flying phobia (Bakal, 1981; Brann, 2012; Deyoub & Epstein, 1977; Milne, 1988), driving phobia (Hill, & Bannon-Ryder, 2005; Kraft & Kraft, 2004; Morgan, 2011;

Williamson, 2004), dental phobia (Bills, 1993; Brann, 2012; Gow, 2006a, 2006b; Wilson, 2006), claustrophobia (Brann, 2012; Kraft, 1973; Velloso et al., 2010), hospital phobia (Waxman, 1978), fear of buses (Kraft & Burnfield, 1967), and more unusual phobias including fear of contamination (Scrignar, 1981) and penetration phobia (Frutiger, 1981).

Driving phobia is perhaps one of the most prevalent of the situational phobias. Driving phobics often experience fear and panic behind the wheel, but also often feel anxious when anticipating the possibility of driving (Wald & Taylor, 2000). With others, however, the fear is focussed on specific driving situations, for example, the motorway (Kraft & Kraft, 2004), in traffic, on quiet roads, on bridges or through tunnels (Ehlers, Hofmann, Herda, & Roth, 1994). Again, this leads to avoidance or safety behaviours, and the more complex the strategies become—for example, taking an aeroplane home from, say, Manchester, rather than driving home—the more it has an effect on mobility and day-to-day functioning (Williamson, 2004). In addition, driving phobics often experience bullying from members of the family (Taylor & Deane, 2000).

Much of the literature has focussed on patients who have become phobic as a result of having had one or more motor vehicle accidents (MVAs) (Taylor & Deane, 2000) or near collision (Munjack, 1984); however, driving-related fear is not always a function of previous accidents (Taylor & Deane, 1999). Nevertheless, in all four of the examples included in this report, patients had experienced at least one accident. And, in three out of four case studies, it was a second incident that precipitated the phobic response, having been primed by the original traumatic event (Kraft & Al-Issa, 1965; Kraft & Kraft, 2004).

Driving phobics are usually highly motivated and are ready to make the necessary changes in their lives. For instance, in the Morgan study (2001), the patient, Maureen, knew that, for her to complete her nursing studies, she had to overcome her fear. When establishing that the patient has the motivation for treatment, it is essential to define treatment goals in the first session. Morgan, for example, devised four goals which consisted of her being significantly or completely phobic free as a driver, passenger and pedestrian. She also wanted to develop coping strategies and her emotional resilience. The treatment approach worked along the lines of gradual desensitization, although this was placed within a cognitive-behavioural framework; indeed, using the principles outlined by Bruce and Sanderson (1998), the first few sessions consisted of (a) assessment, (b) psycho-education with regard to the management of stress and understanding phobic anxiety, (c) the development of coping strategies and cognitive restructuring, and (d) preparation for the imaginal exposure. In

the fifth session it was evident that Maureen was not improving, and so the therapist asked the strategic question, “What is stopping you from overcoming the phobia?” to which she replied that she did not believe in herself enough “to be able to cope.” Further investigation revealed that her family had been bullying her about her fear. As a result, the therapist decided to use hypnosis to re-develop her confidence and self-esteem by “acknowledging previous skills” and by giving suggestions that previous “positive experiences” would return. This was built on in the next session in which, using a lake metaphor (Stanton, 1994), she was encouraged to find three pebbles which represented serenity, courage and confidence. A posthypnotic suggestion was also seeded in that this personal landscape of courage could return whenever she wished. After the hypnosis, the therapist suggested that rather than listening to what she described as “the woes of the news” and “delta blues”—which are often melancholic—she would be better off listening to more “affirmative” music in the car. Maureen devised driving tapes which, in turn, developed her confidence over the next three appointments. The last session involved in vivo desensitization at a bus intersection, which she coped with without any difficulty.

Hill and Bannon-Ryder (2005) also used motivation as a “driving force” for the therapy in the treatment of a 37-year-old woman with driving phobia. Her motivation became her main goals for treatment, and these were: (a) being able to visit her mother-in-law locally, (b) visiting her parents in the country, and (c) being able to drive on holiday. As in the previous study, it was felt that a fair amount of psycho-education was needed, and, to this end, she was asked to read a paper by Nash (2001) about hypnosis and its use in clinical practice. After establishing suitable goals, she was asked to visualize successfully completing a familiar journey, and to experience feeling relaxed and confident in her special place (Callow, 2003). Over the next two appointments, she reported that she had made a number of successful journeys and, at the beginning of each session, she gave herself a new goal for the following week—for example, visiting her mother-in-law. In the third session, although she had some thought intrusions which had affected her confidence, she said that she had made significant progress and had experienced no anticipatory anxiety. The therapist capitalized on this progress by encouraging her to use her special place to clear her thoughts, to realize her goals and to solve any problems that were still present. She was also given the opportunity to look at the sky and to imagine her unwanted thoughts drifting away like clouds; further, she was asked to visualize her goals, and this was combined with the anchoring word “success.” The authors commented that the success of the treatment—in four sessions—was due to her determination

and motivation to drive, as well as her ability to use imagery to reduce her “negative evaluations” of driving in general.

One’s ability to visualize, or to project one’s self into the imagined situation, can be a significant factor in the successful treatment of driving phobia. This can be seen clearly in a case reported by Kraft and Kraft (2004) in which the patient, a 55-year-old married woman, was able to re-create vivid scenes in the hypnosis, using all the sensory modalities. The authors pointed out that it was “this verisimilitude, akin to ‘virtual reality exposure therapy’ (VRET), that contributed significantly to her complete recovery.” Once the patient was able to visualize a familiar route without any difficulty, a graded hierarchy of more challenging scenarios was devised; and, as her phobic anxiety reduced, she no longer felt the need to control the situation by describing the minutiae of each journey.

Visualization was also incorporated into the treatment program of a 34-year-old driving phobic, reported by Williamson (2004); however, this study used a multi-modal approach which included self-hypnosis training (Heap & Aravind, 2002), use of a calmness anchor (Bandler & Grinder, 1979) and positive mental rehearsal, while the visualization consisted mainly of dissociative imagery (Ibbotson & Williamson, 2010; Williamson, 2008).

After the initial explanation of the efficacy of hypnosis, using the concept of right and left brain, the therapist (Williamson, 2004) explained that hypnosis was akin to being completely absorbed in a good book; and, as her focus of attention became more inward, she described how calm she felt, and how she would lose track of time when she painted. She was given the opportunity to develop a special place—real or imaginary—where she felt calm, safe and happy; while, at the same time, she performed an “unconscious search” (Erickson & Rossi, 1979) in order to find that special place. Further re-vivification (Kroger & Fezler, 1976) of a time when she was painting moved her into hypnosis. After a brief period for reflection, the patient, Mrs T, visualized a rubbish chute in which she could throw away any unwanted “symptoms,” emotions or thoughts; and, in her special place, she was given the opportunity to look around to find something that symbolized calmness to bring back with her. She was also asked to practise self-hypnosis in order to reactivate this calmness throughout the week.

It was perhaps her ability not only to visualize but also to experience—using all her senses—that helped her to feel this strong sense of calmness and confidence. The therapist employed more visualization, using the cinema technique (Ibbotson & Williamson, 2010); here, the patient was able to exercise

greater control over her driving, first, by being the projectionist and, second, by directing the film and making the necessary changes to each scenario. Owing to the fact that many driving phobics report having had at least one traumatic event which has precipitated the phobic anxiety, traditionally, this type of fear reaction has been treated using regressive techniques (e.g. Balson & Dempster, 1980) which often lead to an abreaction. However, dissociation seems to be as effective, and the combination of using this with further imagery and re-framing, as in the Williamson report (2004), helps patients to make the appropriate changes to increase their coping strategies and resourcefulness.

Dissociative imagery can be employed simply by asking the patient to imagine someone else in the situation and this can be done using the “My friend John” approach (Erickson, 1964), a technique which was utilized by Bakal (1981) in the treatment of flying phobia. The therapist explained that he took each patient through the flight, step by step, while normalizing any unusual features during the journey. For example, he re-framed turbulence and described it as being similar to a drive on a bumpy road. Bakal also pointed out that airport and flight staff often unintentionally use negative words and phrases which might exacerbate unconscious fear—for example, the use of the words “terminal,” “last and final call,” and “don’t be alarmed.” He also explained how unhelpful it was that one of the first things that a passenger experiences on the flight is how to cope with a possible crash. Bakal encouraged each patient to notice and be aware of these negative comments—thus reducing their impact—and to enjoy the scenes from the window, while perceiving the noises of the landing gear retracting and the flaps moving up and down as “safe,” “comforting” sounds.

Deyoub and Epstein (1977) also employed visualization in the treatment of a 30-year-old female with flying phobia. After the induction, the patient was asked to imagine a plane flight as someone who had successfully completed the therapy. She was able to imagine the journey in great detail, feeling calm and relaxed; however, during the landing process, she felt anxious, and so the therapist set up an anchor to reduce this tension by instructing her to touch her forehead while saying the word “relax.” She was asked to rehearse these hypnotic visualizations during the week; and, when she arrived for her third and final appointment, a day before her flight, she reported that she had been able to reduce her anxiety significantly during each rehearsal. Her therapist built on these treatment gains and told her that she would be even less fearful if she could now describe, and subsequently resolve, the main focal point of her anxiety. During this process, she reported a previous episode in which she feared being completely out of

control, and in the hands of a complete stranger. In the hypnosis, the therapist set up a scene in which she met the pilot and he was described as being confident and distinguished. He then gave the suggestion that it was “often advantageous to allow others to be in control” and this important insight contributed significantly to a complete elimination of her phobia. Importantly, the patient gained control by giving it freely to the pilot—indeed, the authors pointed out that, “the appropriate acceptance of dependency [was given to] ... someone else (the pilot), while the anchor and positive mental rehearsal provided her with the self-mastery she needed to effect change.”

Control is one of the main components in most, if not all, phobias (Aizley, 1999; Kraft & Kraft, 2004; Ritow, 1979; Segal, 1954) and dental phobia is no exception to this rule (Sartory, Heinen, Pundt, & Jöhren, 2006). It is for this reason that Gow (2006a) emphasizes that rapport and complete trust must be built before any major dental work can be done. For example, he points out that it is important not to underestimate the time of a dental procedure because, if any unexpected complications occur, the dental procedure is likely to become a lengthier process, and this might result in a breakdown of trust (Gow, 2006a). Patients suffering from dental phobia often experience a great deal of anticipatory fear (Kent, 1997) and this leads to avoidance of having regular check-ups or dental surgery (Kent & Blinkhorn, 1992). In addition, patients often fear the unknown (Epstein & Roupenian, 1970; Smyth, 1999) and this has the effect of exaggerating the fear associated with dental treatment: It is perhaps for this reason that Gow shows the dental equipment to his anxious patients and explains how each piece of equipment is used.

In the treatment of a female patient requiring extraction of the upper left third molar, Gow (2006a) employed a seven-stage “needle desensitization” hierarchy in order to help her to cope with the anaesthetic,² and this was done in the second session after the intra-oral examination and radiographic investigation. Adapted from McGoldrick (see Gow 2006a), this technique is useful for two main reasons: First, it makes clear what was previously unknown and thus reduces an exaggeration of the fear, and second, it provides the patient with more control in the surgery. For example, he first showed the patient the topical anaesthetic and explained that this allows the needle to glide into the mucosa without pain; the patient then holds the local anaesthetic cartridge and the syringe. The next stage is to look at the

² Although the patient feared needles, a diagnosis of dental phobia was given due to high Corah and Modified Corah Dental Anxiety Scores of 16/20 and 25/30, respectively (Corah, Gale, & Illig, 1969; Gow, 2006a).

needle, and here it is important to accentuate the fact that it is “very, very small.” Gow also recommends practising applying the topical anaesthetic and holding the needle up to the mucosa, first, with the cap on, and then with it off. Once the patient feels comfortable with these seven stages, extraction can take place—this desensitization process normally takes two or three sessions. In the case reported by Gow (2006a), he was able to perform an emergency extraction in Session 3. He employed special place imagery utilizing all the sensory modalities (Callow, 2003; Kalisch et al., 2005; Kraft, 2012b), asked her to repeat the words “calm, control and confident” and, with the additional use of glove anaesthesia, he was able to extract her molar without any difficulty. (Battino & South, 1999; Gow, 2002).

No greater trust can there be between a dentist and a blind patient, and Gow (2006b) utilized all his skills as a dentist and therapist during the treatment of a blind lady, Jo, with chronic adult periodontitis (Mitchell & Mitchell, 1996), requiring extraction. Here, Gow used the “Tell/Show/Do” technique (Locker, 1989) in order to build trust and to reduce her anxiety. Indeed, after two sessions, which included an intra-oral examination, rapport building and hypno-education, she created a special place using her four intact senses—hearing, smelling, taste and touch—and she held the dental instruments in her hands while her dentist gave her an explanation of their use. The following week, Jo returned for a scale and polish. Approximately three months later, she coped extraordinarily well with the extraction, following local anaesthesia: Incidentally, Gow also used “rubbing it better” suggestions based on Melzack and Wall’s (1965) gate control theory of pain during the process.

The term claustrophobia is a compound word which comprises the Latin word *claustrum*, which denotes “a place that is shut up” (Lewis & Short, 2002)—for example, an enclosure, lock, door or gate—and the Greek word *phóbos*, meaning fear. Many individuals suffering from this condition fear being unable to escape or being trapped—for example, on the underground, in lifts, in tunnels, cellars or in a crowded place—and this often can lead to panic. The fear of being trapped is often associated with a traumatic incident in the past, and it is, therefore, important for the patient to come to terms with this event during the therapy. An example of this investigative process in treatment can be found in a case study reported by Kraft (1973), although the bulk of the therapy involved desensitization and hypnosis. The patient, a 57-year-old married woman, stated that her phobia began when she was trapped on a train 22 years previously; however, the onset of her phobic symptoms coincided

with the death of her husband, and her problems were exacerbated when she found out that her second husband was having an affair.

In the psychodynamic psychotherapy, the patient investigated her feelings of being trapped at home and the connection between this and her phobic state. By contrast, in the hypnosis, she worked through a graded hierarchy in which she practised travelling by bus, being left alone in rooms of increasing size—with the door open and shut—using a lift, and being locked in a bedroom. The patient made a dramatic improvement and this was maintained at the two-year follow-up.

