

AUSTRALIAN JOURNAL OF CLINICAL AND EXPERIMENTAL HYPNOSIS

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**AUSTRALIAN JOURNAL OF
CLINICAL AND EXPERIMENTAL HYPNOSIS**

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subscriptions should be addressed to the Editor.

EDITORIAL

This first edition of the journal for 1998 contains detailed information regarding the 28th ASH Congress and Workshops, which will be held in September 1998 at Rydge's Plaza Hotel in Alice Springs and at Ayers Rock Resort, Northern Territory. The information provided is supplemental to that made available in the Main Announcement and Registration Form, distributed to all members of the Australian Society of Hypnosis earlier this year.

The 28th Congress and Workshops are being held in Alice Springs and at Ayers Rock Resort for several reasons. When members of the Federal Executive commenced planning for the Congress several years ago, it was decided we needed to "bring the branches of the Society together." There was no more logical place with that in mind, than Central Australia. Not only do we hope to bring the membership together in a collegial, professional, and social setting, but we wish to provide a setting that is distanced from the daily activities and pressures of work. Each and every registrant has to travel some distance to get to the Congress and Workshops — and, in so doing, each can set aside the preoccupations of one's life and enjoy the many and varied professional activities the Congress has to offer.

Another reason for choosing Alice Springs and Ayers Rock Resort for our 28th Congress and Workshops was to provide members of the Society and their families the opportunity to visit a magnificent part of our country. There are a range of natural attractions and other tourism opportunities to satisfy the needs of we jaded suburbanites! In conjunction with the Northern Territory Convention Bureau, we have put together an extensive range of social, partner, and tourism activities (many of which are included in the cost of registration), that will enable you to enjoy not only the professional activities of the Congress and Workshops, but a range of social and other activities.

As you will see from the information to follow, our two internationally recognised guests for the Congress and Workshops are Jeffrey Zeig PhD and Sam LeBaron MD, PhD. In addition to these renowned clinicians and teachers, the Congress will feature eight symposia in the major applications of hypnosis, chaired by eminent Australian researchers and/or clinicians. Their symposia are described in the Main Announcement and later in this edition of the journal. Finally, the Congress will also feature a Scientific Session, wherein members of the Society can present their own work.

Of course, holding the Congress and Workshops in a remote location that requires each registrant to travel entails some risks — members of the Society are busy professionals, many self-employed who do not have the luxury of paid leave or reimbursement of costs. With this in mind, the Organising Committee has put together the most extensive professional program of any ASH Congress. Background papers for the entire professional program will be made available to each registrant in their complimentary copy of *Hypnosis in Australia* — the

Congress Proceedings. The registration fee represents significant value for money — in short, this Congress is the one Society event you should not miss.

On behalf of the Congress Organising Committee, I ask you to attend and participate in the ASH 28th Congress and Workshops.

Call for Papers

The success of any professional journal, measured in its distribution and utility to its readership, is dependent upon the willingness of contributors to submit theoretical papers, clinical reports, case material, and other items of interest for editorial review.

The journal is open to all members of the Society to submit papers for peer review and possible publication. The decision to publish papers is made on several criteria, with interest to the readership being the criterion upon which I place greatest emphasis. Obviously, quality of writing and adequate depth of research are also important. I invite each ASH member to consider submitting a paper — it not only enhances your professional reputation, but strengthens the journal and, by implication, the Society, at a time when our professional society is under its greatest challenge by lay groups and individuals now allowed to legally use hypnosis, without the checks and balances of professional training and underpinnings. It may be, ultimately, that membership of ASH and the professional credibility of published papers will be the factor in helping your professional services being chosen over those without membership of ASH.

Barry J. Evans
University of Melbourne
May 1998



The Australian Society of Hypnosis

28th Annual Congress and Workshops

will be held at

Rydge's Plaza Hotel, Alice Springs, N.T.

Wednesday 9 – Monday 14 September 1998

and

Ayers Rock Resort, N.T.

Wednesday 16 September 1998

INTERNATIONAL SPEAKERS

Jeffrey K. Zeig, PhD

Jeff Zeig is a clinical psychologist in Phoenix, Arizona, in private practice and consulting. He is a Fellow of the American Psychological Association and the American Society of Clinical Hypnosis, and a member of other professional associations. Jeff had more than six years study with Milton Erickson and conducts workshops in Ericksonian techniques in over 30 countries. He is founder, Director, and President of the Board of Directors of the Milton H. Erickson Foundation and has published over 14 professional books and five monographs on Ericksonian therapies, psychotherapy, and hypnosis. Jeff has recently established a new publishing house in the behavioural sciences: Zeig, Tucker and Co.

Keynote Address: *The Personal Growth and Development of the Hypnotherapist*

First Workshop: *Hypnosis in Time-Limited Therapy: Advanced Ericksonian Hypnotherapy*

Second Workshop: *Hypnosis, Psychotherapy, Phobias, and Anxiety*

Samuel LeBaron, MD, PhD

Samuel LeBaron holds degrees in medicine and psychology and is currently Associate Professor of Medicine at Stanford University School of Medicine. He is a member of numerous professional organisations and has held senior academic and administrative posts in medical, psychological, and hypnosis societies. Samuel has received several prestigious awards from Stanford University for excellence in teaching, research, and writing. He is author, editor, or co-editor of over 100 papers, books, book chapters, and abstracts, with significant publications in pain control and cancer. His hypnosis expertise is in the areas of family medicine, pain, cancer, and other medical applications, with the added expertise and experience of psychology in relation to medicine.

Keynote Address: *What You and I Don't Know*

Workshop: *Research in Hypnosis and Pain Management: Implications for Clinical Practice*

AUSTRALIAN KEYNOTE SPEAKERS

Wendy-Louise Walker PhD

Wendy-Louise Walker held academic posts at the University of Sydney and has many years experience as a counselling and forensic psychologist and hypnotherapist. For many years, she was Editor of the *Australian Journal of Clinical and Experimental Hypnosis* and has written about, and conducted workshops on, hypnosis, music, and imaginative involvement.

Workshop: *Hypnosis, Music, and Imagination*
(Co-Chair: June Jackson from Queensland)

Leonard Rose MBBS

Len Rose is currently Federal President of the Australian Society of Hypnosis. He is an accomplished physician, for many years working in the area of pain management and hypnosis.

Keynote Address: *Hypnosis: The Australian Experience and Developments Into the New Millennium*

SYMPOSIA PROGRAM

The 28th Congress will feature a number of symposia in the major applications of hypnosis, chaired by eminent Australian researchers/clinicians. Each will provide the opportunity for developing and enhancing practitioner skills. A full research and clinical update paper on each symposium will be included in the proceedings of the Congress, a copy of which will be included with your registration.

Hypnosis and Anxiety Disorders

Chair: Joe Hinora BA, DipAppPsych [S.A.] with text by Barry J. Evans, PhD [Vic.] and Greg J. Coman, MSc [Vic.]

The anxiety disorders are a pervasive group of disorders which affect a significant number of people in the community. Many suffer from the disorders without understanding the nature of their problem, the aetiology, and treatment approaches available.

This symposium will introduce participants to the clinical features of each of the anxiety disorders, including post-traumatic stress disorders. The written text will review the range of treatment approaches applicable to the disorders, and the symposium will focus on the effective role that may be played by hypnosis as an adjunct to treatment. Participants will have the opportunity to practise clinical skills and will also be able to present their own cases for discussion.

Hypnosis and Mind-Body Healing

Chair: Graham Wicks, MBBS [S.A.] with text by Roger Booth, PhD [N.Z.]

This symposium will present a theoretical background for understanding the mind-body equation, both from a psychobiological and a psychodynamic perspective. Emphasis will then be directed towards the development and utilisation of practical hypnotherapeutic techniques designed to communicate with the unconscious, to access inner resources, to stimulate and mobilise healing mechanisms, and to overcome resistance to positive therapeutic change.

There is continuous interaction between the mind and the body, with changes to one affecting the other. These effects can be both positive and negative, with research into stress reactions clearly illustrating this. It has now been proved beyond doubt that emotional responses and psychological states trigger the release of hormonal messenger molecules (also called information substances) by nerves, organs, and tissues in one part of the body, which are picked up by receptors in the cell walls of other body tissues. This "activation" of the cell

wall turns on other "secondary messenger systems" within the cell to initiate the characteristic metabolic activities of the cell. This seems to be the basis of so called "state dependent" memory, learning, and behaviour.

The external elements and internal perceptions of a particular experience can thus become encoded in the neural networks of the brain and then re-accessed when a similar psychological state is reactivated or re-experienced.

Habit Disorders — Treatment with Hypnosis

Chairs: Rosalyn Griffiths, PhD [N.S.W.], Barbara Wardman-Newton, PhD [N.S.W.], and Greg Coman, MSc [Vic.]

This symposium will address the role of hypnosis for the treatment of anorexia and bulimia nervosa, problem gambling, and smoking. Its objectives are to overview the clinical and research information for these problems and to provide participants with practical skill training in the use of hypnosis for these problems.

The topics to be covered are: review of the literature on clinical applications of hypnosis with eating disorders; hypnotisability and its constructs in anorexia and bulimia nervosa, and a hypnobehavioural model for bulimia nervosa. For problem gambling, topics include a review of the types of addictive gambling; strategies for dealing with problem gambling; and dissociative capacity, gambling, and the use of hypnosis. In the smoking section, topics cover a review of outcome of the use of hypnosis with smokers; two different types of treatment using hypnotic techniques; and case presentations illustrating the use of hypnosis with both methods.

Hypnosis and Performance Enhancement

Chair: Harry Stanton, PhD [Tas.] with text by Simon Stafrace, MBBS, FRANZCP [Vic.]

The objectives of this symposium are to encourage participants to share their skills and knowledge with each other; to demonstrate and discuss a number of techniques which usually enable people to rapidly improve their performance; and to emphasise the importance of morale building as the essence of psychotherapy, whether this be applied to the clinical, educational, business, or sporting arena.

The session will be interactionist in nature. Although the chairman will provide considerable input in the form of lecturettes and demonstrations, there will be ample time for participants to share their own experiences and skills. This will usually be in the context of small groups.

The orientation of the symposium will be eclectic, drawing on traditional hypnotherapeutic techniques, Ericksonian approaches, and neuro-linguistic programming. Case taking, hypnotic induction, deepening, imagery, suggestion (both direct and indirect), ego-strengthening, drawing on unconscious potentials, using stories, process instructions, reframing, and self-hypnosis will all be considered within the context of enhancing performance over a wide variety of areas.

Hypnosis, Recovered Memories, and Clinical Applications

Chairs: Kevin McConkey, PhD [N.S.W.] and Peter Sheehan, PhD [Qld]

This symposium will familiarise participants with theoretical issues and empirical evidence concerning memory and amnesia, repression and the recovery of memory, and hypnosis and related phenomena. Also, the symposium will present case analyses relating to the recovery of memory, the evaluation of recovered memories, and the retraction of recovered memories. A particular focus will be the principles and guidelines associated with competent and ethical practice when dealing with hypnosis and recovered memories in the clinical context. This focus will be examined within the context of participants' own clinical case interests and cases, and the symposium will involve a mixture of presentations by the co-chairs, demonstrations via videotapes, discussion of clinical cases, and role-play and practice of relevant techniques and skills.

Specific topics:

1. Memory, amnesia, and repression.
2. Hypnosis and the recovery of memory.
3. Dealing with recovered memories.
4. Professional and ethical issues.

Hypnosis with Children and Adolescents

Chairs: Lachlan Lipsett, MBBS, FRACS [N.S.W.] and Wendy-Louise Walker, PhD [N.S.W.]

Human development is a product of nature, nurture, and time. Children and adolescents differ from their adult state in how they integrate thought and action, reaching the adult state by passing through general phases of development. Individuals have different experiences which colour their development and this accounts for the great diversity of behaviour. If someone approaches an individual with the aim of influencing his/her behaviour (thought and action), then the particular conformation of variables (genetic endowment, experience, and age) in the targeted individual is all-important to the outcome. This is true of the hypnotic interventions of clinician, parent — or advertiser — with a child or adolescent.

Hypnosis with children and adolescents may aim overtly to control them, for example, in the provision of medical and dental care. Hypnosis may also be employed to promote an individual's development by providing a structured experience — often a pleasant experience of feelings of mastery, competence, joy, etc., thereby broadening the individual's understanding of the world and adding to his/her behavioural repertoire.