Re-visiting a traumatic event can be done in hypnosis safely using dissociative imagery (Williamson, 2008). An interesting approach, and one which helps clients to feel detached and also protected from danger, is the “magic bubble technique” (Alden, 1995), a modified version of which was employed in a vignette reported by Brann (2012). The patient, Helen, was able to explore the source of her claustrophobia—which consisted of being shut in various enclosed spaces as a punishment for resisting abuse—by entering her protective bubble which removed unpleasant thoughts and feelings, allowing more positive ones to flourish inside. She was also able to use this technique, combined with a visualization of her “relaxing place,” so that she could have an MRI scan without experiencing anxiety.

Claustrophobia can be a major problem for radiographers performing MRI examinations; in fact, it has been shown that between 25% and 37% of all patients experience moderate to high levels of anxiety during the procedure (McIsaac, Thordarson, Shafraan, Rachman, & Poole, 1998). Sedation is offered for some patients, but this requires an anaesthesiologist being present, and constant monitoring. The use of hypnosis reduces any risks that may occur as a result of the anaesthetic—for example, respiratory depression or other collateral effects—and is, therefore, a cost-effective adjunctive approach to treatment (Simon, 1999). In addition, patients who use hypnosis are able to remain still throughout the scan so that a good image quality can be obtained (Westbrook & Kaut, 1998); they can also maintain voluntary apnoea if required (Velloso et al., 2010).

Velloso and colleagues (Velloso et al., 2010) used hypnosis with 20 claustrophobic patients, and post-treatment results indicated that 15/16 of patients (93.8%) showed no signs of fear, and were able to complete the MRI scan without sedative drugs. The approach used the following techniques:

1. use of the safe place,
2. suggestions of stillness throughout the procedure,
3. suggestions of time distortion,

4. suggestions of analgesia,
5. re-framing the sounds of the scan, and
6. suggestions to reduce heart rate.

After the examination, further reinforcement was given to each patient.

The use of systematic desensitization (in vitro) has been shown to have been effective in the treatment of other situational phobias—for instance, bus driving phobia (Kraft & Burnfield, 1967); wedding phobia (Kraft, 1970), in which emotional imagery was used because of her lack of ability to visualize adequately; hospital phobia (Waxman, 1978); and traffic phobia (Kraft & Al-Issa, 1965). In all of these examples, hypnosis was employed in order to enhance the desensitization process, develop their coping strategies, and capitalize on their resourcefulness. However, in some instances, a multi-modal approach to therapy is needed to effect change. In a case described by Scrignar (1981), for example, in the treatment of contamination phobia with concomitant hand-washing compulsion, the initial desensitization had had little effect on the patient's behaviour and fear response. The patient, Mr M, had a morbid fear of "anything that [came] from other human beings," and this included faeces, sweat, saliva, urine, germs, nasal and mucous discharge. Scrignar employed imaginal flooding (Stampfl & Levis, 1967) in which he asked Mr M to imagine lying in the bath and to watch a man pour a bucket of nasal discharge all over him. After 20 minutes of this visualization, his anxiety subsided, and he was instructed to visualize having a shower. At the next session, he reported that his daily hand washing had significantly reduced—from approximately 200 times a day to 12 times—although he was still unable to touch certain objects around the house. The therapist then asked him, in the hypnosis, to touch everything that he thought was contaminated without washing his hands, and this had an immediate effect on Mr M's behaviour. This improvement was maintained at the two-year follow-up.

Another example of how the general principle of systematic desensitization can be augmented by other approaches is one presented by Frutiger (1981) who treated a 26-year-old married lady with penetration phobia. The patient was unable to have coitus with her husband and engaged exclusively in oral sex; this had had an effect on her marriage, and, during the term of treatment, she was separated from her husband. In the initial stages of treatment, she reported that she had never discussed sex, she had never masturbated, nor had she engaged in pre-marital sex. Indeed, she had never managed to have intercourse successfully and her phobia was reinforced on each failed attempt: On each occasion, she would experience a great deal of anticipatory anxiety

which caused her vaginal muscles to tighten. In the hypnosis, Frutiger used the principles of desensitization to reduce her anxiety about penetration: He then gradually introduced the possibility that she should begin to practise masturbating, and slowly and systematically worked towards her imagining having intercourse. Further *in vitro* desensitization was employed, and this consisted of her imagining a man of her own choice getting into bed, caressing her, and, again, this would lead to sexual intercourse—from the female superior position. She was also given suggestions to practise masturbating each night after progressive muscle relaxation. In further sessions, the therapist introduced the idea of dilation exercises³ and sought advice from a local urologist who recommended the use of specifically designed test tubes. Frutiger consulted the patient's gynaecologist and psychiatrist and, with their agreement, asked her whether she would be willing to try a series of test tubes for dilation purposes. Her permission given, she began to practise each night and, after some resistance, made a dramatic recovery; she also reported that she was able to achieve orgasm with the largest test tube and, after four months, she and her husband were back together. Interestingly, a graded hierarchy was used here both on a psychological and physical level: The desensitization helped her gradually to visualize having mastery and control of her sex life, while the dilators helped her progressively to have more control of her vaginal muscles and increase her levels of sexual pleasure. It might have been helpful in this situation to bring the husband into the consulting room. In this case, this was perhaps not possible due to their temporary separation, and it is not certain whether this would have helped or hindered the therapy. Certainly, the patient benefited considerably by being given the chance to reduce her anxiety on her own.

COMMENT

This report has demonstrated that hypnosis can be used effectively in the treatment of animal phobias and situational phobias. In most cases, when patients were able to access their inner resources, their perception of control altered, and they were able to effect change on their behaviour. Patients were able to gain this control through systematic desensitization, by using coping strategies, by re-framing the feared stimulus or by uncovering and

³ It is important to note here that the therapist consulted both the patient's gynaecologist and psychiatrist before offering this treatment. This type of intervention—that is to say, advising the use of dilators and recommending masturbation—should not be employed by therapists who are not medically qualified and, further, it is recommended that all therapists have additional training in psychosexual dysfunction before working with individuals suffering from sexual disorders.

understanding the source of the phobia. In many instances, however, a multi-modal framework, which is tailor-made to suit the individual needs of each patient, is recommended. Hypnotherapy, therefore, offers a rapid and cost-effective form of treatment for these conditions, and it is recommended that these procedures are used as a first-line treatment approach.

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HYPNOSIS AS AN ADJUNCTIVE TREATMENT IN THE MANAGEMENT OF CRICOPHARYNGEAL SPASM

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The following case demonstrates how hypnosis can be used as an adjunct in the treatment of a stress-influenced physical spasm of the cricopharyngeal muscle. Hypnosis was used first to explore precipitating contextual events related to the spasm and second to induce a relaxation response and related soothing of the spasm-prone muscle when tense. This provided a sense of control and mastery for the patient and insight was gained into the circumstances surrounding the muscle spasm. Self-defeating thoughts which increased the stress and anxiety the patient experienced were explored and related to the cricopharyngeal spasm through cognitive-behavioural therapy. Alternative ways of managing stress and anxiety were addressed and encouragement to use social support actively provided. Treatment resulted in a decrease in voiced discomfort and occurrence of cricopharyngeal spasm making hypnosis an easy adjunctive treatment to swallow.

Keywords: hypnosis, relaxation, muscle spasm, stress.

PATIENT'S PRESENTING PROBLEM AND REFERRAL DETAIL

A 45-year-old self-employed male, who will be referred to as Billy, in the service industry was referred by his general medical practitioner for the psychological treatment of cricopharyngeal spasm identified by the medical practitioner as being related to stress. Cricopharyngeal spasm results from a spasm in the cricopharyngeus muscle and is characteristically described by patients as having an intermittent lump in the throat which tends to get worse later in the day. Such spasms are often impacted by stress levels.

A cricopharyngeal spasm, henceforth referred to as spasm for the sake of brevity, can be simulated by pressing lightly on the cartilage on the neck just below the Adam's apple (Thomas, 2003). The medical referral was for psychological treatment involving individual counselling, supportive psychotherapy, cognitive-behavioural therapy, and stress/anxiety management.

PATIENT'S PRESENTING FEATURES AND RELEVANT PERSONAL INFORMATION

Billy noted few biopsychosocial difficulties save work stress and stress related to a divorce which occurred over seven years previously involving his two children apart from his related complaint of spasm. He communicated normally, generally freely, and in an interactive fashion with this clinician. He presented with no obvious mood difficulties and made few complaints save the level of stress he experienced at work and the noted spasm. He was occasionally measured in his speech and at times exhibited thought blocking. His score on the Kessler Psychological Distress Scale (K10) indicated a moderate to high level of distress (25) (Andrews & Slade, 2007; Kessler, Andrews, Hiripi, Mroczek, & Zaslavsky, 2002).

Billy indicated in interview that he believed the experienced spasm was stress-related and reported additional physical symptoms including tightness in the chest and difficulty breathing. He noted being distracted by symptoms. Spasm was stated as being present throughout the last few years and that for a few months prior to psychological contact the symptoms increased, thus resulting in psychological contact. He noted he himself can trigger spasm within five minutes by thinking about various work and family pressures and other stressors. Specifically, when he thought about and acknowledged feelings about being "overwhelmed" by legal bills and administrative activities at work and not performing as well as he would like he could trigger spasm. He described himself as wanting to perform at a high level.

The spasm became bothersome two to three times per week and was reported as generally worse later in the day. The spasm caused Billy discomfort and distress and he had two main ways of coping. First, he noted the moderate ingestion of alcohol (a standard glass of wine or two) in the evening when a spasm was present and, second, he would externally manipulate the throat area; specifically, Billy used his hand to stroke and soothe the muscles of the front of the neck. The use of wine was noted as mildly helpful by Billy and was within

the Australian guidelines for healthy drinking (National Health and Medical Research Council, 2009). No medication was being taken by Billy.

Socially, Billy presented an unremarkable history describing a divorce and shared custody of his two teenage children. He indicated a happy childhood with some sadness regarding the loss of his father early in adulthood and feeling as though he was not appreciated as a child. Conceptually this lack of appreciation was thought to be possibly related to Billy's current perfectionism as well as feeling inadequate occasionally regarding work.

He noted few friends versus associates. He reported not sharing how he was feeling stressed and generally experiencing his work environment. He stated that there was much about his work that he liked. He indicated not wishing to contaminate his home life with work talk and that such discussions with colleagues would not be appropriate for someone in his position at work. He openly acknowledged a lack of support in this area which was likely the source of his general medical practitioner's referral to include supportive psychotherapy.

SUITABILITY OF PATIENT FOR HYPNOTIC PROCEDURES

Billy's identified anxiety and stress suggested that hypnosis would be a potentially useful adjunctive treatment modality to a cognitive-behavioural approach as hypnosis has been successfully applied to anxiety and stress in this way (Bryant, Moulds, Guthrie, & Nixon, 2005; Hurley, 1980). The discomfort component of the spasm also indicated hypnosis as a treatment given the long known success of hypnosis in treating pain that is both acute and chronic (Jensen, 2009; Kuttner, 2009; Patterson & Jensen, 2003). Additionally, muscular spasm has been noted in case studies to be amenable to hypnotic influence (Dolan, 2009). As the medical difficulty had been fully explored by his medical practitioner there was no danger of masking symptoms that would interfere with diagnosis or otherwise exacerbate a medical condition. Additionally, no work cover or legal processes were underway or planned by Billy and thus there were few, if any, contradictions to the use of hypnosis in this case (Yapko, 2003).

When the possibility of hypnosis was discussed with Billy in our first meeting he was intrigued and noted a personal engagement in meditation activities with great success. For instance, after viewing a show on the use of meditation to treat migraine headaches he noted practising one of the techniques demonstrated just to see if he could replicate the technique despite

not personally suffering from migraines. Specifically, he taught himself to warm his hands and body temperature. He noted pride in being able to do this activity and celebrated his skill when he felt cold and was able to warm himself by focusing on being warm. Billy was commended for his focus and practice of such meditation that has, similarly, been used to treat headaches with success (Blanchard et al., 1990). Billy's ability indicated a clear talent for a special state of focused attention to enhance his health and comfort.

As a result of the applicability of Billy's problem areas to hypnosis and his success in using meditative techniques, hypnosis was seen as a potentially useful adjunct to a cognitive-behavioural, supportive, and stress-management approach designed to help develop appropriate coping behaviours to mediate Billy's experience of anxiety and stress. Specific treatment techniques would be multifaceted and address coping, discomfort, and social support. Cognitively we would examine Billy's beliefs about work and his performance at work. Coping would strive to strengthen his resilience to stress and socially Billy would examine how to best gain support from others appropriately. Special attention would be paid to identifying and targeting perpetuating factors as this approach has been deemed useful for lowering stress and anxiety related to somatic complaints. Such an approach can then allow for perpetuating factors to be addressed addressing long-term change in symptoms (World Health Organization Collaborating Centre, 2004).

TREATMENT PROGRESSION

The first clinical session was spent orienting Billy to treatment and completing a biopsychosocial history, as well as history of Billy's spasm, paying attention to precipitating events. Billy was aware of stress being related to work but provided little detail regarding possible precipitating events or circumstances and at times noted enjoying work.

As Billy noted a history of mild success in reducing spasm via ingesting one to two standard glasses of wine, this clinician asked Billy to refrain from self-medicating with wine, or other alcoholic substance, any spasm activity but instead to drink water and note any impact, if at all, this had on the spasm as it too is a swallowing activity. He was also asked to attend to precipitating events regarding the spasm with an eye to discussing these with this clinician at our second visit. He agreed and it was hoped that this would provide a clear indicator of spasm activity and associated events and consequences by increasing his focus on events versus the nature of the spasm itself without

the possible influence of alcohol. Additionally, for long-term improvement Billy would need to engage in alternative coping skills as alcohol cannot appropriately be ingested on a regular basis as a medicinal treatment for spasm.

“BEING HYPNOTIC”

Although hypnosis was not used as a technique in Session 1, clinical language in the session was purposefully structured by this clinician to refer to “the” versus “his” (Billy’s) spasm to separate, differentiate, and prepare to dissociate Billy from the spasm. Hypnosis along with a variety of approaches and techniques typically used by this clinician were discussed briefly at the end of our initial meeting. Our work together was structured as a “joint project” to discover and work through the stress and related spam issues presented by Billy. It was thought that an overt structuring of the collaborative nature of our “project” would suit his lack of social support and style of work involving service industry project management. Consequently, the clinician was purposefully “being hypnotic,” focusing on a utilization approach (Erickson, 1980) in the first meeting which eventually led into our “doing hypnosis” in following sessions.

In this case, hypnosis was used first to explore and discover factors related to the spasm and then to give suggestions about how to manage the symptom more effectively. In Session 2, two weeks after our initial meeting, Billy noted a reduction in spasm activity and thus little opportunity to explore precipitating events and circumstances and test the use of water versus alcohol in soothing the spasm. He was unable to link the lack of spasm activity to any change in his activities or circumstances save being able to discuss his current functioning in therapy. Consequently, as we were engaging in a “joint project” to discover influences on the spasm we engaged in an imagery-based activity to try to illuminate any influences on the spasm.

ENGAGING IN HYPNOSIS

Specifically in Session 2, hypnosis was induced as a means of examining specific influences on the spasm. A gentle conversational induction was used and Billy eagerly engaged in the activity. He was asked to make himself comfortable using his past meditation experiences as an induction. He was then asked to imagine himself in a vehicle with the swaying and motion and sound of the motor. This travel imagery was used as the building in which we were working was experiencing construction noise similar to motors and the wind present

on the day provided some reverberation in the room in which we sat, allowing for the utilization of such characteristics in a motorised movement scenario. The vehicle imagined was then set on a trip to and from work, a recent trip during which he recalled experiencing a spasm. As Billy sat in an unmoving and relaxed posture he was asked to detail precipitating events and context. He noted detail regarding his work situation which could be helpful in identifying precipitating factors for the spasm experienced.

Through the exercise it became clear that Billy worked at many worksites and the spasm experienced tended to occur when he had to collect mail from his post office (PO) box as part of his work activities. The reasons for this co-occurrence were unknown by Billy who communicated same during the experience. No abreaction occurred during the hypnosis session (Yapko, 2003). Consequently, the posthypnotic suggestion that Billy would be an investigator and able to note details of his thoughts and feelings as he approached his PO box was applied.

The hypnosis in Session 2 was a means to an end for information and exploration. Hypnosis was not initially used to remove the symptom of spasm or to make the spasm more comfortable but to explore influences upon the spasm. This hypnosis use allowed a preliminary foray into the use of hypnosis for Billy and its gentle exploratory use captured Billy's curiosity about hypnosis as well as identifying the possible importance of the PO box trips which he literally found "hard to swallow."

In Session 3, a fortnight after our last meeting, Billy noted a flash of insight into the experience of his PO box visits and associated spasm had occurred since Session 2. He noted that he often received divorce and custody papers at the PO box. This caused him great stress and Billy then noted he was thinking of his childhood and discussed how he felt that he was not appreciated for the boy he was so many years ago. The session then focused upon his perceptions of not living up to certain high standards, including feeling defeated by his divorce, and associated family circumstances, in terms of his childhood as well as current work and general life circumstances. He was able to make links conceptually between his current family stress, who he was as a child, and visiting his PO box and how this could relate to the spasm experience. Alternative ways of thinking were reviewed and Billy was challenged to reframe both past and present circumstances in a multitude of ways resulting in a kinder evaluation of self.

In Session 4, Billy reported little spasm activity. Nevertheless, hypnosis was engaged in as the main treatment technique designed to help Billy be able

to engage in relaxing his throat muscles, thus easing discomfort. In a manner similar to the treatment of chronic pain (Jensen, 2009; Kuttner, 2009; Patterson & Jensen, 2003) as well as bruxism as presented by Hammond (1990), Billy was encouraged to focus on and relax his throat muscles while being generally aware of the tension held in the neck and jaw, and being able to adjust the sensations he was experiencing. Phrases such as “gritting one’s teeth” and some things being “difficult to swallow” were used metaphorically in terms of being able to “chew manageable chunks” of stress to aid in the use of coping skills. Hypnosis imagery based on warmth and on soothing Billy was provided and the posthypnotic suggestion was that he could warm, soothe, and relax his throat muscles just as he can warm his hands when he is aware of any tension. This was designed to build upon his success of being able to warm himself via meditation.

Specifically, in Session 4 an eye-fixation induction was used as this clinician noticed Billy studying the artwork in the therapy room. He was asked to look about the room and find an object of interest upon which he could focus. His focus was upon the beach imagery in one of the paintings and thus Billy was taken to the beach to relax, experience multiple sensations, and feel warmth on his skin and hands which was then applied to his throat area. Upon conclusion of the hypnosis experience Billy noted not having thought of applying his ability to warm his hands to the spasms he experiences. He was thankful for this new-found use of his meditative capacity.

COMMENTS ON THERAPY APPLICATION AND OUTCOME

Billy indicated clear recall of precipitating events and related spasm while engaging in hypnosis. Following this session Billy was able to verbalize the improved level of awareness he had for the impact of specific aspects of his PO box visits which precipitated the spasm. He noted that cognitively addressing his thoughts of unease regarding this aspect of his work and family involvement was helpful in reducing his stress and subsequently lessened the spasm experienced. He was able to link the current stress of feeling inadequate to his childhood and thus a possible source of his maladaptive cognitions. Additionally, Billy had developed the ability to soothe his emotions and experience of cricopharyngeal spasm

In conclusion, hypnosis was used in this case to identify, explore, and work through issues impacting Billy’s stress levels and maladaptive cognitions, and to

change a targeted physical response resulting in discomfort making use of two main applications of hypnosis in psychological work (Winsor, 1993).

COMMENTS OF THE CLINICIAN, IN RETROSPECT

When I met Billy I made a conscious effort to separate him from the spasm experienced. I did this purposefully and hypnotically by referring to “the” versus “his” spasm in order to objectify the spasm for us to work upon as a “joint project.” I thought such a separated approach would suit Billy’s working style. Additionally, I hypothesised that dissociating Billy from the spasm would enable distance and lower his focus on the spasm and “create” an item upon which he could work to change. In retrospect I wonder if this was the best course of action. I could have chosen to address Billy as a whole person without separating him from his total experience. Nevertheless, perhaps separating the spasm, versus his entire cricopharyngeal muscle, in language use was honouring enough of Billy as an entire person and yet showed camaraderie in the identification of a problem upon which to work.

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**THE USE OF HYPNOSIS AS AN ADJUNCT TO
COGNITIVE–BEHAVIOURAL THERAPY IN THE
TREATMENT OF POST-TRAUMATIC STRESS DISORDER
IN A PATIENT PREVIOUSLY RESISTANT TO OTHER
MODES OF THERAPY**

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This case study describes the use of hypnosis in the treatment of post-traumatic stress disorder, resulting from exposure to wartime atrocities and social media events. It demonstrates the effectiveness of hypnosis as an adjunct to cognitive–behavioural therapy in the management of a patient who was proving to be resistant to treatment. Therapy was aimed at stress management, trauma focus, relapse prevention and maintenance, with the client reporting improvement within seven sessions.

Keywords: hypnosis, cognitive–behavioural therapy, post-traumatic stress disorder.

PRESENTING PROBLEM

Mr X is a 50-year-old male who was referred to me by his general practitioner for the management of his 20-year history of depressive symptoms. Despite receiving various treatments over this time including drug therapy, cognitive–behaviour therapy (CBT) and other psychotherapy, Mr X's symptoms failed to improve. Mr X had disengaged himself from therapy; however, recent deterioration in global functioning and failure of a business had prompted him to seek assistance.

CLIENT'S PRESENTATION

Mr X's problems stem from traumatic experiences in Africa when he witnessed war atrocities leaving him with post-traumatic stress disorder (PTSD). However, due to his reluctance to discuss these events, he had been diagnosed (possibly misdiagnosed) with illnesses such as chronic depression, anxiety and attention deficit disorder (ADD).

Mr X's presenting symptoms were consistent with the diagnostic criteria of the DSM-IV-TR for PTSD (American Psychiatric Association, 2000). He experienced disabling intrusive thoughts, and suffered ongoing sleep disturbance due to chronic nightmares. He exhibited emotional numbing with loved ones and the loss of interest in activities he once enjoyed. He was experiencing immense feelings of guilt and suffered from emotional lability. He was irritable and had poor anger control, although he was never physically violent.

Mr X had low self-esteem and self-confidence, poor concentration and a lack of motivation which had impacted on maintaining relationships or forming any type of relationship professionally or socially. He believed that his disorder was so debilitating that it was impossible for him to engage in or maintain any full-time employment, spiralling him into feeling overwhelmingly isolated and alone.

RELEVANT PAST PSYCHOSOCIAL AND MEDICAL HISTORY

Mr X is a father of two children aged between 23 and 25 years, who live with him and his wife in rented housing. He reported having an uneventful childhood and was close to his parents. He was a good student and completed formal education and an apprenticeship in motor mechanics. While travelling in Africa in the 1980s, he witnessed human rights atrocities such as mass killings, rape and torture. This led him into a career as a war correspondent/photographer for nearly a decade and then a news photographer. He later tried commercial diving for a career and on meeting his wife started a driving school business. This eventually failed due to his presenting psychological and medical issues.

Mr X's nightmares worsened when his children were young. He felt at that time that discussing what he had experienced was not an option and chose "to bury it." He attempted suicide twice, but did not wish to discuss the details within the scope of our sessions.

Mr X demonstrated avoidance of any cues, thoughts and feelings about any aspect associated with the traumatic events that he had endured. He was reluctant to talk about what he had witnessed in the past, resulting in a multitude of possibly ill-informed diagnoses making treatment difficult. He had been treated by two psychiatrists, several psychologists and a general practitioner before seeing me. He was taking dexamphetamine for ADD and recently had his antidepressants changed to obtain better control. Mr X was referred to another psychiatrist for a second opinion concerning the ADD, but failed to attend.

Mr X suffered from chronic migraines which occur several times a week. He believed the migraines were triggered by stress, which was an ongoing problem as Mr X felt that he was in a constantly stressed state of mind. The migraines caused him to isolate himself and become less interactive with his family or others.

HYPNOTHERAPY

Suitability

Mr X had no previous experience and minimal knowledge about any type of hypnosis, whether it was clinical or stage hypnosis. To assess Mr X's degree of hypnotizability I chose to demonstrate hypnotic phenomena in a safe and relaxing way. I used the Stanford Hypnotic Clinical Scale, in which Mr X convincingly demonstrated moving hands together, finger locking, and experienced auditory hallucinations and time distortion.

Informed Consent

Informed consent was obtained during Session 2. According to Schefflin (2001) it is imperative that the client is informed so that they are knowledgeable enough to make a conscious decision about giving informed consent. The hypnotic process and CBT were discussed and his concerns were addressed. It was explained how using both of these therapies together he would be able to reframe the maladaptive memories and associated feelings so that they were less intrusive and more manageable, to which he was “willing to give it a go.”

Therapy Goals

The aim of the therapy sessions (seven weekly sessions) was to build a professional relationship with Mr X to facilitate trust, open communication

and provide a foundation for effective participation in therapy—a vital element that may have been missing in previous professional interactions.

Other essential therapy goals were stress management and trauma focus. Mr X was introduced to a number of different techniques to minimize stress in the hope that it would alleviate the immediate stress, as well as equip him for managing stress in the future. This was an important skill required to assist with relapse prevention. It was hoped that alleviating some of the stress would assist in reducing the frequency of his migraines.

Trauma focus was aimed at reducing his nightmares in frequency and the debilitating effect of this experience. The aim was to demonstrate how Mr X could be in control in his nightmares resulting in stress reduction and empowering him with techniques to prevent relapses.

Treatment Approaches and the Rationale for its Use

Cognitive-behavioural therapy was chosen as the primary therapy to address the patient's chronic symptoms of PTSD. Keane (1995) advocated the use of CBT in the management of PTSD during his phase-orientated treatment program, stating that the patient has to be stabilised emotionally and behaviourally before commencing trauma education and then stress management. Only when this has been achieved can the therapist's attention be focused on the trauma, relapse prevention and follow-up/maintenance.

There appear to be many features of PTSD which have a notable resemblance with hypnotic phenomena (e.g., hallucinations, dissociation, depersonalization, and time distortion). Evans (2003) argued that hypnosis was the most favourable adjunct for CBT in assisting those suffering from PTSD. He believes that PTSD is a condition which occurs in the highly hypnotizable more than other psychiatric disorders or in the general population, and is therefore acquiescent to treatment with hypnosis. This has also been reported by Kirsch, Montgomery, and Sapirstein (1995) who found a positive mean effect when using hypnosis as an adjunct to treatment with CBT. Therefore, the addition of hypnosis could only enhance the treatment gains.

After gaining invaluable knowledge by the second session about how Mr X had been resistant to most types of treatment in the past, I believed that using hypnosis therapy similar to Keane's phase-oriented treatment program could be effective for stress management, trauma focus, relapse prevention and maintenance in Mr X.

Session 1

The first session was focused on establishing rapport, building trust and history taking. Mr X indicated that he was having great difficulty adjusting to “normal life” away from the onslaught of horrific events, which he had witnessed on a daily basis. He felt that he was devoid of emotions, feeling numb in almost all situations. Frequently he would feel anxious and panicky, concerned that his family and himself were in direct threat of their life, despite that not being the case.

Mr X suffered from a recurring violent nightmare, which he believes was the catalyst for him starting his high-risk career. A rebel group had invaded a village he was staying at in Ghana and he and a family from the village were trapped. The family was systematically killed and he was holding a young girl who was shot in his arms. The rebel group spared his life for him to report on what he had seen. Despite being fearful for his life, he went on to become a foreign correspondent for more than a decade.

Mr X responded positively to my empathetic acknowledgment of how he was placed in an inconceivably dangerous situation and he was suffering from PTSD. According to Evans (1991), my acknowledgement of his experiences was significant in building a rapport with someone who is experiencing PTSD. The session concluded with the provision of simple arousal reduction deep-breathing exercises with a positive visual/distraction relaxation technique.