In this symposium, some current models of human development will be briefly reviewed, to provide a basis for applying hypnosis in clinical interventions. The use of hypnosis through imaginative involvement, story-telling, and more directive approaches will be discussed and some techniques made explicit. As children and adolescents will not be available as subjects, some plausible rehearsals will be offered through role-playing. Workbooks will be provided.

Indirect Methods of Hypnosis

Chair: Doris Brett, MA [Vic.] with text by Michael Yapko, PhD [U.S.A.]

This symposium aims to foster an understanding of indirect methods of hypnosis. The basic principles of indirect methods will be discussed but the primary focus will be experiential.

We will look at the contrasts between direct and indirect methods and discuss the kinds of clinical situations in which indirect techniques can be an advantage. Such issues as overcoming "resistance" will be discussed.

The bulk of the symposium will consist of small group practical experience aimed at practising indirect techniques. Indirect techniques can seem daunting to beginners, but in this symposium, we aim to make them both manageable and enjoyable.

Participants should leave this symposium with a practical as well as theoretical knowledge of indirect techniques. They will have practised a number of indirect techniques as well as having experienced them as hypnotic subjects. This symposium aims to give participants the skills, the confidence, and the enthusiasm to continue practising and exploring indirect techniques in their clinical work. It is suited for those who have little experience with indirect techniques.

Clinical Applications of Hypnotic Assessment

Chair: *Vicky Powlett, BA, DipCrim [Vic.]*

For hypnosis to be an effective therapeutic tool, clinicians would benefit by using either formal or informal standardised measures of hypnotisability. Most clinicians do not measure hypnotic capacity.

It is important to establish if your subject has the capacity to go into trance, to what depth, and in what ways that are unique to that person — some may have many ways of entering hypnotic trance, others merely one. Individuals with identical scores on a formal scale may well have passed different items and possess different talents.

In this symposium, we will explore various ways of assessing hypnotic phenomena — both formal and informal measures. There will be the opportunity to view video presentations of formal scales, such as the SHCS and HIP, demonstrations of hypnotic phenomena, and small-group experiential work. Discussion will also include legal implications.

A therapist needs to recognise the talents and capacity of the presenting client and listen to his or her story. This symposium will let you choose your own structured way of assessing the hypnotic phenomena and talents which each person brings from their lifetime experiences into therapy.



**To receive a copy of the Main Announcement
for the 28th ASH Congress and Workshops**

including full details of the scientific program,
social program, accommodation, costs, and
other relevant information

Contact

The Congress Secretariat

PO Box 405

Heidelberg, Victoria 3084

Tel: (03) 9243 1159

Fax: (03) 9243 1158

Email: bevans@alphalink.com.au

MEMBERS OF THE AUSTRALIAN SOCIETY OF HYPNOSIS WILL
AUTOMATICALLY RECEIVE INFORMATION ON THE CONGRESS AND
DO NOT HAVE TO CONTACT THE SECRETARIAT

POST-HYPNOTIC SUGGESTION, AMNESIA, AND HYPNOTISABILITY

Amanda J. Barnier

University of New South Wales

Kevin M. McConkey

University of New South Wales

We present an analysis of post-hypnotic responding for a large sample of Australian students ($N = 4,753$) who completed the Harvard Group Scale of Hypnotic Susceptibility, Form A (HGSHS:A). This analysis examined the relationships among post-hypnotic suggestion, amnesia, and hypnotisability. Also, it explored the relationship with hypnotisability of other selected HGSHS:A items that were similar to post-hypnotic suggestion and amnesia, but differed in terms of the time of their administration and testing. Consistent with theoretical accounts, post-hypnotic suggestion was a relatively difficult item that was associated with amnesia in the case of some individuals. However, contrary to these accounts, post-hypnotic responding was not exclusive to these subjects and was not necessarily associated with amnesia. The findings are discussed in terms of specific factors that may influence behaviour and experience in response to a post-hypnotic suggestion.

Post-hypnotic suggestion is especially interesting because it is performed in a setting that may be temporally, physically, and socially separate from the setting in which the suggestion was administered. It has been of enduring interest not only because of its theoretical importance, but also because of its potential

The research reported in this paper was supported in part by a grant from the Australian Research Council to Kevin M. McConkey. Amanda Barnier was supported by an Australian Postgraduate Award. We are grateful to Bernadette Bibb, Richard Bryant, Sandra Hejmanek, Jason Noble, Natalie Watson, and Heather Wilton for assistance in data collection.

Requests for reprints should be addressed to Kevin M. McConkey, School of Psychology, University of New South Wales, Sydney, N.S.W. 2052. Email: K.McConkey@unsw.edu.au

utility in the clinical setting. Post-hypnotic suggestions usually involve instructing hypnotised subjects to have a particular experience and/or show a particular behaviour after hypnosis when they are exposed to a signal or cue. The post-hypnotic suggestions reported in the literature have ranged from simple, benign responses such as scratching an ear (Orne, Sheehan, & Evans, 1968) to complex, multifaceted, and unusual responses such as hallucinating a gipsy and a dancing American bear (Liégeois, 1889). Post-hypnotic suggestion has usually been seen as a very difficult hypnotic phenomenon to experience. Hilgard (1965), for instance, argued that "true" post-hypnotic responding is exclusive to high hypnotisable individuals, and Sheehan and Orne (1968) stated that "the most effective post-hypnotic response occurs in those subjects who have an outstanding aptitude for trance" (p. 219). Although such comments convey that only the most talented hypnotic subjects can respond successfully to a post-hypnotic suggestion, there has been relatively little formal investigation of the relationship between post-hypnotic suggestion and hypnotisability.

Because the suggestion for amnesia is typically administered during hypnosis and because amnesia is typically tested after hypnosis, there has been a general view that post-hypnotic amnesia is a specific instance of post-hypnotic suggestion. Moreover, there has been one view that amnesia (whether suggested explicitly or implicitly during hypnosis) is typically associated with subjects' responses to post-hypnotic suggestions. For instance, some accounts of post-hypnotic suggestion have argued that amnesia covers the source of post-hypnotic behaviour and inhibits resistance to the suggested response (Hilgard, 1965; Sheehan & Orne, 1968; Weitzenhoffer, 1957). However, other accounts have argued that amnesia for the suggestion is not necessary and that its presence does not change the quality of post-hypnotic behaviour (Barber, 1962; Edwards, 1965; Fisher, 1955; Marcus, Hill, & Keegan, 1945). These arguments notwithstanding, there has been relatively little formal investigation of the relationship between post-hypnotic suggestion and amnesia.

In this article, we explore these issues in a heuristic way by analysing the performance of subjects on the most widely used standardised assessment of hypnotisability, which includes items of post-hypnotic suggestion and amnesia, and by taking advantage of a large amount of normative data. Specifically, we present an analysis of the responses of a large sample of subjects who completed the Harvard Group Scale of Hypnotic Susceptibility, Form A (HGSHS:A; Shor & Orne, 1962). The HGSHS:A is a particularly valuable instrument for considering hypnotic phenomena because of the variety of items that it contains and because of the number of normative samples that are available across time and countries since the original normative work (Shor & Orne, 1963; for instance, see Bongartz, 1985; Coe, 1964; Lamas, del Valle-Inclan, & Blanco, 1989; Laurence & Perry, 1982; McConkey, Barnier, Maccallum, & Bishop, 1996; Sheehan & McConkey, 1979; Zachariae, Sommerlund, & Molay, 1996).

In summary, our aim was to examine the relationships among post-hypnotic suggestion, amnesia, and hypnotisability. We were interested in who responds to a post-hypnotic suggestion, the response similarities and differences in post-hypnotic suggestion and amnesia, and whether amnesia is associated with responding to post-hypnotic suggestion. Moreover, we were interested in using the data to raise some issues that are not explicit in the literature on post-hypnotic suggestion, but that we believe need to be considered if the field is going to develop an account of post-hypnotic suggestion that is theoretically coherent and practically useful.

METHOD

Subjects

Four thousand, seven hundred and fifty-three (1,310 male and 3,443 female) individuals who ranged in age from 17 to 73 years ($M = 22.24$, $SD = 7.77$), and who were undergraduate psychology students at Macquarie University in the years 1985 to 1992, voluntarily participated in the testing in return for research credit of one hour.

Procedure

The procedure was described and subjects were informed that they were free to withdraw their participation at any time without penalty. The tape-recorded standardised version of the HGSHS:A (Shor & Orne, 1962) was administered. The induction procedure was followed by the 12 test items: head falling, eye closure, hand lowering, arm immobilisation, finger lock, arm rigidity, hands moving, communication inhibition, hallucination, eye catalepsy, post-hypnotic suggestion, and amnesia. The post-hypnotic suggestion involved telling subjects that after they were awakened from hypnosis they would hear a tapping noise and that they would then reach down and touch their left ankle. The amnesia suggestion involved telling subjects that after they were awakened from hypnosis they would not be able to recall anything that had occurred during the session until the experimenter said "Now you can remember everything." Although amnesia was a global suggestion in the sense that it targeted all of the events of the hypnosis session (rather than the post-hypnotic suggestion specifically), it was administered at the same time as the post-hypnotic suggestion.

Scoring

Scoring of responses to the test items followed the standard procedure described by Shor and Orne (1962), with the exception of the amnesia item; scoring for this item followed the procedure recommended by Kihlstrom and Register (1984). For items 1 to 11, a pass (score = 1) was awarded if responses met the

behavioural criterion for the suggestion; a fail (score = 0) was awarded for responses not meeting this criterion. For post-hypnotic suggestion, subjects were scored positively if they estimated that an onlooker would have observed them reach down and touch their left ankle or make any partial movement to do so. For amnesia, scoring followed Kihlstrom and Register's (1984) recommendation that a "reversibility" criterion be used to score amnesia, since the loss and recovery of memory more nearly reflects the theoretical basis of the amnesia suggestion. Specifically, participants were awarded a score of "1" if they recalled fewer than four items on the first test of recall, and also recalled two or more items on the second test of recall following the signal to remember. The scores were summed to yield a HGSHS:A score in the range 0 to 12.

RESULTS AND DISCUSSION

Subjects in our sample had a mean HGSHS:A score of 6.28 ($SD = 2.64$), which fell within the distribution of mean scores of previous normative samples of the HGSHS:A (for review, see McConkey, et al., 1996).¹ Further, the distribution of HGSHS:A scores was consistent with those reported in these previous samples; in our sample, 16% of individuals scored in the low hypnotisability range (0–3), 72% scored in the medium range (4–9), and 12% scored in the high range (10–12).

We were interested in the relationship between post-hypnotic suggestion and hypnotisability and in how it compared with the relationship between amnesia and hypnotisability. Figure 1 presents the percentage of subjects who passed post-hypnotic suggestion and amnesia across the total score distribution, less the post-hypnotic suggestion and amnesia items, respectively. One thousand two hundred and twenty-nine (26%) subjects passed post-hypnotic suggestion. Those subjects who passed post-hypnotic suggestion ($M = 6.67$, $SD = 2.52$) had higher total scores (less post-hypnotic suggestion) than those who failed ($M = 5.79$, $SD = 2.52$), $t(4751) = 10.60$, $p < .001$. The correlation between post-hypnotic suggestion and total score (less post-hypnotic suggestion) was significant but modest, $r = .15$ ($p < .001$). Although approximately 35% to 55% of high hypnotisable subjects responded to post-hypnotic suggestion, around 15% to 30% of low and medium hypnotisable subjects also responded; in other words, response to post-hypnotic suggestion was not exclusive to high hypnotisable subjects.