Session 2

In the second session I used CBT/psycho-education to help him understand what he was feeling and to demonstrate that his behaviour was normal for what he had experienced. The session focused on challenging or reframing negative thoughts and providing techniques to help him relax. We discussed the option of trying a combined therapy of CBT and hypnotherapy. Mr X had not heard of this type of treatment and was apprehensive. He was most concerned about losing control and being humiliated.

To alleviate some of his concerns Mr X was asked if he would like to see how hypnotizable he was and to experience some of the hypnotic phenomena for himself. I used the Stanford Hypnotic Clinical Scale, to which he was very receptive. Mr X was allowed a week to consider using hypnosis as part of his treatment.

Session 3

In the third session, Mr X agreed to try hypnosis after admitting he had researched the treatment and was confident that this would help him. I suggested using hypnotherapy for progressive relaxation and guided imagery so that he had a secure and safe place where he could retreat, relax and heal, and this would also help build more positive self-esteem and self-confidence. Using these relaxation techniques would enable him to facilitate periods of relaxation by refocusing his attention away from the constant arousal and tensions which are a significant characteristic of anxiety.

Mr X was informed that he could stop the session at any time if he felt unsafe. A safe trance induction was performed and at the end of the session he reported that he was calm and relaxed, a state he had not allowed himself to be in for a long time. A recording of the session was given to him and he was asked to listen to the CD each night prior to going to sleep until his next weekly session.

Mr X asked if it was possible during the next hypnotherapy session for him to complete the nightly recurring nightmare. He reported that he had never been able to complete this nightmare as he woke in the same place each night, sweating, feeling anxious and unable to get back to sleep. This insomnia was interfering with Mr X's ability to concentrate, gain or maintain any type of employment, interfered with his social and family life and his ability to cope with everyday stressors.

It was discussed how the use of hypnosis might allow Mr X to gain control of his nightmare, which would assist to promote a better sleeping pattern and emotional control. Spiegel & Spiegel (2004) and Gilligan (1988) argued that the fundamental principles of hypnosis in treating PTSD is allowing the client more accessibility to traumatic memories and nightmares, giving them the ability to control the intense affects and psychological responses by restructuring them.

Session 4

This hypnosis session was used to help Mr X complete his unfinished nightmare in a safe and controlled place so that he could reframe the recurring nightmare and eliminate it, giving him a sense of self-mastery and improving his self-efficacy.

We discussed a way that he could communicate while experiencing this dream and an ideomotor signal was set up. We explored the option of him

being the “observing third person” but he wanted to go through the dream and complete it. Therefore we had the simple yes and no signals as well as a safety signal if he felt he needed to end the dream. Mr X had the expectation that this session would have a positive outcome. The induction helped him move from his conscious state to a relaxed and safe state. Deepening was in the form of a descending staircase; he was guided down the staircase and into a bed where he could visualize the dream, which he did very quickly.

I maintained contact with him as he processed the dream. In the last scene he was asked to repeat the dream, but add elements that would change the content of the dream and make him less anxious. According to Erickson (1959) the revivification of a nightmare is designed not to alter the memory of the event but to add a coping element so that the dream no longer has a negative impact on the person. After completing this suggestion Mr X was guided back to a conscious state. He reported that he felt there was an ending to the dream and that he was safe.

Session 5

Mr X reported that he had slept better over the past week with the nightmares diminishing but not completely disappearing. However, the nightmares were less intense and were described as being more of a “weird dream.” Mr X felt that he was in control and was able to go back to sleep soon after the event.

Before the hypnosis session ideomotor signals and anchoring, which were to be set up for his emotional safety, were explained. Session 5 involved imagery and dissociation techniques by Bandler and Grinder (1982), referred to as “the theatre of the mind.” This hypnosis technique focuses on flashbacks and negative responses to stimuli which the client associates with traumatic events.

After induction and deepening, Mr X was asked to imagine that he was seated in a movie theatre. He was viewing a black-and-white snapshot of himself performing a safe activity at a time before the traumatic event. Both the movie screen and the picture on the screen were dissociation techniques. Mr X was then asked to imagine himself floating out of his body and floating up into the theatre projection booth situated behind him, another dissociation technique. He was then asked to watch himself looking at the snapshot of himself on the movie screen. At this point he was asked to anchor using his thumb and little finger touching each other to reinforce this dissociative safe feeling if required, and instructed on how to use the anchoring.

When this was completed Mr X was instructed to turn the snapshot into a black-and-white movie of the traumatic event and watch himself be a part of the events from the beginning to the end. At the end of the movie my client was asked to stop it and signal that he was all right. When this was done he was asked to imagine the end snapshot of the movie in colour and then to step into the colour movie and experience it being played backwards at high speed, only taking one to two seconds. He was asked to do this five times and finally the movie was played forwards, with my client asked to focus only on the positive things that made him feel in control. After completing this safe-place positive imagery, ego-strengthening directive techniques were implemented and the session ended.

Mr X reported that he was surprised that he had watched the traumatic scenes and felt little discomfort. I asked him some questions about his traumatic events that evoked anxiety when Mr X first presented and to his surprise he did not feel any anxiety. He was given a disk of the session and asked to play it nightly until his next session.

Session 6

Mr X reported that he had not experienced any nightmares and his family felt he was more positive and motivated to do things. He was still having some dreams and feelings that made him uncomfortable; however, he was able to cope with these by utilizing techniques such as safe place and positive visual relaxation techniques as well as listening to the CDs given to him during the sessions.

In the final hypnosis session, ego-strengthening and coping strategies for dealing with any difficulties and negative responses were included in the recording. Mr X was asked to practise self-hypnosis and coping strategies each day/night and continue to listen to the recordings of the hypnosis sessions.

Final Session and Therapy Outcome

No hypnosis was used in Mr X's last session. He reported that he was feeling "emotionally stronger" and his anxiety had lessened. His migraines had decreased in frequency and were often of less intensity. He now believes that the terrible events that he had witnessed were not his fault. He has many photographs stored away and has decided to write a book about his life, which he believes he could not have achieved prior to therapy. It was mutually agreed that there was no need for any further sessions at this stage and Mr X could contact me if required.

CONCLUSION AND RETROSPECT

Mr X is an example of how hypnosis and cognitive-behavioural therapy can be effectively used together to manage post-traumatic stress disorder. I believe, however, that the success of this methodology can also be attributed to Mr X's willingness to openly communicate his experiences that resulted in his PTSD, the establishment of rapport and trust, and Mr X's active participation in the therapy. Potentially, these factors may have been absent in previous attempts to assist with his mental wellbeing.

In retrospect, I have come to believe that the success of Mr X's therapy could be attributed to the therapeutic alliance which was formed and was as important as the combined cognitive-behavioural therapy and hypnosis.

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HYPNOSIS, ZEN BUDDHISM AND THE CANCER EXPERIENCE WORKSHOP PART 1: HYPNOSIS AND ZEN BUDDHISM

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Dr Norman Shum and Dr Sue Stefanovic jointly presented this Workshop at the Australian Society for Hypnosis' Annual Congress in September 2012 at Daydream Island. Part 1 is Dr Shum's reflections on this workshop while Part 2 is the cancer section submitted by Dr Stefanovic.

Below is the outline of the workshop:

- *What is hypnosis? Group induction*
- *Introduction to Zen Buddhism and meditation*
- *Similarities and differences between hypnosis and meditation*
- *Mindfulness*
- *What is cancer?*
- *Cancer statistics and risk factors for developing psychological difficulties*
- *Principles of cancer management*
- *Chemotherapy side-effects*
- *Psychological issues*
- *Case studies*
- *Why use hypnosis—review of evidence, and immune system response*
- *Pain control*
- *Sleep difficulty*
- *Self-hypnosis*
- *Hypnotic experience—group induction*

Keywords: hypnosis, Zen, Buddhism, meditation, mindfulness.

What follows are my reflections before, during and after my participation and presentation in a workshop which I presented with my friend and colleague, Dr Sue Stefanovic.

HYPNOSIS, ZEN BUDDHISM AND THE CANCER EXPERIENCE

Hypnosis and Zen might seem like strange bedfellows, but add the element of cancer and a connection emerges.

Hypnosis concerns the mind.

Zen concerns the spirit.

Cancer concerns the body.

On Daydream Island it was assumed all attendees would be interested in hypnosis. Some ASH members may know about or be interested in Zen Buddhism. A small number may have had personal or close encounters with cancer.

As clinicians we may be asked to see a client or patient suffering from cancer. While we may be competent and comfortable managing either the mind or the body aspects, the spiritual is an area that has been rather neglected in our clinical training. However, having an awareness and knowledge of hypnosis and Zen adds another dimension to our clinical skill set.

My interest in hypnosis began as a seed sown when I was a mere schoolboy. I found a small case containing a small shiny metal hammer. My father told me it was for use in hypnosis and said no more. The memory of this finding lay dormant for about 35 years and resurfaced in 1984 when I undertook an introductory hypnosis course in the Department of Psychology, Flinders University. Eventually to formalise my training, I completed the ASH course in 1988–89.

A quiescent interest in Zen Buddhism was reawakened in 2002 when a physical injury prompted looking at alternative means of enhancing the healing process. Using self-hypnosis was immediately obvious but the possibility of adding meditation techniques similar to those used in the martial arts was another option. The book, *Zen in the Martial Arts*, by Joe Hyams, was the reference.

My close encounter with a potentially malignant tumour, that is, cancer, was as a medical student in 1966. It certainly made me interested in cancer both personally and professionally. Originally discovered in 1960 on a routine chest X-ray done as part of a pre-compulsory military training medical

examination, the tumour was dismissed without investigation or follow-up as I had no symptoms.

By Christmas 1965 I definitely had symptoms but these were dismissed as glandular fever. Another X-ray in September 1966 found the tumour had grown! Instant referral to a cardio-thoracic surgeon followed. The tumour was operated on and removed within days. Pathology showed *no* cancer cells. However, at my post-surgery outpatients follow-up I could barely walk or talk! So the surgeon pointed across the road to the hospital and I was readmitted. A definitive diagnosis was made and I went on medication for the next two years!

The drug treatment allowed me to return to my medical lectures and walk the hospital wards talking to and “clerking” patients. I was assigned two patients with similar tumours in their chests. Both were dead within six months from their tumours which had the same origin as mine, the thymus gland. But definitely neoplastic and lethal.

THE HYPNOSIS, ZEN AND CANCER WORKSHOP

Our workshop was scheduled for the Wednesday morning 19 September, the morning after the Congress BBQ! There was no obvious diminishment of the audience numbers so perhaps the registrants had restrained themselves from over-indulgence the night before.

I began by asking for an indication of the disciplines present and, expectably, most of the audience consisted of psychologists. One participant was a registered nurse and there were three medical specialists: Dr Bob Large, associate professor, consultant psychiatrist; Dr Geoff Hawson, a haematological oncologist; and myself.

Sue started proceedings with a welcome and introduction to the workshop. This was followed by a Zen breathing focus exercise demonstrated by me. The audience was then invited to participate.

Everyone stood, feet about shoulder width apart. Arms hanging by the sides. The thumb was placed in the palm of the hand and the fingers curled over, wrapping the thumb. The people lowered their “centre” gently downwards by bending the knees together. The centre is 2–3 centimetres below the navel. As they lowered their centres, the people slowly exhaled as they tightened the fingers over the thumb. After a pause the people slowly rose up briefly on to tiptoes. As they rose, the group inhaled and released the curled fingers so the hands became open. And then everyone rested momentarily with the feet flat.

The sequence was repeated several times.

The group was asked what they noticed while carrying out the exercise. Its intention was to generate the first level of mindfulness awareness while making a connection between the earth and the sky. The body acting as a conduit for the universal energy or force, *ki* in Japanese (or *chi* in Chinese), between the earth and sky. The group was quite surprised at how a seemingly simple exercise required considerable mental focus to stay with the movements. The exercise also had the effect of breaking loose any pre-existent mind sets.

Sue continued with a brief overview of our understanding of hypnosis with my preferred version being Kihlstrom's (2008) definition: "Hypnosis is a process in which one person designated the hypnotist, offers suggestions to another person, designated the subject [patient] for imaginative experiences entailing alterations in perception, memory and action" (p. 21). No other discussion of the history or nature of hypnosis was given as this was presumed knowledge for the group. To ensure a relaxed receptive mind before my view of Zen Buddhism was presented, I carried out a group induction using one of my more meditatively oriented scripts called "Deep Trance" (see also in this issue).

AN OVERVIEW OF BUDDHISM

This was given before considering the Zen version.

Buddhism emerged from the polytheistic Hindu tradition but is not a religion like Islam or Christianity. Perhaps it is more a philosophy.

The word Buddha literally means "awakened one." Buddha began his life as the historical figure Prince Siddhartha Gautama. His father was the titular head of a small kingdom just below the Himalayan foothills on what is now the border of Nepal and India.

Born around 560BC, to King Suddhodana and his wife Mayadevi, Siddhartha lived a life of luxury. His father's intention was for Siddhartha to be his successor and rule the kingdom. While initially shielded from it, Siddhartha eventually learned of the outside world. Venturing out, he became aware of people suffering old age, sickness and death. This caused him great distress.

After several more trips accompanied by friends, Siddhartha withdrew from them and sat under a rose-apple tree reflecting on what he had seen. He saw a possibility of confronting his fear of death and achieving composure. Later, after meeting a holy man, a saddhu, and noticing the saddhu's sense of peace, the prince decided to leave his wife, son and palace life to begin his quest for similar enlightenment.

The prince studied various systems practised by ascetics and yogis. The following six years of self-mortification, self-denial and deprivation only served to sicken Siddhartha until he collapsed. Revived by some rice in milk brought by a village girl, Siddhartha remembered his experience under the rose-apple tree and decided this might be the path. He made a grass cushion under the Bodhi Tree and vowed to stay until his understanding was complete and he had seen ultimate reality.

During this period of seven days of meditative absorption, Siddhartha was said to have been tempted and tormented by Mara and his seductive daughters. Mara is the figure representing all the obstacles to enlightenment as well as being an embodiment of death. Meditators know well the distractions that can emerge while trying to maintain focus.

While practising what is called “insight meditation,” *Vipassana*, Siddhartha gained certain special kinds of knowledge. Memories of many former existences. Knowledge of the workings of karma, the law of cause and effect. And knowledge of sensual desires for existence, and our ignorance of their true nature.

The record states that at dawn the morning after the night of the full moon of May, Siddhartha saw the morning star Venus rise. He saw the world for the first time with extraordinarily clear eyes. He was Siddhartha no more, but *the Buddha—the awakened one*. It was six years since he left the palace.

For a while Buddha sat enjoying the sense of freedom. Then he began wondering if he should try and teach others what he had learned. Finally he decided to carry out the vow he made at the beginning of his quest, to try and alleviate the suffering in the world.

Buddha spread his word. “I have obtained deliverance by extinction of self.” During his enlightenment experience he had arrived at the concept of *anatman* or “non-self.” In contrast to *atman*, the physically real and indestructible soul in Hinduism.

While there is doubt as to the authenticity of what has been handed down as the Buddha’s words, the essence of the Buddha’s early teaching is contained in the discourse delivered to his first students in the Deer Park at Samarth in Northern India. Those first students were the five ascetics who had earlier shunned him for giving up asceticism, but now seeing his radiance they followed him.

That first discourse is now known as the *Four Noble Truths*.

1. *All life is suffering*. Suffering is an approximate translation of the Pali word, *dukkha*, implying *impermanence*, *imperfection* and *unsatisfactoriness*.

2. *Suffering is caused by selfish craving.* Suffering comes from ignorance, that is, a basic bewilderment of not knowing who or what we are. From this *not* knowing, we base our perceptions on an idea of ourselves as a permanent entity known as the “self,” or “ego.” Looking for this continuing sense of “self,” we find there is nothing concrete, real or solid that we can call “me” or “I.” This leads to constant insecurity. And not seeing the truth of impermanence and “ego-lessness,” we suffer as we do, not knowing who we are. The more we crave and cling to the belief in a “self,” the more pain and alienation we experience. This ignorance causes continuous suffering.
3. *Suffering (i.e., selfish craving) can be overcome.* This is achieved by letting go of this idea or concept of being an individual “self.” That is, by attaining the total sense of freedom known as “enlightenment.” This state cannot be described in words. It can only be experienced.
4. To do so, there is a path one can follow to end suffering. The steps have been codified and are known as the *Noble Eightfold Path*, which divides into three categories or elements.

In form, the Buddha’s message followed the protocol of ancient Indian physicians who were to articulate, in this order; the symptoms, the cause, the possibility of a cure, and the remedy for a given ailment. His principles assumed a belief in reincarnation; the cycle of birth, death and rebirth which Buddha called the *wheel of life*. Attachment to matters of this world, its thoughts and its things, keeps one chained to that never-ending cycle. The challenge the Buddha posed was to break free. His solution suggested a progression of practices to follow and hence move toward Nirvana.

The first element, *Wisdom*, consists of: *Right Understanding* and *Right Thought*.

1. *Right Understanding*: Adjusting our view of life. Engaging in clear thinking and commonsense, free from confusing emotions. But not blindly accepting Buddha’s Way; rather, we are to test the teachings against our own experiences.
2. *Right Thought*: Means correct motivation in becoming less *ego-centric* (i.e., less self-centred) and more *allo-centric* (i.e., more altruistic, centred on others). In other words, more *selfless*. Changing to attitudes of altruism and benevolence including acting responsibly towards the environment.

The second element, *Morality*, consists of: *Right Speech*, *Right Action*, *Right Livelihood*, and *Right Effort*.

3. *Right Speech*: Means being honest in communication; no lies, slander, swearing, or wasting time in idle chatter. Generally, not using our speech faculties in harmful or unproductive ways.
4. *Right Action / Conduct*: is about decent behaviour and assenting to the *Five Precepts*:
 - i. To refrain from killing,
 - ii. To refrain from stealing,
 - iii. To refrain from misuse of the senses,
 - iv. To refrain from telling lies, and
 - v. To refrain from intoxication from alcohol or drugs.
5. *Right Livelihood*: to achieve this is increasingly difficult in contemporary society but we should at least attempt “harmlessness” as far as other people, animals and the environment are concerned.
6. *Right Effort* is required to follow the eightfold path with the correct amount of energy, not too much, not too little, but with perseverance.

The third element, *Meditation* or *Mental Discipline*, consists of:

7. *Right Mindfulness*, and
8. *Right Meditation / Concentration*:

Mindfulness awareness requires diligent effort to clear and calm the mind so as to see things for what they are. Meditation is to cultivate detachment in both mind and body and thereby approach the higher trance states. All personal problems and preoccupations are set aside to gain awareness of present reality within oneself without craving or aversion. To reach:

- i. *Samatha* – tranquillity
- ii. *Vipassana* – insight

In *Samatha* (tranquillity), concentration (*Samadhi*) is brought to bear on a single object to the exclusion of all else. The object is neutral, unexciting, and un-evocative.

While this sounds simple, it is seldom this easy. Attention slips, the mind wanders off onto thoughts and fantasies. When this happens, the mind must be brought back to the object, probably time and time again. The task is to be aware of this wandering moment by moment and accept it non-judgmentally. This is the beginning of *mindfulness* training.

As concentration develops, the mind becomes increasingly tranquil. *Samatha* meditation can lead to more refined states but in lay communities it is usually only practised briefly to establish a workable degree of mental calmness in preparation for *Vipassana*.

In *Vipassana* (insight meditation) the mind is opened and awareness is directed to all that enters its ambit. Initially, much previously submerged psychological material rises into consciousness. Again the meditator remains neutral and non-judgmental towards this emergence. Simply accepting, not rejecting, not suppressing, not repressing.

Later, as the mind quietyens down, attention may be directed in a more systematic way. Traditionally there are said to be four “foundations” of mindfulness. Being fully aware of:

- i. Bodily activity,
- ii. Feelings / emotions,
- iii. States of mind, and
- iv. Mental contents.

Again, whatever enters the field of attention is observed and analysed. Invariably it will be found to be subject to three conditions or “marks” (see Appendix 1)

Expansion of Buddhism Into China and its Transformation Into Ch’an or Zen

Elements of Buddhism filtered into China along the Silk Route from about the first century.

The existence of Confucianism in China was an obstacle to the easy assimilation of Buddhism. The core of Confucianism is “humanism,” focusing on the cultivation of virtue, the maintenance of ethics and social order.

Taoism by contrast, enabled the assimilation of Buddhism.

Taoism is a philosophy and quasi-religious tradition emphasizing living in harmony with the *Tao*. The word Tao has two general meanings in English. One is “the way,” “the way of nature.” The other sense means “to speak.”

Which leads to the opening words of Lao-tzu’s famous book, translating as “*The Tao that can be spoken is not the eternal Tao.*” And, “*The way that can be expressed is not the eternal way.*” (See Appendix 2 but readers are also invited to independently and personally explore Tao.)

Leading to the principle of non-interference with the natural order of reality. Emphasizing *wu wei* (action through non-action).

Chinese Buddhism (see Appendix 2)

China being a vast country, Buddhism there took on many forms. As well as incorporating the Indian Mahayana schools, new, distinctly Chinese forms also began developing.

The school of Buddhism which had the most influence on the future was the *Ch'an* school which later became known as *Zen*, especially in Japan.

Ch'an / Zen began its rapid growth during the early Tang dynasty (618–907), when the Indian (possibly Sri Lankan) monk Bodhidharma brought Buddhism to China, where it later merged with Taoism. Bodhidharma became the first Patriarch of Buddhism in China. He wrote a verse capturing the true spirit of Zen:

A special transmission outside the scriptures
 With no reliance on words and letters
 A direct pointing to the human mind
 And the realization of Buddhahood.

Bodhidharma's encounter with Emperor Wu is quite famous. Wu asked what merit he had earned from his good deeds. Bodhidharma replied, "None." Wu asked what was the primary meaning of the sacred truth. Bodhidharma responded, "limitlessly open, nothing is sacred." Wu asked who are you?" Bodhidharma answered, "I don't know," and walked off leaving one very perplexed emperor!

Bodhidharma's teaching methods were still essentially Indian in character. By nature, insubstantial and more metaphysical. The history of Ch'an / Zen began in earnest with the Sixth Patriarch Hui-neng (601–674). From this time Zen took on its characteristic Chinese flavour. A product of the down-to-earth, practical attitudes of the Chinese personality.

Hui-neng began life as an illiterate menial worker but was eventually chosen by the Fifth Patriarch to succeed him. This break from the traditional way of succession caused a split in the Ch'an school. The southern school of Hui-neng and the northern school, led by Shen-hsui who had been Hui-neng's competitor for the succession. Their doctrinal difference was whether enlightenment was gradual, as Shen-hsui claimed, or sudden, which was Hui-neng's view. It was Hui-neng's Southern school which eventually prevailed.

Traditionally, the Buddha was regarded as the originator of Zen. Teaching at Vulture Peak Mountain, several thousand people gathered to hear him speak. The factual details are obscure. Either the Buddha sat before them in silence. Or after he had spoken, remained silent, and the listeners pondered on Buddha's meaning. Time passed and the silence continued. At last he held up a flower. Nobody understood the gesture except Mahakashyapa, a senior monk. He smiled, understanding that words were no substitute for the living flower. He understood the essence of the Buddha's teaching. And with this the

first transmission, from Buddha's mind to Mahakashyapa's mind, Mahakashyapa became Buddha's successor.

This lineage of transmission is vital to Zen, as the authenticity of the enlightenment experience can only be carried out by an enlightened teacher. It is this direct transmission from teacher to student that has kept Zen vital and alive through the centuries.

Ch'an / Zen was about a return to essentials. All the teachings, texts, practices, codes of morality and behaviour, etc., etc. that sprang up around the basically simple teachings of the Buddha were intended as aids to progress ultimately to *enlightenment*. A diligent practitioner over the years could become attached and trapped in the delusion of rituals. So the driving impetus behind Ch'an / Zen was to sweep away all the training paraphernalia of Buddhism and go straight to the core of the matter: the direct insight that transformed Siddhartha Gautama into the Buddha beneath the Bodhi Tree.

The rejection of book-learning and verbalization typified Ch'an / Zen; that special transmission, outside the scriptures, placing no reliance on words or letters. What was transmitted was Buddhahood, *enlightenment*, a seeing into one's own nature. By being handed from master to disciple.

The ostensible rejection of scriptures of course could only be done by those well versed in the traditional texts. One cannot give away wealth if one does not have it, or transcend the ego where no stable, mature ego exists; so too with book-learning.

Zen points to enlightenment being found in the present moment. All its methods aim to wake up the student to understanding. More than any other school Zen stressed the prime importance of the enlightenment experience and the futility of religious ritual and intellectual analysis for the attainment of liberation.

Hui-neng established two pillars of Zen practice—*Zazen* meditation and *Koan* study.

The four basic techniques of *zazen* meditation and *koan* study (see Appendix 3):

1. Counting the breaths,
2. Following the breaths,
3. Shikan-taza, and
4. Koan study.

MEDITATION: ITS RELATIONSHIP TO HYPNOSIS

Attentional focusing is very important in hypnosis.

In recent years significant advances have been made in our understanding of the neural substrates of attention. A growing body of data indicates humans can acquire some degree of control over usually autonomous psychobiological processes through a variety of procedures.

One of the oldest techniques for achieving such self-regulation, particularly of attention, is *meditation*. It is appropriate to examine the concepts, benefits, and techniques of meditation in some detail so they can be integrated with hypnosis and therapy.

Meditation Conceptualized

The common element in all the diverse practices of meditation seems to be the *active restriction of awareness to a single unchanging process* and the *withdrawal of attention* from ordinary thought.

It does not seem to matter which actual physical practice is followed; whether one symbol or another is employed; whether the visual system is used or body movements repeated; whether the awareness (i.e., attention) is focused on a limb, on a sound, on a word or on a prayer. The process might be considered an attempt to cycle around a limited number of neural circuits in the nervous system.

The instructions for meditation are always consistent with this aim: to disregard any awareness of any thought, except about the object used for the meditation. To withdraw from the main flow of ongoing *external* activity. To pay attention *only* to the object or process of meditation. Almost any process or object seems usable and probably has been used.

With the emphasis given to *disengagement*, the elements of meditative practice converge with those of hypnosis.

1. The meditator usually begins by closing their eyes. The surroundings are relatively quiet as the meditator isolates from social and environmental demands. This is true of most (non-dramatic) hypnotic techniques.
2. The meditator sits, adopting a relaxed posture while preserving a degree of alertness. A straight back requires less muscular effort and avoids constricted visceral discomfort.
3. Attentional focusing is directed to a simple repetitive word, phrase, or mental image (or in some systems, a repetitive brief cycle of movements).

In both hypnosis and meditation, the student is encouraged to adopt a disinterested and tolerant attitude toward intrusive cognitions. To gently dismiss and/or let them pass from the centre of awareness. This is “concentrative” meditation, not the “opening-up” meditation. (*samatha* vs *vipassana* = tranquillity vs insight).

Meditative techniques often involve a procedure which restricts the attention of the meditator. Adopting a passive, detached attitude is especially emphasized.

In hypnosis the same encouragement toward a detached attitude is also emphasized coupled with instructions to focus the attention.

In heterohypnosis techniques, the subject (patient or client), is usually invited to focus her attention on suggestions of relaxation and concentration, which are monotonously repeated by the hypnotherapist. Thus meditation and hypnotic relaxation can be viewed as techniques for regulating the information from the environment as well as lowering the intensity and variation of external stimuli.

Phenomenologically, both meditation and hypnosis are therefore “altered states of consciousness.”

In meditation the control of attention, until recently, has been of greater priority than in hypnosis.

Meditation specialists recognize the great difficulties many people have in acquiring and maintaining a relaxed but focused attention. Hypnotherapists are now more aware that failing to learn attentional control may also lessen the benefit gained by patients as they exhibit lower levels of hypnotic capability.

An alternative, more neutral term for meditation could be “cognitive centring technique.” That is, simply different ways of talking about the control of attention.

CONCLUDING REMARKS

What has been written above is obviously much more detailed than what was presented during the Daydream Island workshop. That is the natural distinction between an article written for publication and the words verbalized by a workshop presenter to his audience / participants. Parts of the workshop have been omitted and parts have been expanded. Specifically, the general introduction to hypnosis has not been mentioned and the third part of the workshop, “The Cancer Experience,” is being written by Dr Sue Stefanovic as a separate article (also published in this issue of the journal).