Nine hundred and thirty-nine (20%) subjects passed amnesia. As with post-hypnotic suggestion, those subjects who passed amnesia ($M = 7.38$, $SD = 2.12$) had higher total scores (less amnesia) than those who failed ($M = 5.78$, $SD = 2.50$), $t(4751) = 18.37$, $p < .001$. The correlation between amnesia and total score (less amnesia) was significant but moderate ($r = .26$, $p < .001$). Although approximately 25% to 50% of high hypnotisable subjects responded to amnesia, around 5% to 20% of low and medium hypnotisable subjects also responded; in other words, response to amnesia was not exclusive to high hypnotisable

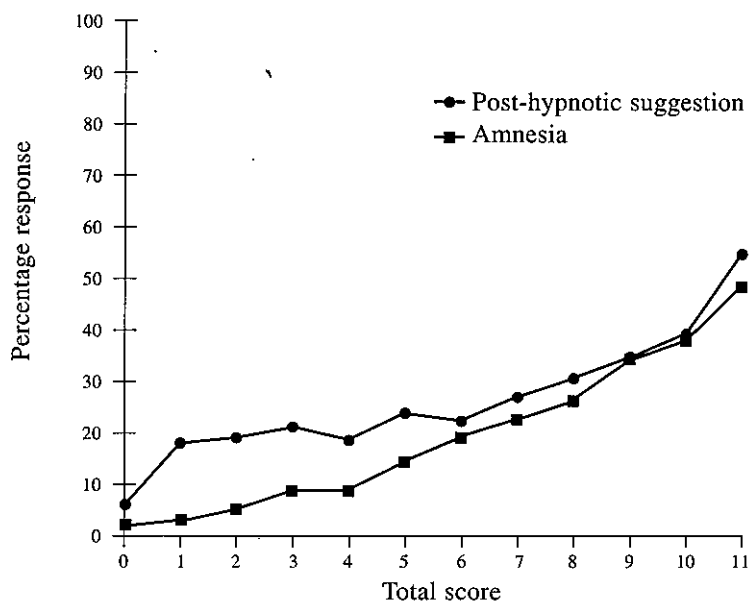
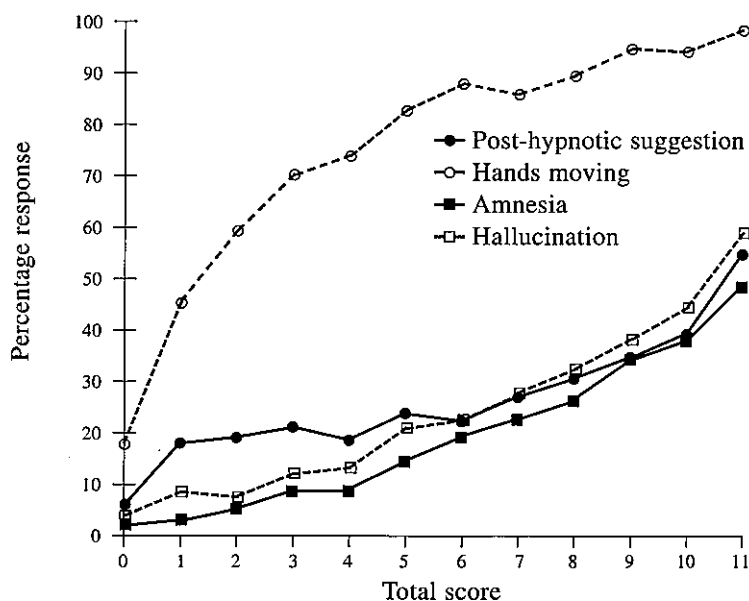
subjects. In comparison with post-hypnotic suggestion, however, fewer subjects overall responded to amnesia and this decreased level of responding was especially the case in the lower range of hypnotisability. Although these findings are generally consistent with the view that post-hypnotic suggestion is a difficult hypnotic item (Hilgard, 1965; Sheehan & Orne, 1968), the findings also point to the potential for low and medium hypnotisable subjects to respond successfully to a post-hypnotic suggestion.

Of the subjects who passed post-hypnotic suggestion, 308 (25%) also passed amnesia; the correlation between post-hypnotic suggestion and amnesia was significant but very modest, $r = .08$ ($p < .001$). To explore this relationship further, we calculated a total score (range = 0–10) that omitted subjects' responses to both post-hypnotic suggestion and amnesia. Overall, subjects who passed both post-hypnotic suggestion and amnesia ($N = 308$, 25%; $M = 7.52$, $SD = 1.89$) had significantly higher total scores than those who passed post-hypnotic suggestion and failed amnesia ($N = 921$, 75%; $M = 6.05$, $SD = 2.36$), $t(1227) = 11.02$, $p < .001$. Although those who passed both post-hypnotic suggestion and amnesia were more hypnotisable than those who did not, a more complicated pattern emerged when these data were considered in detail. In particular, high hypnotisable subjects who passed both post-hypnotic suggestion and amnesia ($N = 178$, 53%; $M = 8.85$, $SD = 0.79$) had significantly lower total scores than those who passed post-hypnotic suggestion and failed amnesia ($N = 155$, 47%; $M = 9.31$, $SD = 0.46$), $t(331) = 6.59$, $p < .001$; this finding is somewhat counterintuitive and inconsistent with theoretical comments by, for instance, Hilgard (1965) and Sheehan and Orne (1968). Specifically, this finding indicates that amnesia is not necessary for post-hypnotic responding. However, it should be acknowledged that the amnesia item was a global suggestion, and did not specifically target the post-hypnotic suggestion. Nevertheless, other work (Barnier & McConkey, 1997) that has compared post-hypnotic suggestion with or without specific accompanying amnesia has found no difference in the response of subjects. Taken together, these findings imply that amnesia is not central to post-hypnotic responding.

In addition to comparing the relationship of the HGSHS:A items of post-hypnotic suggestion and amnesia to hypnotisability, we were interested in examining the relationship with hypnotisability of other selected items that were similar to post-hypnotic suggestion and amnesia in various ways, but were administered and tested during hypnosis rather than administered during and tested after hypnosis. We chose the HGSHS:A items of hands moving and hallucination. Hands moving is an ideomotor item in which subjects are told that their hands are moving together; it is similar to post-hypnotic suggestion in the sense that the experience and response required involve a simple physical movement. In our sample, 3,765 (79%) subjects passed hands moving. Hallucination is a cognitive item in which subjects are told that they will experience a fly buzzing around them; it is similar to amnesia in the sense that the experience is an internal one, and it is similar to post-hypnotic suggestion in the sense that it is assessed in terms of whether a simple physical movement occurs.

In our sample, 1,176 (25%) subjects passed hallucination. Figure 2 presents the percentage of subjects who passed post-hypnotic suggestion, amnesia, hands moving, and hallucination across the total score distribution (less, for each, the score for the relevant item). This figure illustrates the relative similarity in response pattern of hallucination with post-hypnotic suggestion and amnesia, and the substantial dissimilarity of hands moving with post-hypnotic suggestion and amnesia. This is consistent with the findings of analyses of the HGSHS:A and other scales of hypnotisability (e.g., Hilgard, 1965; McConkey et al., 1996; McConkey, Sheehan, & Law, 1980), but it also raises a number of issues that have not been considered explicitly in the literature.

First, given that the types of movement involved in hands moving and post-hypnotic suggestion are reasonably similar, then why are the response patterns so different? If, for instance, post-hypnotic suggestion was administered and tested during hypnosis, rather than administered during and tested after hypnosis, would the response pattern be more similar to that of hand moving or to that of post-hypnotic suggestion? Other research of ours (Barnier & McConkey, *in press a*) indicates that high hypnotisable subjects are more likely to respond to an item administered and tested during hypnosis than the same item administered during and tested after hypnosis. Second, given that post-hypnotic suggestion and hallucination are both cognitive items and are both assessed in terms of whether a simple physical movement occurs, then why do more subjects in the low to medium range of hypnotisability pass post-hypnotic suggestion? Is this because a suggested action (e.g., touching an ankle) is less difficult than a suggested desire (e.g., experiencing a fly buzzing), regardless of how they are behaviourally assessed? Other work that we have conducted (Barnier & McConkey, 1996) indicates that a behaviourally focused suggestion leads to a different pattern of response than an experientially focused suggestion. Third, given that the response pattern for post-hypnotic suggestion, amnesia, and hallucination are, for the most part, similar (which is consistent with factor analytic studies of the HGSHS:A; for example, see McConkey et al., 1996; McConkey et al., 1980; Peters, Dhanens, Lundy, & Landy, 1974), then why do almost twice as many low hypnotisable subjects pass post-hypnotic suggestion than pass hallucination or amnesia? We believe that the scoring criteria for each suggestion may influence response at this end of the distribution. Of these suggestions, post-hypnotic suggestion could be said to have the least strict response criterion; response is scored for any complete or partial movement consistent with the suggestion. In contrast, the response criterion for both amnesia (i.e., the loss and recovery of memory) and hallucination (i.e., an observable acknowledgment of the hallucinatory experience) are more strict. Other research of ours (Barnier & McConkey, 1996, *in press b*) indicates that "technically correct" or complete responses should be differentiated from incomplete or partial responses, and that the criterion for response is a critical factor in determining how researchers think about various hypnotic phenomena.

Figure 1: Percentage Response to Post-Hypnotic Suggestion and Amnesia Across the Total Score Distribution**Figure 2:** Percentage Response to Post-Hypnotic Suggestion (PHS), Amnesia, Hands Moving, and Hallucination Across the Total Score Distribution

CONCLUDING COMMENT

Our examination of these data underscores that post-hypnotic suggestion is a relatively difficult item that is passed predominantly by those with high hypnotic ability. Also, for some individuals, it is associated with amnesia. However, post-hypnotic responding is not exclusive to high hypnotisable subjects and it is not dependent upon amnesia. Moreover, the finding that some low hypnotisable subjects may respond to a post-hypnotic suggestion implies that different subjects may respond for different reasons. Importantly, our comparison of post-hypnotic suggestion with other selected HGSHS:A items suggests that post-hypnotic responding may be influenced by factors such as the nature of the suggested task, when the suggestion is administered and tested, and how responding is scored. Overall, the development of a full theoretical and practical account of post-hypnotic suggestion will depend upon an understanding of how these factors influence responding at both the level of observable behaviour and the level of subjective experience.

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¹ To check the reliability of our analyses, the sample was randomly split into two sub-samples and the analyses were cross-validated (N Sub-sample 1 = 2,390; N Sub-sample 2 = 2,363); the pattern of results was identical across these sub-samples. Thus, the results are presented for the entire sample.

EXPERIENTIAL ANALOGIES AND HYPNOTHERAPY

Norman R. Barling

Psychologist

This paper discusses the therapeutic use of experiential analogies with clients in a hypnotic trance. The argument that experiential analogies can facilitate powerful therapeutic outcomes, especially when they are paired with multi-sensory suggestions, is developed. Two case histories are elaborated on to exemplify the creative use of experiential analogies with multi-sensory suggestions.

Experiential analogies are therapeutic techniques which enable clients to imagine, act out, engage in, or act, "as if" they were someone or something else. They are built on the inference that because one idea, thing, or behaviour resembles another in certain aspects, it also does in other aspects. For example, the human brain is analogous to a computer as they are both able to logically solve problems. Thus, as the computer can be programmed, so too can the human brain. Also, because the computer can be turned off and on, so too can the human brain. Experiential analogies allow the client to develop understanding and to experience the context, the actions, feelings and emotions associated with the doing of the actions. In order for the client to optimise the experience, and the insights from this experience, it is recommended that multi-sensory experiences be created, and that the client be in a trance state.

For example, a client who experienced difficulty in her marriage because she felt her husband had all the power, and that she was being closed off from her interests, was encouraged (while in trance) to experience the view from her kitchen where she stood to do the dishes. She had assisted her bricklaying husband build the fence which, in reality, had obscured the view. The client was encouraged to get a ladder and a hammer and to remove each layer of the fence, brick-by-brick. While doing so she was encouraged to feel the force of the hammer knocking out the bricks, see the expanding view, smell the fresh air, touch the decaying wall and the space beyond, taste the success of her actions, and experience the meaning that the task held for her. Emphasis was placed on

Requests for reprints should be sent to Norman Barling, Bond University, Gold Coast, Queensland, 5072.

experiencing her feelings, being aware of her thoughts, and imagining what could be seen from her line of sight, off into the distance. Barling (1995) has also elaborated several other examples of experiential analogies which were paired with metaphors in hypnotherapy.

While several arguments can be developed for the utilisation of experiential analogies and their integration into the therapeutic setting, perhaps the most powerful argument for their use in therapy is that they work and they facilitate the achievement of positive therapeutic goals. Like the use of metaphors in hypnotherapy, the use of experiential analogies is often reported by clients as being a turning point from which they are able to perceive their problems from a different perspective, seek creative insight, and facilitate resolution of them. That is to say, it has been the author's experience that experiential analogies enable clients to see their problems in a different light and from a new perspective. When the experiential analogy is personally relevant to the client, it will enable the client to more easily identify with the experience, and build on it in a meaningful manner. In all cases, "it is essential in any treatment with hypnosis that therapy be tailored to the individual and the techniques match the subject's mental set" (Leung, 1994, p. 110). In the case of the experiential analogies technique, it is probably not enough for the experiential analogy to match only the mental set. The client should have some real life experience of the analogous situation in a behavioural first-hand relevant manner. The desirability for the client to have behaviourally relevant experience will most likely enhance learning, and insights, as the client can build on some relevant experiences with the utilisation of further sensory awareness.

Another argument for the use of experiential analogies is that the client's insight and learning is increased and facilitated if the client is able to access all modes of sensory experience. This point has been recently discussed by Burns (1995) when he elaborated on the use of his Sensual Awareness Scale (SAS), asking clients to identify the sights, sounds, smells, taste, touch, and activity associated with enjoyments. Burns concluded that utilising the SAS, "allows us to create personally relevant imagery and thus enhances the establishment and effectiveness of hypnosis. It can also provide themes for, and contexts in which to set metaphors" (p. 283). Or, as being argued here, contexts to set experiential analogies. Further, the inclusion of multi-sensory experiences while in a trance state is just as likely to facilitate learning and insight as in a normal state of alertness. Since it recognises that people have different learning styles which may respond differentially to a variety of different inputs from their senses, utilising a multi-sensory approach can account for such individualisation, and may further expand the client's insight and learning.

Experiential analogies are perhaps even more effective when they are able to integrate both the cognitive and the affective domains of human experience. The pioneering work of George Brown (1995) and his colleagues, with the ideas of "confluent education" and gestalt, have reinforced the concept that the most effective learning is personal learning. As expressed by Cassarino (1995),

personal learning is enhanced through “the developing of a fluidity between the outer-human world and the inner-human world. Education, if it is to be relevant to life, must approach knowledge in a very human way — through the human faculties of the mind, the senses, and the emotions” (p. 174). Thus, if we see education as synonymous with therapeutic learning, insight, and behavioural change, it follows that client therapeutic movement will be optimally facilitated when thoughts, senses, and emotions are utilised within the experiential analogy.

However, beside the importance of the integration of cognitive and affective experiential domains, the context, and the range of experience of the client, the experiential analogy needs to be contextualised. Contextualisation refers to the process of linking and associating the experiential analogy with the specific situation in real life. This is accomplished through a post-hypnotic suggestion which links the hypnotic experiential analogy to the future real life experience. As Yapko (1994) stated:

Without the use of post-hypnotic suggestions to serve as a bridge between the hypnotic state and the person’s “usual” waking state, it is highly probable that whatever gains might have been made during the hypnosis session will be limited to that session and not extended to the rest of the client’s life. (p. 45)

The following case studies illustrate the use of experiential analogies. However, they can also be part of a total therapeutic treatment program, which integrates other strategies to work toward the goals of therapy. As such, experiential analogies with multi-sensory input should be seen as a subset of a hypnotherapeutic approach to resolution of a client’s problem and movement toward the goals of therapy.

CASE HISTORY 1

Client

John, aged 52 years, is married and lives and works on the family farm with his wife. He supplements the farm income from cattle and mixed farming with income from fence contracting. Eight and a half years ago John was diagnosed with a malignant brain tumour. After surgery John was recovering when, during the last eighteen months, he experienced further symptoms indicating that there was still an active tumour in his brain. The continued growth of the tumour was being treated with chemotherapy and ray therapy. John was still recovering from these when I first saw him.

Presenting problem

John was having difficulty sleeping and wished to employ a more positive attitude toward beating his recurring problem with cancer.

Background

John had led an active life of which 22 years were spent with a concrete contractor. He grew to dislike the competitive working environment when delivering concrete in his own truck so he resigned and took on fencing contracting and grass mowing with the local councils. He built up the family farm but suffered a setback when he contracted the brain tumour. He presented as a well-built and strong person who was suffering a lack of coordination, and insomnia. He was dwelling on the stressful time as a concrete contractor, and a need to use all his abilities to beat the re-emergence of the brain tumour.

Treatment

John was seen on two occasions for one-hour sessions, a month apart. He attended with his wife, who was only present at the beginning of each session. After collecting background information it was decided that initially we would focus on strategies to facilitate his sleeping and general relaxation. John was familiar with hypnosis and was a good willing participant. A trance state was induced through breathing, relaxation, and visualisation. Self-hypnosis was taught as a means of inducing relaxation and sleep. One month later John returned feeling more positive about himself and his condition. He was sleeping better and now wanted to try to use his mental powers to try and beat his tumour.

Experiential Analogy

After a trance was induced and deepening strategies were employed, John's farming and fencing experiences were woven into the following scenario. He was asked to visualise his brain as a tarpaulin that he could lay out on the workshop floor. With careful observation he would be able to identify those parts of the tarp that had an active growing fungus on them. Pulling the tarp across his anvil he could beat the fungus to a pulp and destroy it with his blacksmith's hammer. The scenario was enriched with directions for him to experience the awareness of the force of his hammer, the sweat on his brow, the taste of destruction in his mouth, the smell of the fungus being destroyed, and the sight of the fungus being pulverised. With all his strength and willingness to rid the tarp of the fungus, John engaged in the activity with conviction, as if it were the diseased parts of his brain affected by the tumour. For the difficult sections of the fungus he was encouraged to take his manual star picket driver and drive pickets into the fungus. Again he reported that he was actively engaged in the activity as he was encouraged to experience his senses, feelings, and thoughts. A post-hypnotic suggestion was given to enable John to return to this experiential scenario whenever he felt distressed, or when he felt capable and wanted to actively inhibit his tumour.

Outcome

While the two sessions were of limited success in curing John's condition, they did achieve some important goals. First, a good rapport was established with John, and he left each session feeling better about himself and feeling that he was more in charge of how he was coping with his situation. Second, he could more easily access the power of his mind, to enable himself to sleep better, and he was less worried and more at peace with himself. Through his ability to engage in self-hypnosis he was able to revisit the scenarios or create his own, in a way that he could choose to visualise the eradication of his disease. At the time of writing this paper John is still alive, although his condition has deteriorated. Had the circumstance of client-therapist location not changed, there could have been an ongoing role for hypnosis as John's physical condition become worse.

CASE HISTORY 2

Client

Sue was a 32-year-old single mother of two boys. She had been divorced for two years, and had started a university course in nursing. Unfortunately she had contracted cancer of the ovaries and recently had the cysts removed by major surgery. She was in her convalescence when she consulted the author.

Presenting Problem

Sue presented with the problem that her life had become more stressful and that she wished to de-stress and relax more than she had in the past. She was worried about how she would cope with her university work, her children, and life in general. She also wished to use the power of her mind to make sure that the cancer was gone from her body.

Background

Sue married Brian at 19 years of age and they had two sons who were now 8 and 12. The marriage did not work out and after a difficult eight years they separated. Two years after separating, Sue learned she had ovarian cancer and that she would require an operation if she was to have any chance of survival. The operation was a success. However, Sue was not sure the surgeon had "got it all." She was concerned to do all in her power to make sure it was all gone and that it would not return.

Treatment

Sue was seen on three occasions, to help her reduce her anxiety, to realistically appraise her future prospects, and to manage her life. On her first visit rapport

was established and goals of therapy were elaborated. Hypnosis was discussed as she wanted to use more of her mind to exercise more personal control. Trance was induced through a concentration on her breathing, and deepening was achieved through walking down steps in a country garden. She was taken to her special place (a eucalypt forest) and encouraged to explore in an experiential way some aspects of her special place that she had not previously explored, such as the colours, sounds, textures and smells of the forest. She was requested to practise daily and a tape was made of the session for her to replay at home in her own time, each day. Her second visit was a week later and again involved facilitating trance, which she had become quite proficient at achieving, and revisiting her special place.

Experiential Analogy

During her second visit and when in a deep trance, and comfortable in her special place, Sue was encouraged to imagine that she was back at home, working on her computer and playing with the Pacman robot character game. She was then to imagine that she was the commander of the Pacmen and that their mission was to seek out and destroy any mutated cancerous cells in her body. Sue was to lead the army of Pacmen to the individual mutated cells, and destroy them with their ray guns. The different terrain of her internal organs was explored and any abnormal cells destroyed as if they were noxious weeds growing on the living landscape. Sue was encouraged to explore what the mutated cells would look and feel like, and what sounds, smells, and visual experiences would be present when they were destroyed. The Pacman army was to explore all aspects of her body from her toes to her head, seeking out any mutated malignant cells and destroying them. Emphasis was placed on her ability to see the cancerous cells, notice their texture, their colour, and their smell. She was also told that she could engage in this activity any time she chose to enter a trance and scan her body for malignant cells.

Outcome

Sue's health improved and a few months later she was able to resume her studies at university. Her ability to cope with life improved, her relationship with her sons was good, she was able to set aside time to relax each day, and her optimism for life improved. She felt better in her self, and at the time of writing had improved considerably, and her cancer was still in remission.

Conclusion

The preceding case studies have elaborated on the integration of experiential analogies within the psychotherapeutic context. While it is difficult to attribute the clients' attainment of medical and therapeutic goals solely to this technique, both clients reported it was this aspect of their therapy which was significant for them. They enjoyed it and felt a greater sense of control and power over their

disease. Experiential analogies in hypnotherapy can facilitate the client's achievement of therapeutic goals, and these case studies support this argument. Further, it is the author's experience that experiential analogies are enriched, and the probability of success is greater, if: the analogy is one of which the client has some experience; the five senses are explored; they include an exploration and confluence of the client's feelings and thoughts; and they are linked to concrete experiences in their day to day lives.

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ABSORPTION, HYPNOTIC EXPERIENCE, AND INSTRUCTIONAL SET

Suzanne M. Roche

University of New South Wales

Amanda J. Barnier

University of New South Wales

Kevin M. McConkey

University of New South Wales

On an administration of the Tellegen Absorption Scale (TAS), we first investigated the impact on absorption scores of whether subjects had or had not experienced hypnosis. On a subsequent administration of the TAS, we then investigated the impact of instructions for subjects to respond as if they were high or low hypnotisable. On the first administration, subjects who had and had not experienced hypnosis scored similarly. On the second administration, subjects instructed to respond as high or low hypnotisable increased or decreased their absorption scores, respectively. Implications for understanding the relationship between absorption and hypnotisability and the impact of instruction are discussed.

Absorption is a personality characteristic that involves an openness to experience emotional and cognitive alterations across a variety of situations (Tellegen, 1981; Tellegen & Atkinson, 1974; see also Roche & McConkey, 1990). The genesis of the construct of absorption lies in the search for reliable personality correlates of individual differences in hypnotisability. Tellegen and

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Requests for reprints should be addressed to Kevin M. McConkey, School of Psychology, University of New South Wales, Sydney, N.S.W. 2052. Email: K. McConkey@unsw.edu.au

Atkinson (1974) originally showed that hypnotisable individuals were more open and more likely to have subjective experiences in which their attention was almost wholly engaged in an altered sense of reality (see also Crawford, Brown, & Moon, 1993; Glisky & Kihlstrom, 1993). They labelled this "absorption" and introduced the Tellegen Absorption Scale (TAS) as the instrument for assessing absorption. The TAS asks respondents to consider 34 items that concern their involvement in various internal and external events (e.g., "I can sometimes recollect certain experiences in my life with such clarity and vividness that it is like living them again, or almost so," "When I listen to music I can get so caught up in it that I don't notice anything else") and to give a "true-false" response to each of those items. In the standard format, absorption is scored by summing the number of "true" responses to yield a score between 0 and 34; alternatively, a 5-point Likert-type format (0 = strongly disagree, and 4 = strongly agree) has been used for each item and then summed to yield a score between 0 and 136.

Roche and McConkey (1990) argued that absorption is central to an understanding not only of subjective experience in general, but also of particular aspects of cognition and behaviour. Consistent with this, Glisky, Tataryn, Tobias, Kihlstrom, and McConkey (1991) showed that absorption is related to "openness to experience" as indexed by the Openness to Experience subscale of the NEO Personality Inventory (Costa & McCrae, 1985; McCrae, 1993, 1994). Most research involving absorption, however, has focused on its relationship with hypnotisability (Roche & McConkey, 1990), which is a relatively stable characteristic of an individual that can be assessed through the use of standardised scales. These scales consist of an induction procedure and suggestions for various hypnotic phenomena, and subjects' responses are scored in terms of objective behavioural criteria and summed to give a measure of hypnotisability. The relationship of absorption with hypnotisability has been examined across most contemporary scales of hypnotisability, and a positive, usually modest, relationship between absorption and hypnotisability is well established (for reviews see de Groh, 1989; Roche & McConkey, 1990).