What are the derivatives emerging from Zen Buddhism or more specifically Zen meditation, when compared to hypnosis? The first is the overlap between

the two mental processes or the use of consciousness required.

The mind under most circumstances is very ill-disciplined and unruly. But with training and practice it can learn to be still to a greater or lesser extent. The choice of using meditation or hypnosis to develop this stillness depends on the desired outcome. And perhaps, even the rate at which an outcome is achieved. Which immediately leads to consideration of the supposed purposes of these two mental activities.

Buddha observed that all life was suffering, that there were causes of this suffering, and that it could be relieved by following the eight-fold path. This is a progression through a set of instructions on how to live one's life, the final goal being the attainment of nirvana or enlightenment. Most patients and clients attend we clinicians in the hope of relief from suffering, whatever words they use to describe the suffering caused by their symptoms.

One of the ways I use to describe to a patient "how" hypnosis works is to liken it to getting a fire to burn more fiercely, or a chemistry experiment to proceed more quickly. With the blacksmith's forge, if you pump air into the fire using the bellows it burns hotter as a result of the oxygen being added. In the chemistry laboratory, if you add a catalyst to the mixed solutions in a glass beaker, and perhaps some heat, the end product is produced more quickly. So I explain anything you can do within a hypnotic trance, you can do without the trance. But in a trance it does seem to proceed more quickly if the motivation is present.

By contrast, meditative instructions and techniques, originally, were less aimed at specific kinds of suffering (=symptoms) and outcomes. However, in recent times mindfulness, evolving from a Zen Buddhist tradition, has moved into Western culture and especially into usage by health professionals. The time frame in which health outcomes are gained seems to be growing shorter than the previous time needed to reach enlightenment.

It seems to be a benefit if a patient / client trains in attentional focusing by meditation exercises to enhance their hypnotic experience ... with an expectation they will reach recovery or wellbeing sooner. I am not sure if being adept at utilizing trance makes a subject a better meditator facilitating their gaining enlightenment sooner, with an associated relief of their suffering.

Still, as Charles d'Eslon said after Louis XVI's Royal Commission had discredited Mesmer's "cures" using hypnosis as only imagination; "if the medicine of imagination is best, why not practise it?" Irrespective of whether it be done through or by meditation or hypnosis.

APPENDIX 1

THE THREE MARKS OF EXISTENCE

1. *Dukkha*—unsatisfactoriness.
2. *Annica*—impermanence.
3. *Anatta*—not self.

Dukkha refers to the flawed nature of all that exists; its inability to give lasting satisfaction or provide us with an indisputable basis of stability and security.

Annica points to the observable fact the world is a flux; nothing ever stays the same for long and ultimately and inexorably is heading towards dissolution.

Anatta is perhaps the most profound discovery to be made in meditation; that search as hard as we will, we can never point to anything in ourselves we can definitely say *is* the self! Neither the body, nor the thoughts, nor the emotions, can be self, for they are *dukkha* and *annica*, unsatisfactory and impermanent.

All this we can observe, while the observer, the one who knows, remains ever elusive, standing outside the field of sense perception, outside the world.

THE THREE YANAS

None of Buddha's discourses were written down during his lifetime. However, according to Tibetan tradition his teaching was divided into three distinct *yanas* or vehicles.

The *Hinayana* or the "Lesser Vehicle." Perhaps more accurately "the narrow way" to exercise strictly disciplined meditation to narrow down and tame the speed and confusion of the mind.

The *Mahayana* or "Greater Vehicle." In contrast to *Hinayana*, *Mahayana* goes beyond the level of individual liberation with the aim of liberating *all* living beings.

The *Vajrayana*, is the third yana. Literally, it means the diamond or indestructible vehicle. The more modern term is "*Tantra*." Essentially, *Tantra* is about transforming the gross body, speech and mind into those of a Buddha by means of special practices.

The Madhyamika School was one developmental form of Mahayana. It was founded by a south Indian philosopher, Nagarjuna. He claimed that nothing affirmative or definitive could be said about ultimate reality. His method, *dialectic*, aimed to eradicate the tendency to cling to the notion that

the ultimate is an entity or a state existing in itself, separate from concrete experience. Thus, the understanding of emptiness was stretched to include both persons and phenomena.

APPENDIX 2

CONFUCIANISM, TAOISM AND BUDDHISM IN CHINA

Legends tell of a Han emperor sending envoys to India to learn of a “god” called Buddha. They returned years later bringing a white horse and some scriptures. The emperor immediately built a monastery dedicated to the white horse. Supposedly this was how Buddhism was established in China. However, the truth is less simple.

In South-East Asia Buddhism was assimilated into the prevailing cultures relatively easily. China was different. This ancient and vast empire was dominated and structured around clearly defined social, cultural and political systems developed over centuries. China regarded itself as superior in every way to its neighbours. It was not receptive to what it saw as a cult espousing doctrines of individual liberation.

The core of Confucianism is “humanism,” the belief that human beings are teachable, improvable and perfectible through personal and communal endeavour, especially that of self-cultivation and self-creation. Confucianism focused on the cultivation of virtue and maintenance of ethics, the most basic of which are *ren*, *yi*, and *li*.

Ren is an obligation of altruism and humaneness for other individuals within a community. *Yi* is the upholding of righteousness and the moral disposition to do good. *Li* is a system of norms and propriety determining how a person should properly act within a community. Confucianism holds that one should give up one’s life, if necessary, either passively or actively, for the sake of upholding the cardinal moral values of *ren* and *yi*.

Although Confucius, the man, may have been a believer in Chinese folk religion, Confucianism as an ideology is humanistic and non-theistic. And it does not involve a belief in the supernatural or in a personal god.

Originally Tao translated as the *way* or *path*. Now, however, it denotes an obscure metaphysical force which is ultimately ineffable: “*The Tao that can be named is not the absolute Tao.*” According to a Taoist, the Tao is the source and essence of everything that exists.

Taoist propriety and ethics may vary depending on the particular school, but in general they tend to emphasize *wu wei* (action through non-action),

simplicity, spontaneity, harmony between the individual and the cosmos, and the three treasures: *Compassion, Moderation, and Humility*.

Taoism has had a profound influence on Chinese culture over the centuries. Pre-existent for perhaps five thousand years in mystical shamanism, Taoism is based on the reformed and revived teachings of the sage, Lao Tzu, a contemporary of Buddha. But the question remains. Where do the original teachings of the Yellow Emperor, Huang Ti (2698–2597 BC) fit into this history?

The central concept of the Tao has been translated as the Way, the Law, God, Reason, Nature, Meaning and Reality. But actually no one English word adequately conveys its true meaning.

The Chinese character “Tao” is composed of symbols signifying rhythm, or periodic movement, and intelligence, but as Lao Tzu said, “The Tao which can be described in words is not the true Tao” and it is best left untranslated. Suffice to say, the general idea behind Tao is of growth and movement; it is the course of nature, the principle governing and causing change, the perpetual movement of life, never for a moment remaining still.

Coupled with the doctrine of Tao is the teaching of *wu wei*, the secret of mastering circumstances without asserting oneself against them. This principle underlies the martial arts of jiu-jitsu and aikido. The principle of yielding to an oncoming force such that it cannot harm you and at the same time changing its direction by pushing it from behind instead of resisting it from in front. The skilled master of life never opposes things; he never tries to change things by asserting himself against them; he yields to their full force and either pushes them slightly out of direct line or else moves them around in the opposite direction without ever encountering their direct opposition. That is, he treats them positively; he changes them by acceptance, by taking them into his confidence, never by flat denial.

APPENDIX 3

ZAZEN MEDITATION AND KOAN STUDY PRINCIPLES

1. *Counting the breaths*. Either the inhalation or exhalation is counted from one to ten. For example, inhale, exhale, one; inhale, exhale, two; inhale, exhale, three and so on to ten. Then repeat.
2. *Following the breaths*. The student is to be constantly *aware* of the breaths, *without* counting. The breath is allowed to follow its natural rhythm, but as

practice progresses, it tends to become slower, deeper and more even.

3. *Shikan-taza*. Simply sitting *without any* object of concentration.

4. *Koan study*. A provocative riddle inviting the student to answer the ultimate question stated as: “Who am I?” or “What is the absolute?”

We are conditioned to form conceptual answers to questions and it comes as a shock to find there is no answer which fits the question! Paradox is essential to transcend conceptual or logical thought, to short-circuit the whole intellectual process and experience ultimate reality directly.

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HYPNOSIS, ZEN BUDDHISM AND THE CANCER EXPERIENCE WORKSHOP PART 2: THE CANCER EXPERIENCE

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When cancer clients/patients come into our consulting rooms they may expect miracles from hypnosis. Hypnosis is not magic, but its positive effects may sometimes seem nothing short of miraculous for the cancer client/patient in the way that it can help the patient cope with the diagnosis and treatment of cancer, and increase their self-efficacy. This paper will outline the use of psychological intervention and more specifically hypnosis with cancer clients/patients. It is based on the workshop presented at the Australian Society of Hypnosis Congress in 2012 on Daydream Island. The workshop was divided into two parts. The first part was presented by Dr Norman Shum and discussed Zen Buddhism and meditation, and how meditation fits within Buddhist philosophy. It also included some aspects of psychological intervention, such as pain control, which for brevity purposes was included in this section. The second part focused exclusively on cancer and the use of hypnosis with cancer clients/patients, and was presented by Dr Sue Stefanovic.

Keywords: cancer, Zen, Buddhism, hypnosis, mindfulness.

What is hypnosis? Kihlstrom (2006) defined hypnosis as an “altered state of consciousness where sensory input is processed differently”. Yapko (2003) described hypnosis as a state of “dissociation and focused absorption.” Perhaps the best illustration of how to conceptualize hypnosis and the unconscious is simply to think of a pink elephant. What happens when you are asked *not* to think of a pink elephant? No matter how much the conscious mind attempts to suppress the thought, the unconscious mind returns to a pink elephant. In this manner, the unconscious overrides the conscious.

A question that is commonly asked is how are hypnosis and meditation similar? Both hypnosis and meditation are altered states of consciousness that emphasize attention, concentration, and letting go of thoughts. While hypnosis is based on suggestibility, meditation often focuses on mindfulness and remaining present. Research suggests that hypnosis has greater theta wave activity and may involve greater muscle activity, while meditation tends to reduce muscle activity. Mindfulness meditation in particular involves greater awareness of bodily processes and sensations.

What is meant by “mindfulness”? In *Full Catastrophe Living* Jon Kabat-Zin (1990) states “Mindfulness means paying attention in a particular way: on purpose, in the present moment, and non-judgmentally.” For a number of years Umass Medical Centre has run a mindfulness-based stress reduction (MBSR) group program for stress reduction, relaxation and treatment of chronic diseases. The program consists of yoga and meditation exercises to increase mindful awareness.

How is mindfulness relevant to cancer? Carlson and Garland (2005) have found that an eight-week MBSR program was effective in reducing sleep difficulty, stress, fatigue, and mood disturbance in a heterogeneous sample of 63 cancer patients. Classes were held once a week and were of 90 minute duration. The program involved understanding the theory of mindfulness, meditation practice and facilitating group support and problem solving. The authors found a very high level of sleep disturbance in their patient population, 90% as compared to the average 50%. Following the completion of the program, there was a significant improvement on all measures of sleep, with the largest improvement occurring in sleep quality, efficiency and duration. Additionally, a significant reduction was found in the overall stress symptoms, fatigue and mood disturbance. Similarly, Speca, Carlson, Goodey, and Angen (2000) found that a seven-week mindfulness-based group program (modelled on the MBSR program) was effective in reducing depression, anxiety and stress symptoms in a group of 90 heterogeneous cancer patients. Further studies have found that such gains are maintained at six months following treatment (Carlson et al., 2001).

The current cancer statistics suggest that 21.4 million people are diagnosed with cancer every year, and 41% of adults will develop cancer in their lifetimes. In Australia, cancer affects one in three Australian men and one in four Australian women. One in eight Australian women will develop breast cancer. It is noteworthy that since 1988 breast cancer incidence rates have risen by

10%, but with a consistent drop in mortality rates. In terms of psychological difficulty, 15% to 23% of cancer patients will experience anxiety, 20% to 42% will experience depression with 9.6% experiencing major depression, 68% will be diagnosed with adjustment disorder (transient anxiety and depression symptoms), and 3% to 12% will experience PTSD, while 10% to 88% will experience sexual difficulties.

Managing a cancer client/patient requires assisting the client/patient to understand their therapeutic options. Therapy is multimodal and often includes surgery, chemotherapy, radiotherapy, endocrine therapy, bone marrow transplantation. Assessment involves assessing the tumour, “staging,” and establishing whether there is an attempt to “cure,” or whether palliation is required.

Chemotherapy and radiotherapy often involve adverse side effects. They can affect any organ system but especially gastro-intestinal tract. Mucositis, inflammation of the gut lining, is often experienced, and can cause intense pain depending on site. Nausea, vomiting or diarrhoea are common, as is alopecia (hair loss). Richardson et al. (2006) conducted a literature review on the effectiveness of hypnosis on alleviating nausea and vomiting in cancer chemotherapy and concluded that hypnosis is a useful intervention for anticipatory and cancer nausea and vomiting. However, they cautioned that suggestions would need to be adapted to individual client/patients’ needs. They did not detail the suggestions given to clients/patients; however, others, such as Hammond have suggested using an “off switch” for unpleasant sensations, posthypnotic suggestion of pleasant taste for chemotherapy medication, stomach dissociation, lake metaphor, substituting other imagery for chemotherapy, time contraction of the chemotherapy treatment session, concentrating nausea in another part of the body, or having an image of protective coating (such as Teflon) lining the stomach and oesophagus.

Let us now consider the psychological issues experienced by cancer clients/patients. Clinical Practice Guidelines (2005) provide an excellent outline of the psychological issues experienced by cancer clients/patients. Cancer clients/patients often experience anxiety/depression related to their diagnosis, treatment and prognosis. Anger can be directed towards staff and family members. Cancer clients/patients can experience depression related to their self-concept and body image, and this can result in sexual difficulties. Post-traumatic stress disorder symptoms are not uncommon, as are fear of recurrence and uncertainty about the future. It can be also difficult to cope with the residual symptoms of treatment such as fatigue. Relationship issues

and establishing new relationships poses a further challenge for the cancer sufferer.

Who is at risk of developing psychological problems? It appears that age is an important determinant of risk. Younger people and young children are particularly at risk of developing psychological difficulties. Degree of support is also important, and a lack of social support results in more frequent psychological difficulty (Chou, Stewart, Wild, & Bloom, 2012). Single, separated, divorced, widowed, and individuals living alone, and those with poor partner support are particularly at risk. Prior cancer history also causes additional problems, as does past history of psychological difficulty. Individuals with a history of alcohol or substance abuse are more likely to experience psychological difficulty. Severe ongoing stress or other illness prior to cancer is also more likely to put one at risk of developing psychological difficulty. Stage of cancer experience such as, for example, waiting for results, undertaking chemotherapy and experiencing side effects, and poorer prognosis, are also associated with poorer psychological outcome. Similarly, chronic pain and fatigue can place the individual at greater risk of developing psychological difficulties. An Australian study by Pascoe, Edelman, and Kidman (2000) found that factors such as female gender, restricted activity level, non-English-speaking background, and advanced disease predicted who is more likely to develop clinically significant anxiety and depression. They assessed 513 adult cancer patients at four Sydney hospitals and found low rates of anxiety and depression, 11.5% and 7.1% respectively. However, it was concerning that of those who were experiencing clinically significant anxiety and depression 75% had not received psychological treatment.

In view of such extensive risk factors, it is perhaps not necessary to argue the need for psychological intervention. Numerous studies have attested to the effectiveness of psychological intervention with cancer clients. Almost 20 years ago Tjemslund (1997) found that psychological status affects the immune system function and that chronic negative states such as depression, anxiety, and anger were associated with impaired natural killer cell activity. More recently, McGregor and Antoni (2009) conducted a literature review on the effect of psychological intervention on biological outcomes in breast cancer and concluded that “psychological intervention can influence neuroendocrine and immune function indicators.” Thornton, Anderson, and Carson (2008) note that there is a period of tumour growth which precedes the clinical detection of breast cancer recurrence. They followed up 227 female survivors of breast cancer for 10 years, and found that in the 17

months prior to detection of recurrence in the patients where breast cancer recurred there was higher white cell count, antibody production, and natural killer cell count. These patients also had higher cortisol levels, worse physical functioning, fatigue and poor quality of life, and pain, depression, and anxiety. An interesting follow on from this study published in the journal *Cancer* by Andersen et al. (2008) concluded that psychological intervention reduced the risk of breast cancer recurrence and death from breast cancer. They found in the follow-up analyses that patients who received psychological intervention also had a reduced risk of death from other causes. In a recent review of the randomized controlled trials conducted by Spiegel (2012) he concluded that “psychological interventions that provide emotional and social support, and improve stress management have a positive impact on physiological stress-response systems that affect survival.”

Thus, psychological assistance can help the client/patient manage their anxiety, depression and traumatic stress symptoms more effectively and likely improve their survival. It can also assist the client/patient to manage their uncertainty about the future. Other assistance includes helping the clients/patients deal with loss of control, sexual concerns, and body image problems. Searching for meaning is another important issue for the cancer client/patient, and there is a need for openness, emotional support, and medical support.

Numerous studies have provided evidence for the effectiveness of hypnosis in the area of cancer management. Lioosi and White (2001) have found that hypnosis combined with cognitive–existential intervention was more effective than psychological therapy alone in reducing depression and enhancing quality of life in terminally ill cancer patients. Schnur et al. (2009) found that a combination of CBT and hypnosis was effective in breast cancer patients undergoing radiotherapy, resulting in improved mood throughout treatment. In a literature review Neumann (2005) concluded that hypnosis has a positive effect on the immune system response in breast cancer patients. Laidlaw, Bennett, Dwivedi, Naito, and Gruzelier (2005) found better quality of life (decreased anxiety, improved stress management, increase in the positive mood states, and diminished fatigue) in metastatic breast cancer clients after training in self-hypnosis. Kwekkeboom, Cherwin, Lee, and Wanta (2010) reviewed literature and found an improvement in pain management and fatigue in cancer patients following hypnosis.

Hypnosis and immune system response has been an interesting area of research. There is clearly a bi-directional interaction between the brain and the immune system. Studies have examined T-cell count, white blood cell count,

antibody production, and natural killer cells count, and have found an increase in their production following hypnosis (e.g., Black, Humphreys, & Niven, 1963; Bakke, Purtzer, & Newton, 2002; Hudacek, 2007). Gruzelier (2003) has suggested also that self-hypnosis enhances the immune system, and has argued that *hypnotic imagery is most important*. It is unclear how the effects are produced and what are the moderator variables. Future research needs to clarify how to measure the immune system, the effect of hypnosis versus relaxation alone, as well as explain the role of moderator variables such as trance depth and hypnotizability.

Hypnosis is used in many different areas with cancer clients/patients. It is often used for pain control, to improve the immune system function, to reduce the adverse effects of chemotherapy, to assist with psychological reactions such as anxiety, depression, guilt, anger, self-esteem and sleep, as well as for ego-strengthening, increasing wellbeing and coping ability, and utilizing existing client resources. Self-hypnosis is always encouraged.

Cancer pain is relatively rare as an early presenting symptom, and mainly occurs in later stages and may be a by-product of the treatment. Assessment of pain involves an understanding of the site and the cause. Severity is determined by using a grading scale, such as 1 to 5. Level 1 may require an occasional mild analgesic, and level 5 may indicate strong pain which cannot be managed without strong analgesics. Common relief of pain involves the use of analgesic drugs, local anaesthetic injection, neurosurgical ablation, TENS machine, acupuncture, and psychological techniques.

There are several barriers to adequate pain control. Clients/patients may be reluctant to report pain. There can be also reluctance to take medication or accept alternative pain control approaches. Doctors may be reluctant to prescribe an appropriate medication regimen in necessary doses, or may be uncertain how to assess and treat pain.

Psychological interventions can and should begin before invasive surgical, medical or radiotherapy procedures. More frequently, they are used for control or amelioration of chronic pain. Uncontrolled cancer pain can lead to depression, social isolation, disruption of relationships and prolonged disability. Studies have shown that hypnosis is an effective form of analgesia (Montgomery, Du Hamel, & Redd, 2000). Pain is modifiable using hypnosis. To this effect, it is important to assess whether the pain is heavy, dull, sharp, burning, aching, constant, intermittent, fluctuating, localized or extensive. Suggestions are then given to alter the "image" and thus the perception of the pain. Suggestions may include dissociation: that is, separating or distancing

the client/patient from the pain. Amnesia also can be used. Substitution, such as substituting warmth, coldness, numbness, pressure, or introducing time distortion, age regression/progression (such as for example happens spontaneously in sports injuries) is very useful. Distraction including focusing intensely on alternative stimuli in other sensory modalities (auditory, visual, kinaesthetic) is helpful. Guided imagery through changing the shape, size, colour, density, sound, mood, or introducing an image/memory incompatible with pain is also very effective.

Hypnotic cognitive therapy aims to redefine the meaning of the pain. It identifies erroneous links between thoughts, emotions and pain behaviour, and identifies and changes maladaptive pain responses. The client/patient is encouraged to develop more adaptive coping skills. One must remember to consider factors such as gender, sociocultural, and ethnic factors when assessing pain and offering hypnosis for pain management.

Sleep difficulty is another area that often plagues the cancer patient/client. It is often related to worry and anxiety regarding diagnosis, treatment and prognosis. Training in self-hypnosis can be useful to facilitate relaxation. Suggestions may be given regarding cognitive overactivity, and client/patient can be trained to calm their mind. Memory for good sleep can be enhanced and facilitated, and any underlying conflict explored and resolved.

Numerous hypnotic suggestions can be helpful to cancer client/patient. Hammond (1990) suggests to remind the patient that the “body knows how to heal itself and needs to be reminded.” One can “direct the healing to the part of the body that needs it most,” and remind the patient that “cancer cell is a weak and confused cell.” Increase in the white blood cell count may be suggested; however, it is best to stay away from such direct suggestions as the exact role of the white blood cells in the immune system function is not totally understood. Instead, imagery for activation of killer cells may be helpful. Hammond also encourages the patient to evolve the hurt/wounded image into the healed image. Metaphors such as the body being like an orchestra that may need fine-tuning may also be used.

The patient is encouraged to practise self-hypnosis. Self-hypnosis is part of the total approach to cancer treatment and management. There is no special technique more suited than any other. The patient is encouraged to use the one they are most familiar with, and to keep it simple. The emphasis is on the patient’s skill that leads to good outcomes and helps the patient develop their “self-efficacy.” Embedding a self-hypnotic script into a standard induction is effective.

The two case studies below illustrate the above approach.

Case 1

Ms X is a 42-year-old married professional woman diagnosed with breast cancer. She was referred to the author by a psychologist, and also independently by her GP. She presented with high anxiety, but no depression. There was no past history of anxiety or depression; however, there was a past history of marital difficulty, and her mother died of breast cancer when Ms X was aged 19. Ms X was worried about her father's ability to deal with her diagnosis. She reported that she enjoyed work but took a redundancy package due to feeling under-stimulated. She reported a good network of support.

The treatment goals were to reduce her anxiety related to her diagnosis, her mother's death from breast cancer, and her uncertainty about the future, and to increase her coping ability in dealing with her father. Hypnosis was used as a means of relaxation and promoting the body's natural healing ability. Work goals were set in terms of deciding on alternative employment that may be more satisfying and challenging. She responded well to hypnosis and the psychological treatment, and on last review was doing well.

Case 2

Mr Y is a 60-year-old divorced self-employed man with two adult children aged 20 and 18. He was self-referred for sexual difficulties, and was particularly interested in hypnosis. He was functioning well and presented with no clinical anxiety or depression. He reported good support from his partner. However, he reported high PSA levels which were monitored by his GP. With the use of hypnosis his sexual difficulties resolved quickly and he was discharged. However, he re-presented six months later when he was diagnosed with prostate cancer. His relationship had broken down, and he was experiencing clinical anxiety, but no depression.

The treatment goals were to reduce his anxiety related to his diagnosis of prostate cancer, to reduce his anxiety related to his relationship breakdown, and to provide a supportive milieu to discuss his feelings about cancer and its impact on his person and work life. Hypnosis was used as a means of relaxation, and to promote the body's natural healing ability. Mr Y responded well to the psychological treatment and hypnosis, and on last review was doing well.

In summary, hypnosis is extremely useful with cancer clients/patients as an adjunctive treatment to psychological intervention. However, as Hammond

(1990, p. 200) states: “we must remain optimistic, offering hope and treatment options that we believe prove beneficial, and yet we must remain cautious not to make exaggerated claims to the public that imply that hypnosis is a cure for cancer.”

The poem below was written by a client/patient of the author and printed with her permission:

A Note From The Heart

At what time in your life, were you, at your most vulnerable?

Who would you choose to see at that point?

Closest family?

Personal friends?

Unfortunately I do not have that luxury.

Because of this illness, I am required to expose my most vulnerable time with complete strangers. Doctors, Nurses, Receptionists and others gazing with sympathetic smiles in waiting rooms and coffee shops,

Be reminded that “yesterday” I had a job and a career, much like yours.

Realise that I am a mother, a wife, a friend, and a work mate in my world.

Try to recognize fear and anxiety on those entrusted to your care without prejudice or judgment and look past the obvious.

The soul holds the key to life, because we never know what life has in store for any of us.

With respect and gratitude,

Jenny

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DEEP TRANCE

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In the early stages of therapy I use a standard “eye fixation–distraction” induction. Later, when the patient has become more familiar with the process, and moves reasonably quickly into trance, I use a much shorter induction, consisting of only two or three sentences.

However, to go from a moderately slow, measured 20 minute plus induction to one only taking a few minutes seemed to expect too much from the patient. To enable the transition from a longer to a shorter induction to take place smoothly, an intermediate length induction seemed appropriate.

Throughout my years using of hypnosis I have preferred the more “indirect” techniques so strongly attributed to Dr Milton Erickson. The induction script “Deep Trance” evolved over time incorporating some of the elements described as “the basic footprint” by Lankton (2008).

Some clinicians might use an induction like “Deep Trance” right from the beginning of therapy but for me it fits better as the transitional / intermediate induction to use when the patient has had some experience of trance, but is not yet fully adept at entering trance more quickly.

Begin taking yourself into trance *invitation to exercise discipline and self-control*

Experience a sense of security, and just ... rest *reinforcing safety*

Enjoy the sense of quietness, and calmness *it is safe to give up stress and tension*

No pressure, no need to rush, no one to please, no one to satisfy *it is safe to give up stress and tension*

This is just your time ... to rest ... to enjoy ... *a gentle peacefulness it is safe to give up stress and tension*

Just let go ... quietly ... gently ... with nothing to bother you ... nothing to disturb you *it is safe to give up stress and tension*

Free yourself from reality ... allow it to become less and less important *entering a controlled dissociation*

Become more detached ... separate ... apart from everything *entering a controlled dissociation*

My voice might seem different as if coming from far away *entering a controlled dissociation*

It does not matter whether my voice seems close or far away, your unconscious mind will still hear it in the background of your awareness *again reinforcing their discipline and self-control*

Your unconscious is always aware, attentive, and focused *again reinforcing their discipline and self-control*

Let comfort and calmness flow out ... into ... your mind ... your body ... your spirit *deepening*

Enjoy the sense of peacefulness ... quietness ... calmness ... all inner stressors fading *repetition giving up stress and tension*

Allow all those reactions ... stress or strain ... to just fade into space ... growing more and more distant ... further and further away *more controlled dissociation*

Breathe comfortably ... easily ... free of effort *emphasizing again they are in control*

Perhaps you could imagine the air is full of tranquillity *invitation to visualization*

Follow the air as it enters your body and spreads through every part of you *invitation to visualization*

The oxygen goes into every single cell in ... your mind ... your body ... your spirit *invitation to visualization*

This air can take on a very peaceful colour ... becoming a smooth, silky vapour ... moving effortlessly through your body ... carrying a sense of harmony ... serenity *shifting the mind set*

It is powerful ... so cloaked by this beautiful ... silky vapour ... nothing bothers you ... nothing disturbs you ... the universal life force ... chi / ki ... forms a protective shield *reinforcing safety*

It is your choice and privilege to go just as far and as deep into trance, as you would like ... to do whatever is necessary *invitation to therapeutic change*

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ROSIE'S RECOVERY: CASE STUDY OF A CRIPPLING PHOBIA

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The key to an unusual phobia (fear of poisoning someone) is eventually uncovered in an hypnosis session of a long-standing patient after years of establishing trust and respect. The story is told by the therapist and the patient.