Two issues that concern the relationship between absorption and hypnotisability are the possible impact of recent experiences and the potential influence of instructions on absorption scores. In terms of recent life experiences, for instance, the absorption scores of male scientific personnel were higher shortly after, in contrast to before, a period of Antarctic isolation (Barabasz, Barabasz, & Mullins, 1983). In terms of instructions, for example, absorption scores increased when marijuana users were asked to consider their drug experiences exclusively and decreased when they were asked to exclude their drug experiences when completing the scale (Fabian & Fishkin, 1981).

Given these types of findings and given recent discussion about the reactivity of absorption scores to contextual influences (e.g., Council, Kirsch, & Grant, 1996; Oakman, Woody, & Bowers, 1996), "a determination needs to be made of whether absorption scores are influenced by the response set of subjects and by the overt and covert messages that subjects are given in different test settings"

(Roche & McConkey, 1990; p. 93). Accordingly, we investigated the relevance to absorption scores of (a) recent hypnotic experiences, and (b) instructions to respond as either high or low hypnotisable. To do this, we first administered the TAS to subjects with standard instructions. By checking the hypnotic experience of subjects, we could determine whether a recent hypnotic experience influenced the absorption scores of subjects. We then administered the TAS a second time with specific instructions that subjects should complete the scale as they believed high or low hypnotisable individuals would do so. This manipulation of instructional set was intended to determine whether subjects' perceptions of the relationship between absorption and hypnotisability would lead those instructed to respond as high or low hypnotisable to increase or decrease their absorption scores, respectively.

METHOD

Subjects

Four hundred and eighty-six (382 female and 104 male) undergraduate psychology students of mean age 22.60 years ($SD = 8.82$) at Macquarie University voluntarily participated in the study in return for research credit. Subjects were recruited via a noticeboard announcement to participate in a "Questionnaire Study." Parallel to but independent of the "Questionnaire Study" we were conducting a "Hypnosis Testing Study" that assessed the hypnotisability of subjects through the 12-item Harvard Group Scale of Hypnotic Susceptibility, Form A (HGSHS:A; Shor & Orne, 1962; see also McConkey, Barnier, Maccallum, & Bishop, 1996). The HGSHS:A sessions ran before the TAS sessions for three weeks, in parallel for two weeks, and after them for two weeks. By checking the date and time that subjects participated in the HGSHS:A and TAS sessions, we could determine whether they had experienced hypnosis before or after completing the TAS, or not at all. Two hundred and ninety-one (223 female and 68 male; age $M = 22.94$ years, $SD = 9.16$) subjects completed the HGSHS:A before they completed the TAS. Seventy-one (60 female and 11 male; age $M = 23.05$ years, $SD = 10.23$) subjects completed the HGSHS:A after they completed the TAS; and 124 (99 female and 25 male; age $M = 21.85$ years, $SD = 6.97$) subjects did not complete the HGSHS:A either before or after they completed the TAS.

Procedure

Subjects completed the TAS twice in groups of approximately 30 in a standard classroom setting. First, they were asked to complete the TAS with routine instructions; specifically, they were asked to respond to each item "in the way that best represents your opinion or describes yourself." The completed response booklets were collected. Second, they were asked to complete the TAS

in the way in which they thought either a high (or a low) hypnotisable person would complete it; specifically, they were asked to respond to each item "in the way in which you think someone who is very [not at all] hypnotisable would complete it ... indicate the answer that someone who is very [not at all] susceptible to hypnosis and hypnotic suggestion would give." For both the first (TAS1) and second (TAS2) administration of the scale, subjects responded to each item by circling a number that ranged from 0 - 4; these numbers were summed to give absorption scores between 0 and 136.

RESULTS

Table 1 presents the mean TAS1 scores and HGSHS:A scores together with the Pearson correlation coefficients between absorption and hypnotisability. A one-way analysis of variance of TAS1 scores yielded a significant main effect, $F(2,483) = 3.50$, $p < .05$; subjects who did not participate in the HGSHS:A testing at all scored significantly lower on absorption scores than those who participated in HGSHS:A testing before completing the TAS. The overall correlation between absorption and hypnotisability for all subjects who participated in both sessions ($n = 362$) was significant ($r = .124$, $p < .02$). Notably, the correlation between absorption and hypnotisability was significant for subjects who had participated in HGSHS:A testing before completing TAS1, but was not significant for subjects who had participated in HGSHS:A testing after completing TAS1. However, comparisons using Fisher's Z transformation revealed no significant difference between the correlations.

Table 1: Mean TAS1 and HGSHS:A Scores and Correlation Coefficients

	TAS1	HGSHS:A	r^2
HGSHS:A before TAS1 ($n = 291$)	88.35 ^B (16.75)	6.56 (2.71)	.143*
TAS1 before HGSHS:A ($n = 71$)	84.50 (19.94)	6.12 (2.85)	.029
No HGSHS:A ($n = 124$)	84.04 ^B (16.84)		

Note: TAS1 = Tellegen Absorption Scale (first test); HGSHS = Harvard Group Scale of Hypnotic Susceptibility, Form A; B indicates significant difference at $p < .05$; * indicates $p < .01$. Standard deviations appear in parentheses.

Table 2 presents the mean TAS1 and TAS2 scores for the two experience groups (i.e., recent hypnotic experience and no recent hypnotic experience. A three-way (experience \times instruction \times test) mixed-model analysis of variance of absorption scores indicated significant main effects for instruction, $F(1,358) =$

450.50, $p < .001$, and for test, $F(1,358) = 60.01$, $p < .001$, and significant interactions between experience and instruction, $F(1,358) = 4.17$, $p < .05$, and instruction and test, $F(1,358) = 687.22$, $p < .001$. Subjects instructed to respond as highs gave higher absorption scores overall than those instructed to respond as lows. Those instructed to respond as highs or lows increased or decreased their absorption score on the second test; the change from the first to the second test was greater for those instructed to respond as lows than those instructed to respond as highs. Notably, the effect of instruction differed according to whether subjects had been tested on the HGSHS:A recently or not. Of subjects instructed to respond as lows, those who had recent hypnotic experience had lower absorption scores than those who had not; of subjects instructed to respond as highs, those who had recent hypnotic experience had higher absorption scores than those who had not.

Table 2: Mean TAS1 and TAS2 Scores

Subjects	TAS1	TAS2
Previous hypnotic experience		
High	89.43 (14.99)	109.78 (17.10)
Low	87.25 (18.35)	46.65 (19.62)
No previous hypnotic experience		
High	82.25 (16.85)	106.80 (19.39)
Low	86.69 (19.92)	52.16 (18.85)

Note: TAS1 = Tellegen Absorption Scale (first test); TAS2 = Tellegen Absorption Scale (second test); High = instructed to respond as high hypnotisable; Low = instructed to respond as low hypnotisable. Standard deviations appear in parentheses.

We also investigated the relevance of the measured hypnotisability of subjects. To do this, we selected a subsample on the basis of extreme scores on the HGSHS:A. We defined high hypnotisable subjects ($n = 101$) as those who scored 9–12, and low hypnotisable subjects ($n = 55$) as those who scored 0–3 on the 12-item HGSHS:A. A four-way (experience \times instruction \times hypnotisability \times test) mixed-model analysis of variance of absorption scores was conducted with this subsample. It yielded significant main effects for instruction, $F(1,148) = 189.16$, $p < .001$, and for test, $F(1,148) = 27.77$, $p < .001$, and significant interactions between experience and instruction, $F(1,148) = 4.05$, $p < .05$, instruction and test, $F(1,148) = 245.81$, $p < .001$, and experience, hypnotisability, and test, $F(1,148) = 4.19$, $p < .05$. These findings parallel those from the previous analyses, with the additional finding that high and low hypnotisable subjects who had participated in HGSHS:A testing before and after completing the TAS responded differently across the two administrations of the TAS, irrespective of the instruction they were given. Whereas low hypnotisable subjects who had not had recent hypnotic experience before

completing the TAS (M change = -18.27 , $SD = 32.51$; note, mean calculated as change in score from TAS1 to TAS2) decreased their absorption score from TAS1 to TAS2, those who had recent hypnotic experience (M change = -2.80 , $SD = 38.41$) did not. In contrast, whereas high hypnotisable subjects who had recent hypnotic experience before completing the TAS (M change = -15.29 , $SD = 39.66$) decreased their score from TAS1 to TAS2, those who had not had recent hypnotic experience (M change = 5.16 , $SD = 27.31$) did not.

DISCUSSION

We investigated the influence of recent hypnotic experience and the impact of instructions to respond as either high or low hypnotisable on absorption scores. In terms of recent hypnotic experience, subjects who participated in HGSHS:A testing either before or after completing the TAS gave similar absorption scores. The absorption scores of subjects who did not participate at all in the independent hypnosis sessions were lower than those for subjects who participated in those sessions before completing the absorption scale. Although the slight correlation between absorption and hypnotisability was appreciable for subjects who participated in hypnotisability testing before, but not after, completing the TAS, the correlations were not significantly different between these two groups; in other words, the absorption scores of subjects were not influenced by a recent experience of hypnosis. The absorption and hypnotisability scores are similar to those obtained in other studies that have used a Likert-type response format for the TAS (e.g., Glisky et al., 1991) and assessed hypnotisability with the HGSHS:A (e.g., Hoyt et al., 1989). Also, the modest relationship between absorption and hypnotisability for all subjects who participated in both sessions ($r = .124$, $p < .02$) is similar to that seen in other studies between the TAS and the HGSHS:A involving similar numbers of subjects (e.g., Nadon, Hoyt, Register, & Kihlstrom, 1991).

Absorption and hypnotisability were assessed in independent programs of research in the present experiment, and the relationship between them was found to be positive, and consistent in magnitude with that reported in other studies (see Council et al., 1996; Roche & McConkey, 1990). This is not supportive of the view of Council, Kirsch, and Hafner (1986; see also Council et al., 1996) that the relationship between absorption and hypnotisability is an artefact of the context in which absorption is measured. In contrast, our findings suggest that the context of the administration of the TAS has relatively little effect on the relationship between absorption and hypnotisability (see also Nadon et al., 1991). It is reasonable to ask what does affect this relationship, if not context. More parsimoniously, perhaps, the variation in the size of the correlations, both in this experiment and others, may reflect random sampling error due to differences in sample sizes. Nadon (1997) argued that, regardless of administration contexts, studies of the relationship between absorption and hypnotisability that involve relatively small samples produce both small and

large population correlation estimates, whereas studies that involve larger samples produce mid-range estimates that more closely estimate the population correlation coefficient. Notably, in the present experiment, although the correlations were not significantly different, the smaller correlation (.029) was associated with a much smaller subgroup sample size ($n = 71$) than the larger correlation (.143; $n = 291$).

Whereas our results demonstrate that the context of testing, at a general level, does not necessarily influence the relationship between absorption and hypnotisability, there is little doubt that subjects rely on aspects of the situation to guide their interpretation of experimental tasks. This is seen clearly in our findings about the impact of instructions to respond as high or low hypnotisable. Those subjects instructed to respond as highs increased, and those instructed to respond as lows decreased, their absorption scores. This suggests that subjects held particular beliefs about the relationship between absorption and hypnotisability.

Arguably, their responses to the second administration of the TAS, under the special instructions, indicated that they saw the relationship between absorption and hypnotisability to be a strong and positive one. Notably, subjects' perceptions of that relationship are stronger than the actual relationship. In other words, subjects' responses indicated that the TAS scores of lows would be lower, and those of highs would be higher than were found in this experiment. This pattern of response may have been influenced by the general views that people typically hold about the characteristics of those who are high or low in hypnotisability, and it may have been influenced by the wording of some of the items on the TAS. For example, items such as "If I wish, I can imagine that my body is so heavy that I could not move it if I wanted to" convey a positive relationship between absorption and the capacity of people to experience items that assess hypnotisability. Whatever the specific reasons, the absorption scores of subjects changed significantly when they were asked to adopt a particular level of hypnotisability while they were completing the TAS.

These findings demonstrate that TAS scores can be influenced substantially by the instructional set that subjects are given or the response set that subjects adopt (see also Fabian & Fishkin, 1981), and this finding is consistent with the views of Roche and McConkey (1990) and Tellegen (1981). As Tellegen (1981) argued, personality variables, such as absorption and hypnotisability, are inherently contextual in the sense that they become apparent in settings that are consistent with and encouraging of their existence and expression. In other words, the capacity for absorption becomes apparent when the situation is one that encourages the individual to display that capacity. That is what occurred in the present experiment when subjects were asked to complete the TAS as a high (rather than low) hypnotisable individual would. In this sense, there is no question that certain contextual factors (such as instructional set) will play a role in the assessment of absorption, the assessment of hypnotisability, and the relationship of absorption and hypnotisability. However, that role is an integral

rather than an artifactual one.

Finally, to better understand the interactive nature of absorption and its relevance as a personality characteristic, research is needed to clarify the specific private and public situations in which absorption is manifested. As Glisky et al. (1991) pointed out, openness to experience, and absorption as a salient aspect of that trait, is one of the major factors of the "big five" dimensions of personality (McCrae, 1993, 1994). Given this, a more complete understanding of absorption and the factors that influence its assessment and expression can contribute towards our understanding of personality structure, as well as its relationship to hypnotisability and hypnosis.

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HYPNOSIS IN OBSTETRICS

Patrick McCarthy

Medical Practitioner

Clinicians trained in hypnosis often state that hypnosis is beneficial in childbirth, but few have actual personal experience of teaching hypnotic methods to pregnant women. This paper reviews some recent literature confirming the value of hypnosis in childbirth and also outlines a simple structured hypnotic approach for clinicians to utilise which can be taught in just two and a half hours during the third trimester. Labour length, analgesic requirement, and anxiety are decreased; satisfaction with labour and spontaneous deliveries are increased; and there may be a reduction in the incidence of post-natal depression.

From the very start of my basic training in clinical hypnosis, I have been particularly interested in the application of hypnosis to women in childbirth and have sought over the intervening years to discover the optimal and most effective and practical way to help a woman use her hypnotic talents to have a better experience of labour.

There are several textbooks and reviews which mention teaching hypnosis for use in labour (Beck & Hall, 1978; Burrows, 1978; Charles, Norr, Block, Meyering, & Meyers, 1978; Davenport-Slack, 1975; Erickson, Hershman, & Selter, 1961; Fee & Reilly, 1982; Hilgard & Hilgard, 1994; Stone & Burrows, 1980; Waxman, 1989; Werner, Schauble, & Knudson, 1982). Research from the last decade shows the value of hypnotic techniques in labour. The largest study (Jenkins & Pritchard, 1993) compared 126 primigravidas and 136 secundigravidas with 300 age-matched controls in each group. Each of the hypnosis participants received six sessions of individual hypnosis. The end-points measured in the study were analgesic requirements and the duration of the first and second stages of labour. The primigravid women had a highly significant reduction in the duration of the first stage of labour of almost three hours and a smaller reduction in the duration of the second stage of labour. The women having their second child also had a significant reduction in the duration

of the first stage of labour but not as much as the primigravidas and there was no significant difference in the duration of the second stage. This study found that a hypnotised primigravida has the same duration of first stage labour as a non-hypnotised secundigravida. Both hypnosis groups required significantly less analgesics.

Another study (Brann & Guzvica, 1987) looked at 96 women from a general practice, with roughly half the group opting for hypnosis training and the other half opting for relaxation classes. The first stage of labour was reduced in the hypnosis group and this was again more apparent in the primigravid women. Other reported benefits included greater satisfaction with labour, reduction in anxiety, and help with getting to sleep. Harmon, Hynan and Tyre (1990) produced a six-session randomised study using group hypnosis involving 60 volunteer women having their first baby. In this study, the women's hypnotisability was tested prior to randomisation. Half the subjects in each group received a hypnotic induction at the beginning of each group session and the control subjects received relaxation and breathing exercises typically used in childbirth education in Wisconsin. Thus, the 60 women were divided into four groups of 15. High hypnotisables with hypnosis; high hypnotisables without hypnosis; low hypnotisables with hypnosis, and low hypnotisables without hypnosis. What they found was a significant reduction in pain in both the hypnotised groups and in the high hypnotisables in the control group. Again, this study showed shorter first stage of labour, less medication, and more spontaneous deliveries than for the controls. A fascinating incidental find was that the highly hypnotisable women who had hypnosis had lower MMPI scores after birth than the other three groups. This study measured ischaemic pain task scores during the training. The hypnosis subjects performed better than the non-hypnosis subjects, but most of the pain threshold improvements occurred in the high hypnotisables. This backs up work showing a correlation between hypnotisability and the ability to alter pain thresholds (Hilgard, 1979).

Oster (1994) proposed an elegant six-session model for individual use but this takes six hours to teach and reduces its acceptability. More recently a two-session individual approach, has also been reported in two case studies (Sauer & Oster, 1997).

Over the last six years I have developed a four or five 30-minute session individual approach which takes a total of two-and-a-half hours teaching time which I have now taught to over 600 pregnant women. First, there is a fundamental philosophical and practical question to address. Should obstetric hypnosis lessons be given to a group of pregnant women or be taught individually? My view is that we would not claim that one type of dress will suit all the pregnant women in a group; nor would one hairstyle, one pair of shoes, or one pair of spectacles suit each and every woman in the group; so why then should we assume that one standardised hypnotic approach would suit all pregnant women? The only factors that a group of pregnant women have in common are that they are all female and that they are all pregnant! Individuality

is a very important point. When an individual becomes pregnant she becomes a pregnant individual! Some authors and practitioners of obstetric hypnosis advocate group lessons on the grounds of saving time and say that the women are essentially going to have similar experiences so they may as well have similar training. Each woman has her own unique background of culture, education, expectation, and experience. She brings her own parity, hypnotisability, and motivation. She may well be female and pregnant, but most of all she is unique. Teaching someone as a unique individual implies teaching her uniquely and individually.

What should the content of the lessons be? There is not a specific set of words that can be used in hypnosis to wonderful effect with all pregnant women. The principle behind my approach is that of hypnotic phenomena utilisation. The actual words are not vital. We have to think about the hypnotic phenomena we would like to elicit, but also to consider the abilities of each woman and modify our approach which will vary with her hypnotisability and motivation. While it is true that virtually any woman can learn hypnosis and that virtually any therapist can teach hypnosis, the key to success is working together as a team to find the best teaching and learning methods for each pregnant individual.

Listen to a woman who has had a previous awful experience of childbirth. Listen carefully to the language she uses to describe her labour. Listen to how the labour seemed to go on forever; how she could feel the contractions tearing her apart; how she felt unable to push any more; how traumatised and helpless and out of control she felt; how her baby and belly became a "thing"; how, at times, she could even float on the ceiling and see her body below surrounded by doctors and nurses. Listen to such language and listen to the similar language of patients with post-traumatic stress disorder. Listen to the dissociative flavour of the reports of bad labours. The key point I take from this is that there is a clinical association between PTSD, dissociation proneness, high hypnotisability, and a potentially dreadful experience of labour.

Highly hypnotisable women have hypnotic talent. But hypnotic talent can be a double-edged sword. They can use their talent constructively to lessen pain and reduce labour time, but they can also unwittingly use the very same talents of creative imagination to intensify their awareness, their experience, and their suffering.

Let us imagine a highly hypnotisable woman, who is not trained in how to use her hypnotic talent constructively, is having a difficult labour and becomes apprehensive. She could start to use her hypnotic talent inadvertently and unintentionally to intensify awareness. She could begin to distort her perception of time and feel that her contractions seem prolonged. She could feel that the resting gaps between contractions have shortened. She could have the opposite of dissociation — namely, association — and notice her contractions in great detail. She could despair that the labour will never end and have no hopeful light of expectancy at the end of the tunnel. She could only look backwards at all the

contractions she has had and at all the hours she has been in labour. She could start to imagine the baby becoming wedged in her pelvis and she could increasingly become more and more anxious, frightened, and tearful, with a growing sense of being "out of control." This increases her adrenaline production and her nervous system responds by tensing her muscles. The womb is essentially a huge group of muscles. Tense muscles do not work as well. Cervical dilatation will be impaired. Her labour will slow down and she can indeed begin to have a labour reality that nightmares and PTSD are made of.

METHOD

With this in mind, the focus of my approach is to teach a woman how to positively use any of the well-known phenomena of hypnosis that she is capable of generating to enable her to have a better experience and, hopefully, a much better outcome. I start with a pre-induction discussion in which I assess her hypnotisability and correct any mistaken concepts she may have about hypnosis. I explain that there will usually be four hypnosis lessons, once a week, each of approximately half an hour, and that I have found from experience that the best results are obtained by finishing the training as close to her actual delivery date as possible. Like an athlete, I want her to peak her hypnotic performance just before labour. The only problem, however, is that, unlike an athlete, she does not normally know the date on which her championships will be held. Furthermore, she does not know if she is to be entered in a sprint, a middle-distance race, or even a marathon. I invite each woman to personally choose the date of her final teaching session and we then make the appointments for the three previous weeks.

Session 1

The first hypnosis session is her introduction to hypnotic trance. I have found it is best to make this session simple, effective, and soothing. I would normally use directed eye closure; very permissive empowering language; and a slow, gentle, respectful induction of a type which is easy for her to remember and repeat in self-hypnosis. I would normally then use simple old-fashioned progressive muscular relaxation as a deepening technique. Tensing is not necessary. I would normally start at the feet and work up to the head. I then explain that this is what I call a trance and I ask her to verbalise how she feels and what her individual experience of trance is like. I then bring her gently out of trance back to full awareness and let her tell me how that experience felt. I then teach a simple type of self-hypnosis and ask her to practise going into trance at least once each day, perhaps deepening by progressive muscle relaxation and then utilising the trance to think about lovely memories from the past or, even better, to start to anticipate wonderful "memories" of the future. I give her a tape recording of her personalised session to take home.

Session 2

The following week I begin by asking her to put herself into trance. This is the real work session. I deepen trance by inviting her to remember the sound of my voice and the memory of her past trance experiences. I then usually move to imagery of a beach scene. Every image selected is based on the likely physiological sensations she will experience. If she is a very visual person I emphasise the sights of the beach, but also bring in lots of auditory and kinaesthetic suggestions when appropriate. The essence of the beach imagery is of a series of waves that gradually come rolling in, crash and tumble on the beach then go down and down, till they are gone. I point out that this imagery fits with the pattern of a contraction, which rises up, reaches a peak and then goes down. I then invite her to utilise the electrochemical transmissions from the womb to the brain to create and time the imagery of the waves. Obviously the bigger the wave, the more efficient the contraction has been. I then suggest there is no point in remembering each and every wave so that she can allow the washing away of the wave to wash away the memory of the wave and also the memory of the contraction so that each new wave is a whole new experience to enjoy. This imagery usually works extremely well, but towards the end of the first stage of labour there are a few very powerful contractions known as transition. This phase does not last long, but it can be powerful and distressing.

I often insert a reframing suggestion along the following lines: "At some point you may find that the waves change and become big surfing waves. This is the sign that it will very soon be time to start to push the baby out into the world. So before you start the pushing you can take advantage of those last few waves and get on your surfboard and ride the surf in your imagination rather than simply just watching it."

For the second stage, I quickly demonstrate arm rigidity to show that hypnosis is not simply about relaxation but can also produce astonishing strength. I use a basic suggestion of a steel bar within the arm. This is fine for demonstrating muscle rigidity but is the wrong imagery for the second stage. One of the best images I have found to use for the second stage is of standing at the bathroom sink with a full tube of toothpaste. "Take the cap off and place the fingers of both hands at the base and, on the signal 'PUSH,' squeeze the tube as hard as possible and see the toothpaste cascade into the sink. It flows quickly at first, then slows down but still just moving. Quickly reposition the fingers a bit higher up, and as you do so, see the toothpaste start to sink back a tiny fraction into the tube. Then, squeezing again as hard as you possibly can, see and feel the toothpaste pouring into the sink." This imagery fits with the physiological movements of the baby within the birth canal and it conveys the concepts of concentrated effort, selective involvement of the correct myometrial and pelvic muscles and a wide floppy vulva. Then I suggest that, for the final push, the baby will be slippery like a wet bar of soap and can come slithering

out with a minimal push at the very end. This final suggestion prevents explosive delivery and minimises vaginal tears.