Keywords: hypnosis, phobia, recovered memories.

I am going to call this woman Rosie to protect her identity. She kindly gave me permission to write this up and share it with you. For that I am thankful and very grateful as I think that this is a case of great interest and uniqueness to all of us. In fact I would venture to say that it is a cause célèbre.

Rosie was referred by her GP and limped into my surgery. From the moment I met her I realized that she was an intelligent woman, who was under confident and self-doubting. Short and rounded with slightly greying straight hair nicely shaped, she presented a pleasant face and slightly apologetic demeanour. My special interest in her is that she exemplifies the astounding clinical relevance of medical hypnosis which we all know is invaluable in the treatment of many emotional and behavioural illnesses. After she retrieved the precipitating statements that had initiated her phobia, we were astonished by the rapidity of the changes in Rosie's functioning. These occurred when she and I were able to recover memories from the past which revealed the origin of her phobia. These were statements made to her by her husband of that time which underpinned her development of a crippling phobia that she may, without knowing it, poison someone. Recovery of these memories gave her the freedom she needed to let go of her terrible affliction. This was a phobia that had made her life a nightmare for nearly 50 years. She has now reclaimed her joy and happiness in life and can enjoy her family, grandchildren and

friends and can now entertain them with no fear of poisoning them. What is equally important is that her self-esteem and confidence have been boosted and she is now enjoying a totally different life. Where once she was diffident and faltering she is now able to take control and be a leader. So in situations where the damage that had occurred when young women had their babies taken from them is discussed she is able to speak freely and with authority and with all levels of society.

We had worked together over some years on and off and I felt that we were building up a warm and trusting relationship which I knew was necessary, before I could get to the root of her problems. Her smoking was being addressed and her weight needed attention also. I put a virtual lap band on for her as well as making sure she knew about diet. To encourage her and offer a reward I promised her a lovely soft brown suede coat I had bought in Yorkshire some years before but which had hardly been worn and was in good condition. It would become hers when she reduced to fit it. In our cold climate I felt that she would be snug with the lamb's wool on the inside next to her body.

After many stops and starts, over some years our mutual respect had gradually been built up and she had returned for more trance work. Many times over the sessions she had checked with me whether or not she was sane and I would assure her without any doubt that she was one of the sanest people I had had the pleasure of working with.

Nothing alerted me to the fact that today was going to be the day that the big breakthrough would occur. So she lay on the couch in anticipation of perhaps a relaxing session ...

She slipped spontaneously into a deep trance as I watched her eyelids fluttering, her skin colour changing and her breathing showing variations as she lay there before me making her journey of discovery, uncovering the deepest layers of her private hell. I did not know that this momentous moment had arrived until the session ended and she came back to the here and now and sitting up she exclaimed, "I know what it was, I know what it was." She was incandescent with excitement and as her excitement washed over me a feeling of great relief and satisfaction coursed through my body.

"I feel ten feet tall," she exclaimed and I rejoiced with her.

It had been a long and tortuous journey, but my belief in her ability to stay the course had never wavered. This was to be the final stage in a process I was privileged to share with this utterly lovely woman who had suffered more than enough for the smallest of human errors. For a considerable time I had been

aware that this woman had a secret of such enormity for her that she had to be sure that she would deliver it, only into the keeping of someone that she could trust. Life had taught her that she had to be extremely careful in giving her trust to anyone, and she had armed herself well to resist any slip-up in her placement of information that she had guarded so carefully for so long. The tests were so subtle and cleverly constructed that I relied on my long years of practice to accept them for what they were and maintain my patience.

Several years earlier, she had presented as a new patient who was sent by her GP because of a problem with her left leg. A knee replacement had left her with a weak and unstable knee and she had consulted with a neurologist and then came to me seeking whatever help I could offer. During the history taking she casually told me that she had a phobia. She said that she had been unable to be left alone with food or drink as she could never be sure that she would not put poison in it. This had limited her ability to look after her children and her grandchildren and had impacted negatively on her social and work life as well as family life. As it was not the presenting symptom, I attended to her other difficulties before really appreciating the fact that this was probably the real reason she had brought her problem to me in the hope that we may be able to solve it.

It is only in retrospect that I can appreciate the reasons why she had developed her low self-esteem and feelings of inadequacy. I considered that it had most certainly been in response to the treatment she had received at the hands of those who should have cared for her. So she had presented to me in a depressed state, with low self-esteem and lack of confidence. As the presenting problem was the difficulties with her leg, we worked on this problem and her anxieties and depression for some time. There was gradual improvement but nothing major till this life-changing discovery of the trauma that had made her life a virtual nightmare.

Eventually the true story evolved.

Aged 16 she had become pregnant after a fumble with her boyfriend, a situation I have encountered on more than one occasion when I have delivered a baby to a woman who was still virgo intacta (the hymen was still intact). In fact, on one occasion I delivered a baby for a married woman who was still virgo intacta and whose husband did not realize that he had never had penetrative intercourse with his wife. The reason for this was obvious as the hymen consisted of thick fibrous tissue and was one that had not been adequately ruptured to allow the penis to enter her vagina. Surgical intervention was required to remove the obstruction before delivery could proceed.

Rosie's father was of the old school tie variety and like so many people who had a fear of a daughter shaming them by becoming pregnant before they had married he was a product of his era. Even though he was a Mason, and a good Christian man, he insisted that Rosie be hidden away, as was the common practice at that time, after having insisted at first that she "get rid" of the foetus. When attempts to induce an abortion failed, Rosie having been given a handful of tablets that I presume were aperients or the favourite of the times, castor oil, her father had forbidden her to bring the baby home because he considered that it would bring great shame on the family. These days the morning-after pill will prevent the implantation of a fertilized egg and is used extensively and reflects the change in attitude to an unwanted pregnancy.

So Rosie was sent away from home to people her father knew in another state, and then to relatives, well out of sight. She spent the time usefully employed, earning her keep. When the time came for the confinement, she suffered the type of treatment that was dished out with gusto at that time, in a lying-in hospital. This was, of course, a home for unwed mothers where these unfortunate young girls went to have the babies, and were then coerced or tricked into signing the baby over to the adoption agency. Many girls did not see their babies, as they were taken away from them or on some occasions they were told that the baby had died. When Rosie returned home without the "encumbrance" of her son her father allowed her to be married, as a bride, to the child's father, and they set up house and had two little girls.

The marriage was no bed of roses and Rosie was frequently told by her husband that she was stupid. This was not the only way the husband denigrated her as he took the high moral ground. He was at university and possibly, in his mind, he was of superior intelligence. My assessment of this woman's intelligence and personality was that she was highly intelligent as well as being a warm and loving person whose self-confidence had been sapped as she had been undermined by all those who should have supported her and loved her.

As the story unfolded it was revealed that the woman who lived next door to her and her husband had committed suicide, and now, *what she had discovered in her dissociated state, was that her husband said to her, "I reckon you sleep-walked and went next door and poisoned her."* This was not an isolated undermining statement but Rosie's husband reinforced the message on many occasions to make sure he got the maximum effect and she would be in doubt as to her sanity.

He enjoyed tormenting her and did things that he must have known would further reduce her feelings of self-worth. The treatment that this girl had

received from the father was being reinforced by the husband. This need to further humiliate a person who is already at rock bottom is a strange and cruel thing that I have seen so often and I wonder why people can't be kinder to each other. I suppose the old saying about kicking a dog when it is down is some atavistic characteristic that is inherent in some human beings. I consider this to be abuse of the most extreme kind.

Here was a young girl who was grieving for her lost baby, depressed and shattered at being let down by those who should have been her staunchest protectors, being treated in an inhumane way. It does surprise me that this woman, all these years later, is protective of her tormentors as she still does not really look at them as the traitors that they really were. In fact, such is the measure of her big heartedness that she still allows her first husband to be a part of her life for the sake of their daughters and grandchildren. Her innate goodness comes to the fore as she tries to make excuses in an attempt to soften the disgust that she must feel somewhere in her deepest soul.

After this revelation on the couch, I asked Rosie to go home and start to write her recollections, as they emerged, and then we could share them and make further progress in her recovery. I find this to be a powerful way to lead patients through their journey of discovery, and often other traumas that they have suffered come to the surface.

And now that she had some understanding of how her condition had been induced all those years ago, it was as though she had been reborn.

At the next appointment the excitement was palpable and I waited in happy anticipation as she began to work through her trauma. Once she was able to allow herself to recall her experiences, they just spilled out and she had recorded the events for me so that we could work through them. Having suffered so much herself, she was generous in her mild condemnation of her tormentors. This did not surprise me at all, as I had anticipated that her generous spirit would once again assert itself. I had realized early on that I was working with a woman of considerable character and a forgiving nature. This realization was reinforced as more and more of Rosie's story evolved, but didn't really surprise me as I was getting to understand the depth, breadth and width of this unique woman's character.

This is a transcript of Rosie's post-discovery session. I usually get patients to write what they remember from the first intake interview and in this case it was appropriate for her to start to write about the discovery of her life experiences.

WASTED DECADES

Preface

This is my story and I have called it “Wasted Decades” as that is how I feel about all the years that were wasted for me personally. The name of this is certainly nothing to do with my feelings for my children.

I have four great children; they are my greatest love and I am so proud of each of them. They are all wonderful parents all with a commitment to their families; I have eight grandchildren and two great-grandchildren and love them all.

I can proudly state that at no time during all these years have I not loved my children. At times it was difficult to get through each day and even though I developed fears for my children I did everything I could to reassure them that even though their mother was a bit weird I loved them,

As I write, the memories have flooded back—many good and many bad. Regardless, I am impelled to write them down.

I hope if my children and my wider family read this they understand that it has not been written to shock or hurt them with my memories. My only hope is that they come to understand me more.

All of us are fragile to some degree, some more than others and unkind words can sow seeds of doubt in those more vulnerable, which can carry enormous consequences for a very long time.

If one person reads this and feels they need some help in sorting out some emotional problems then it has been worth it. There are many people specializing in all sorts of areas so seek them out and get all the help you need and are entitled to. Don't be afraid or embarrassed to seek help, as attempting to hide your feelings and fears will limit your life, and hold you back from enjoying a full and happy life.

I did just that and eventually those fears ruled my life. Don't continue to see someone who you are uncomfortable with or don't trust, find someone else.

Introduction

An explanation about “my epiphany.”

Since June 2007 I have had regular appointments with a specialist who deals in grief counselling who was recommended.

We talked for hours over that period of time about all my fears, phobias and irrational thoughts. All of it was a wonderful help for me and she taught me so much about understanding myself, relaxing techniques both physical and emotional, all sorts of things that I could do to help me handle and come to terms with many of my limitations. I had many sessions of hypnosis over this period of time, which were wonderful. They

were relaxing and certainly helpful and I became quite good in taking myself away in my mind to a quiet place when I was home to relax and heal myself. During actual hypnosis sessions I was able to remember many things from my past especially to do with my parents and siblings.

I knew that there must be something buried deeply in my subconscious but what it was I didn't know.

Common sense told me that there must have been something that changed me from being a happy person to a miserable, ravaged emotional wreck. My understanding of the working of conscious and subconscious states was zilch, nada. I went along to these sessions with total trust in this wonderful lady who was helping me. Just being there with her, knowing she accepted me for what I was and respected me was enough. I was feeling more confident and I became a little more adventurous in daily things. I was able to go into the city on my own again, go for a walk, visit a friend on my own and have dental treatment without having another adult sitting in with me. Life was bearable.

In February 2012 while having a hypnotherapy session it surfaced! I have no recollection of what she was talking about to me while under hypnosis but as she brought me back it was there. I sat up and said, "I know what it was, I know what caused all my problems." "You have found the answer to all my problems." I sat on the bed and just wept, initially with joy then rage and sorrow and grief. All the emotions that we feel were bubbling around as I wept.

Oh it was wonderful that I knew the lock had been opened. I could now come to understand me all over again. How could I be sucked in to believing all these dreadful things about myself?

I will be forever grateful to my specialist who is also my dear friend for her love, wisdom and trust in me, for giving me back my life and for teaching me to forever look at the positives in my life and never again suffer from "poor me."

I started writing this on the afternoon of my epiphany and intend to stop only when I'm done and there are no more words!

To my friend Judy I thank you for your editing and corrections, constructive criticism and patience.

This story would never have been written without you and your love, trust and support.

Rosie has now completed a novella recording all the life experiences that gave rise to her illness and the effects that these exposed her to. There have been wonderful changes since her epiphany which have given her the life she now has to enjoy and bring great joy to all those people who had been affected by her behaviour.

The marriage didn't last as the husband's duplicity was quickly revealed. They parted and he moved in with his girlfriend and Rosie eventually met another man and they married and had a daughter.

But what of the baby, you well may ask. And this is the wonderful part of this story. Eventually, it appears they each decided to search for the other and both had registered with Jigsaw or some agency I don't remember and did make contact and then met. He is very much a part of this family now and of course this is a very joyful thing for most of those involved. He is a 50-year-old midwife in another state and visits and has his mother visit him. I have met him but that is another story.

When the son was introduced to his father's family, Rosie learned from her mother-in-law that the boy's father had never told his parents of the pregnancy but had told her that his parents agreed that she should go away and have the baby and adopt him out. His paternal grandmother reassured Rosie that, had she known of the pregnancy, she would have cared for him. In no circumstance would she have agreed to deny his existence.

Members of her family and I were all astonished by the rapid changes in this woman's functioning when we were able to recover memories from the past. These memories were the statements made to her by her husband which underlie her development of a crippling phobia. Recovery of these memories gave her the freedom she needed to let go of her terrible affliction. These had made her life a nightmare for nearly 50 years. She has now reclaimed her joy and happiness in life and can enjoy her family, grandchildren and friends as she can now entertain them with no fear of poisoning them.