The next aspect I call pre-natal bonding. I suggest that she imagines having just given birth and holding her baby in her arms and cuddling the baby, feeling surrounded by love, joy, and happiness. This is an age progression. Primigravidas often find it difficult to visualise the baby's face but multips find this quite easy. Often it can be quite emotional. I then make a direct post-hypnotic suggestion that at any time during the labour, if she has any worries or anxieties she can use this "memory of the future" to fill her heart with joy and happiness to wash away any anxiety.

I then usually directly suggest she is already developing a special relationship with her baby and that she can actually communicate her love to her baby while still in the womb. I ask her to think about the baby in the womb and transmit mental pictures of images of cuddling the baby and sending loving images. It is astonishing how often, if the baby is awake, within less than a second the baby in the womb that has been peaceful till then, starts kicking and moving quite dramatically. The rapidity of this change in the baby is astonishing and is not coincidental. I tell her this is her baby communicating in response and that the baby is telling her that the love is mutual. The onset of the dramatic movements seems like a nerve reflex, but there are no nerves in the placenta or umbilical cord connecting mother to baby. If this is a neurohumoral response it would have to travel through two circulatory systems and would thus be too slow. This is the closest thing to telepathy, if such a thing exists. When this physical change occurs I tell the mother that she can communicate in symbolic language with her baby. She can practise this before birth. During labour she can thus "reassure her baby who has no knowledge of labour and the baby can also reassure her that all is going well."

That is a busy session but it conveys the really key points and can be completed in 30 minutes. I tell her to practise this imagery every day and give her a copy of the tape. I find it very useful for her midwife to attend this session and I have found that my own patients obtain particularly good results when a midwife, whom I have trained in the principles of hypnosis, gives supportive suggestions. I am not normally present throughout the delivery but the midwife is. She can tell if there is any diminution of the trance and can give appropriate deepening suggestions between contractions.

Session 3

The third session concentrates on two specific skills — dissociation and anaesthesia. I teach a basic dissociation exercise where the expectant mother steps out of her body and perhaps sits by a stream and feels the cool water on her feet while she sits on some grass with her back supported by a tree. I would teach her how to observe her physical body from a distance in the hope that, should she have a difficult labour, she can either spontaneously or deliberately choose to dissociate to a place of safety.

For anaesthesia I use suggestions aimed at producing glove anaesthesia and when this is established I usually demonstrate the numbness of the hand using a pin. If she responds well to this, with either complete or partial hypnoanalgesia I then give her the option of two suggestions: (a) either a pair of tights made of the same material as the anaesthetic glove, or (b) that she step into a spa pool and a liquid is poured in that is the same colour as the anaesthetic glove. Both these suggestions often produce lower body hypnoanalgesia. Women who have previously had an epidural can be asked to boost the action of the hypnosis by accessing at some level a memory of their prior epidural. Time distortion can be helpful and can also be suggested either directly or, perhaps better, indirectly.

Session 4

The fourth, and usually final, lesson is an opportunity to refresh and clarify any misunderstandings. It can be used to complete the training in a slow learner but I find it best, as in sports psychology, to use the final session as a slight unwinding with very little, if any, new training being given. This is a good time to make a series of simple post-hypnotic suggestions and, because this is the final lesson, they do not have to be remembered for long. Make suggestions regarding a quick recovery, feeling energised, establishing a good milk supply, making a strong bond with baby, and a healthy adjustment to the role of being a mother. Finish the session with genuine praise and encouragement for all the effort and practice she has put in over the last three weeks. Encourage her to continue daily practice and make a fifth appointment as a backup in 10 to 14 days. Normally this would not be needed unless she goes beyond her dates or has chosen very early sessions, but I find that when there has been more than two weeks since the final session that the results are not as good.

The incidence of post-natal depression after childbirth is approximately 10%. However, I realised a few years ago that none of the 600 women to whom I have taught obstetric hypnosis using the above approach has developed post-natal depression, to my knowledge. It is hard to know if this is an artefact of self-selection. All the volunteers might have come from the 90% who were never going to develop it anyway. The recurrence rate for PND when it occurred in a previous birth is about 60% and none of the women who have previously had PND developed it after hypnosis training. However, the numbers are too small to make definitive statements. This could well be a fascinating and useful area of future research.

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HYPNOSIS IN THE TREATMENT OF DYSPHONIA

Anthony Mander

Medical Practitioner

This report describes a case of hysterical dysphonia in a male patient, successfully treated using hypnosis as an adjunct to therapy.

Dysphonia is a disorder of the ventilatory pump or vibrating vocal cords. The pump pushes the expired gases past the vibrating vocal cords and produces the sounds that are then modified by the muscles of articulation to produce speech (Hopkins 1993). Low volume of expired gases, paralysis, or a mechanical problem will all result in dysphonia which, in the patient Trent, presented as hoarseness. Of particular relevance to him was the differential diagnosis of spasmodic dysphonia (SD) which usually appears in adulthood. As the name suggests, speech is characterised by jerky or choppy breaks in phonation, staccato-like catches, strain, strangled or harsh voice quality, and monopitch. It is also frequently associated with laryngitic discomfort and this closely resembles the picture with Trent.

Trent complained that his problem had begun one year previously, after a bout of flu. Again, this is consistent with SD, which often begins after a sore throat. Approximately two-thirds of SD patients have evidence of an organic problem, but the remaining one-third have a totally normal examination, aside from the speech abnormality. In this situation, it is not known whether their disturbance is functional or represents vocal dysphonia (Bradley, Daroff, Fenichel, & Marsden, 1989).

The term "functional disturbance" is often used to describe the group of patients for whom no organic cause can be found. Clearly, in many cases, there may well be an organic cause but one which remains elusive to examination. However, in other cases, there would appear to be no organic lesion and this leads into a consideration of malingering or hysteria. The distinction between these two is often an act of faith on the part of the therapist. In DSM-IV (American Psychiatric Association, 1994) the term "hysteria" has been dropped

in favour of "conversion disorder," the essential feature of which is the presence of symptoms or deficits affecting voluntary motor or sensory function, judged to be associated with the symptom or deficit and not intentionally produced or feigned.

PATIENT'S PRESENTATION

Trent presented initially to his GP. He began having speech difficulties during a bout of flu, but following the resolution of the infection, his voice did not recover. A full physical examination and a computed tomography (CT) scan of the vocal cords showed no abnormality.

A psychological basis for the problem was suspected because Trent's wife had noted he talked normally in his sleep, could talk properly when shouting, and, following a course of acupuncture, had one or two days with a normal voice. In all cases of this disorder, careful exploration of possible secondary gains is mandatory, but none could be found in this case. In particular, there was no pending compensation claim and, if anything, the effects of his affliction were all negative. He had given up his position as a senior instructor at his local gliding club and was close to giving up his post as captain of the local golf club. Immediately before seeing me, Trent had been off work for five weeks as a result of this problem and his job was at risk. Given the pattern of his presentation, a diagnosis of hysterical dysphonia (more correctly referred to as conversion disorder with motor symptoms) was reached.

PERSONAL HISTORY

Trent is a 48-year-old married man without children. He comes from a large family, having four sisters and four brothers. His parents are both still alive, his father being a retired bus driver and his mother a retired school cleaner. There was no history of psychiatric problems in Trent or his family and he had no major medical difficulties. He does not use illicit drugs and, from the age of 16, had only drunk moderate amounts of alcohol well within the accepted safe drinking limits. He described a happy and uneventful early life, joining the navy when he was 16. He was married in his early twenties and had no children because of his wife's fertility problems. He was in the Royal Australian Navy for 22 years. He left under difficult circumstances, having been court-martialled for an alleged misdemeanor, a conviction which was subsequently overturned. He described a long period of soul-searching with regard to his wife's infertility. This seems to have been a major focus of problems for the couple and attempts at adoption had not been successful.

Following his dismissal from the service, Trent started business for himself as a dental technician. He described himself as being perfectionistic and extremely self-critical. As a result of this, he never seemed able to relax and was constantly under time pressure. He would procrastinate and found that he worked in excess of 70 to 80 hours per week, leaving him no time to enjoy his

social life. He was unhappy about this, although careful screening revealed no evidence of a depressive illness.

At interview, he seemed a moody and rather taciturn individual. His history had to be taken over a number of sessions since, after speaking for approximately 20 or 25 minutes, he would find it too painful to continue and his voice would virtually cease.

SUITABILITY FOR HYPNOTICALLY BASED TREATMENT

There were no obvious contraindications to hypnosis with Trent. There were at least two legitimate approaches. One would be to use hypnosis in an analytical fashion and explore the possible blocks to free speech using ideomotor signalling. The second approach, and one which I eventually chose, was to use hypnosis as a way of bringing about muscular relaxation and the return of normal voice patterns. These approaches are, of course, not mutually exclusive. General ego-strengthening also seemed legitimate, given that organic causes had been excluded. The hypothesis that conversion disorders have a psychological cause also pointed to the likely success of hypnosis as an intervention. The case was difficult as there are no clear scripts or approaches for such a condition. Hypnotic capacity was assessed with the Creative Imagination Scale (Wilson & Barber, 1978), on which Trent scored 15.

I elected to use general ego-strengthening (Hartland 1971) and relaxation, using a visualisation approach to the particular muscles involved in phonation. To assist Trent in accurately visualising the area, I used a copy of *Grants' Atlas of Anatomy* which has detailed anatomical drawings of the musculature around the larynx (voice box).

GOALS OF THERAPY

1. To restore normal voice function
2. To explore possible underlying psychological conflicts if this was not successful.

PROGRESS OF THERAPY

As with all patients, treatment commenced with a careful description of what hypnosis entails. This is always important to overcome any misconceptions and possible resistances, particularly relevant to Trent. He is one of the few patients referred to me specifically for hypnosis. In general terms, hypnosis is always used as an adjunct to other therapeutic techniques in the context of helping patients with a specific problem. Trent was desperate and saw hypnosis, not only as a potentially "magic" cure, but also his last opportunity for help. This set up expectations and demand characteristics that could militate against a successful induction.

While his response to the suggestibility scale suggested Trent was a good

subject, in the first session of hypnotherapy following the assessment, only a very light trance could be obtained using an eye fixation and distraction technique. Trent reported some difficulty focusing on mental events and, while a light eyelid flutter was noticed, there was no other sign of relaxation. Because of this, the following session was spent debriefing the first session, to increase the chance of a successful induction. I explicitly discussed the effect of the demand characteristics of the situation and how this was getting in the way of treatment. I reinforced strongly that hypnosis was a skill for the patient to learn and that the more he "willed" it the less likely it was to occur.

During session 3, I changed the induction technique to that described by Chiasson (1990). My rationale was that, with Trent looking at and concentrating on the back of his hand and using a slightly more permissive script to increase his curiosity, we might well be able to offset the difficulty he had in focusing. Whether this is the correct explanation or not, a deep trance was obtained and trance ratification confirmed a very convincing lid cataplexy. Trent was in a deep trance and this was deepened further using a fractionation approach. Amnesia using a post-hypnotic suggestion and the induction of dreams were also elicited.

During session 5, Trent was taught self-hypnosis and was also given a post-hypnotic suggestion to practise this. I was intrigued to know whether there was any improvement in his voice just from the hypnotic state alone. I rarely get a patient to speak when in trance, because of the trance state lightening. However, I reasoned that Trent's trance state was so deep that this was unlikely to be a major problem. This proved to be so and, indeed, his voice quality was nearly normal in the hypnotic trance state. At this stage, I did nothing further but reinforced to him a full and complete memory of his normal voice when out of the trance situation. During the debriefing, it was clear his experience in trance had the beneficial effect of convincing him, first, that there was no serious physical problem with his voice and, second, that hypnosis was going to be effective.

Further treatment occurred over sessions 6 to 10. Hartland's ego-strengthening script (1971), modified to use a more permissive style, was given within each session to try and harness Trent's enthusiasm and positive disposition to the treatment. The main part of each session, however, consisted of him visualising the affected area and then practising relaxing his muscles. Between sessions 6 and 7, he noted that his voice had been returning to normal for periods of up to an hour and the use of self-hypnosis on a regular basis had led to him thinking up a sailing analogy with regards to his larynx. He pictured the muscles of the larynx as being like a sail and used nautical terminology to describe it. He said that, when his sail was "luffing," his voice was not active. The luffing position on a sail is when it is flapping in the wind and only partially filled with air. He then needed to bring his sail into a position that would be equivalent to a yacht that was "close hauled." In this position the yacht is sailing as close to the wind as possible and the sail is fully and smoothly filled and held

tight in with respect to the main axis of the yacht and is, therefore, under the maximum possible tension. This was an interesting analogy; in some ways he was right in that the aim was to get his musculature to be smooth and resonant rather than flapping ineffectively, on the other hand this was to be achieved by relaxation rather than increasing the tension which would be required in his analogy. This put me in rather a quandary, but I decided to go with his analogy as he described it, as I believed that trance logic would operate to make the analogy meaningful. On this basis, I added the suggestion that his sail needed to be close hauled when he felt the first tightness in this throat during a normal conversation. I confidently predicted during his hypnosis that there would be an increase in the number and length of the good spells he was experiencing and encouraged him to use his voice normally.

OUTCOME

After a total of 10 hypnotherapy sessions Trent had approximately 95% function of his voice with only occasional loss, with which he would cope using self-hypnosis. He contacted me two months after the end of treatment to tell me that his voice had returned to normal

CONCLUDING COMMENTS

Hysterical dysphonia is a rare condition and, in this case, presented with none of the usual precipitants, in a patient with an apparently stable premorbid personality and past history. Treatment was challenging, as there were no available scripts for such a condition. I was guided in general terms by suggestions for other neurological disorders, such as the treatment of involuntary muscle jerking and Bell's Palsy (see Hammond, 1990). In addition, Trent was committed to the treatment process and his own suggestions proved to be very powerful in bringing about a resolution. Trance logic appears to have been useful in ensuring that his analogy worked, even though anatomically it was incorrect. The case also demonstrated the importance of taking time to debrief the individual and to deal with unrealistic expectations that might impede a successful outcome.

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PREPARATION FOR SURGERY USING HYPNOSIS

Jacquie Schutz

Medical Practitioner

The power of hypnosis in overcoming strong negative expectations and adverse past experiences is demonstrated in this case history. Hypnosis enabled the client to achieve a sense of mastery over her illness, and maximised the likelihood of a good surgical outcome.

Amanda is an acquaintance of mine. Knowing that I was studying hypnotherapy, she enquired as to whether hypnotherapy would be of assistance in her preparation for surgery. At that time she was also using aromatherapy to promote relaxation and healing.

Amanda sustained a third-degree tear (from vagina through to the rectum) during childbirth, twelve months prior to her presentation. This resulted in the formation of a recto-vaginal fistula, the repair of which required several operations. She underwent the first procedure, the formation of a resting ileostomy, when her son was four months old. This operation was complicated by small bowel obstruction, which resulted in severe pain and protracted vomiting, and doubled her hospital stay. Repair of the fistula was carried out one month later. This involved a large area of her perineum and was complicated by wound breakdown and delayed healing. Amanda endured many months of severe discomfort and embarrassment as the entire area was quite tender and she suffered from faecal incontinence. The delayed healing also resulted in several postponements of the final planned procedure, that of closing the colostomy. This was the procedure Amanda was preparing for.

The traumatic events of the past twelve months had seriously affected Amanda's self-image and confidence. Prior to childbirth, she had been in excellent health and had never considered the possibility that having a child could lead to such morbidity. She found it difficult to explain her problem to most of her friends and even encountered problems with some of the nursing staff caring for her in the hospital. The body area affected was her most intimate

and she found it difficult at times coping with frequent examinations and the number of different doctors involved in her care. She found herself becoming excessively cautious about anything affecting her body and sometimes worried that she was becoming obsessive about her perineum and its fragility. During this time she also had to meet the demands of her infant son, her first child.

Amanda also experienced a profound sense of lack of control. Prior to her confinement she was a successful journalist who also enjoyed hobbies such as art and dance. She was physically fit and financially secure. Her illness drastically altered her body image, prevented her from participating in any sports or employment, and put her in a situation of helplessness.

BACKGROUND

Amanda had a past medical history of mild asthma, which rarely required treatment, and a repetitive strain injury to her right wrist. She had had no past experience with hypnosis but had seen a stage hypnotist on television. She believed hypnosis to be a powerful medium and was interested in seeing if she could benefit from it. She thought that she would not be a good subject as she felt that she was a very analytical person who liked to be in control. Her father voiced his concerns about hypnosis and "the risk to someone else controlling your mind whilst in trance."

Amanda is the second of three daughters in a close and supportive family. Her father is a minister with the Baptist Church and her mother is a teacher. Her parents and younger sister live together nearby, as does her older sister who is married with a young daughter. All of the family are in good health. Amanda's family have been the major source of both practical and emotional support for her. Amanda has been married to Kurt for four years and describes their relationship as very close. Kurt had been extremely supportive throughout her treatment. Their son, Jake, was healthy, but slept poorly overnight and was a very demanding breast-feeder.

Hypnosis was very likely to be beneficial to Amanda for a number of reasons:

1. There were no contraindications.
2. Amanda showed a positive attitude towards alternative therapies including aromatherapy and naturopathy, and was open to the possible benefits of hypnotherapy. After an explanation about what hypnotherapy involved, with careful emphasis on the importance of learning self-hypnosis and mastery over one's self, she felt confident that she would not be harmed by it. She was highly motivated to achieve a better outcome for this operation.
3. Amanda and I had already established good rapport and trust. The therapy was unlikely to take us into areas that Amanda would be uncomfortable sharing with me and she understood that we could cease therapy immediately should she wish to.

4. The presenting problem was amenable to hypnotherapy. Through hypnosis pain control, efficient wound healing and bleeding control can be achieved. Hypnosis can also be used for relaxation and the establishment of a positive expectation about the surgical outcome. Through the use of self-hypnosis and ego-strengthening, some control can be returned to the patient.

TREATMENT PLAN

Amanda was able to visualise very easily and in great detail, a scene suggested to her. Her expertise in painting and drawing also suggested that visualisation techniques would be useful for her. I decided, therefore, to use visualisation to facilitate trance, deepening and to enhance suggestions of healing and relaxation. I planned to demonstrate the mastery that Amanda had over her body in hypnosis to increase her feelings of control, give her direct suggestions that the surgery and recovery would go well, and rehearse the experience with her. Learning self-hypnosis would be an integral part of therapy. In consultation with Amanda it was decided to adopt a direct approach as time was limited and this best suited my abilities.

Session 1

The first session involved history taking and an explanation of what the hypnosis would involve. Hypnosis was induced using Wicks' eye fixation and distraction technique (Wicks, 1996), followed by deepening using progressive relaxation.

I then asked Amanda to think of a place she had been to, in which she felt relaxed and happy. She was asked to look closely at everything around her noting the richness of the colours, the pleasantness of the view, and the good feelings accompanying the site. She was also to notice what the weather was like, what sounds she could hear and what she could smell. Requests for her to note her surroundings were accompanied by suggestions that everything she experience in that place would generate feelings of peace, happiness, contentment and security. I also suggested that she could feel quite healthy and physically comfortable in this place. It was also emphasised that this place belonged exclusively to Amanda and was somewhere she could visit in the future if she needed or wanted to.

Therapy was then continued using Garth's script "The Colors of Healing" (Garth, 1994) as a basis for employing the colours in Amanda's special place to create feelings of healing, vitality and inner peace. At this point, I noted that Amanda was moving her hands as though she was feeling something run through them. I later learned that she had gone to a favourite beach and was sifting sand through her fingers.

I taught Amanda a self-hypnosis technique using eye fixation and a countdown from 5, with eye closure on 1, at which point she would go into trance and find herself at her "special place." After practising this a few times,

I terminated the trance using a count up from 1 to 5 with associated suggestions of return to normality and full alertness, but with retention of the feelings of well-being experienced during the trance.

The session ended with a discussion with Amanda about her experiences in trance and how she felt about them. Amanda enjoyed the experience immensely and said she was reluctant to leave the beach she had "visited." My observations of her during the trance, particularly when she began "sifting sand," led me to conclude that she was a highly hypnotisable subject and this was confirmed by Amanda's description of her experience. She dissociated readily and really felt as though she was at the beach. When describing her experience with the healing colours she reported a sudden, powerful feeling of going deeper into trance when the colour yellow was described (yellow is used to represent the mind in this script). This feeling remained throughout the rest of the colours. When the colour white was introduced, which represents cleansing and purity, Amanda reported feeling the presence of God close to her (she is a practising Christian). This overlap between strongly held spiritual beliefs, their association with particular colours, and their spontaneous appearance in the therapy, was fascinating. I made a note to include these beliefs in future therapy as I took their appearance to indicate that they were very important to Amanda.

Session 2

Prior to commencing hypnosis in this session, I discussed with Amanda the specific aspects of the surgery which worried her the most, so that we could concentrate on these. We decided that the following factors were important:

1. Facilitating healing of the existing perineal wound so that a date for the colostomy closure could be set.
2. Countering negative expectations about the surgery including fears of pain, bowel obstruction and delayed wound healing.
3. Regaining a sense of control and improving self-confidence.
4. Assisting a rapid return to full health and normal body function, including sexual function.

Amanda had been using her self-hypnosis regularly, going to her special beach and imagining the healing colours and good feelings associated with it. Interestingly enough, she found a countdown from 20 was better for trance induction as it more closely resembled the long drive to the beach! I was pleased to see that she had already made this subtle adjustment to customise her therapy.

The session continued with Amanda inducing a trance using her self-hypnosis technique. Again deepening was achieved using progressive relaxation. She was directed to go to her special place and to experience the feelings of contentment, peace, health, and well-being there. I then repeated the "Healing Colours" script, adjusting it to target healing to the perineal area. I left her to enjoy the colours and continued with some suggestions designed to

restore her confidence in her body's ability to heal and to provide some ego-strengthening. Based on Hunter's "Healing Imagery" (Hunter, 1990), I described how every living thing had the innate ability to heal, including herself. That healing force could be contacted, amplified, and directed to specific parts that needed healing using hypnosis. Once this had been repeated several times in different ways I went on to induce partial anaesthesia in Amanda's left hand. I did this to demonstrate to Amanda the power of her unconscious mind, to estimate her depth of trance and to assess the usefulness of the technique for future therapy. Amanda was asked to imagine her hand becoming cooler and cooler until it became comfortably numb.

Once this was achieved Amanda signalled "yes" using ideomotor finger signals. I then pinched both hands firmly while strengthening the suggestion that her left hand was numb and comfortable. The session was then completed with an awakening sequence using a count from one to five, including suggestions of retaining the feelings of peace and well-being and of the return of normal sensations to her body. When asked to recount her experience of the day's work, Amanda reported feeling pleased and intrigued by her mind's ability to induce some anaesthesia in her hand. She felt she was not as deeply in trance as the first time but found the overall experience very relaxing and enjoyable. She was asked to practise self-hypnosis employing the healing colours to facilitate healing in the parts of her body her unconscious mind directed.

Session 3

By session 3 the perineal wound had healed and a date for the colostomy closure had been given. The surgery had been scheduled for the following week, giving us only one more session in which to prepare for it. Amanda felt her self-hypnosis was beneficial but she could only induce a light trance. We decided to concentrate on direct preparation for the surgery in this session. After induction and deepening in the usual manner, I praised Amanda for what she had already achieved, pointing out to her how rapidly her wound had healed once she concentrated on her unconscious healing ability. I then proceeded with the following:

I now want you to see yourself on the morning of the surgery as you are approaching the hospital. As you draw closer you will find yourself becoming more and more relaxed and peaceful. Today marks the beginning of the return of your body to normal, to how it was before any of this happened. Imagine booking in at the admissions office and being shown to your room.

As the time draws closer to your surgery you are able to become more and more calm and confident. You know your surgeon is very skilful and you can be confident he will do a good job. You have strengthened your body for the operation. As each of the preoperative preparations are carried out, such as the nurse recording your pulse and blood pressure, and the visit by the anaesthetist, you can just lie back and rest comfortably.

Even as you are being wheeled into the theatre you will find that you feel completely at ease and relaxed. You know that the procedure will go smoothly. There will only be enough bleeding as is necessary to ensure the beginning of good healing. As soon as the surgery is finished that powerful ability of your body to heal will begin its work. Yes, as soon as the operation is finished you will begin to heal, rapidly, efficiently, and completely.

You will recover from the anaesthetic with no problems and will find that you feel quite comfortable after the operation. Your body will only need to feel discomfort if your unconscious mind needs to alert your attention to something. Indeed, each time someone asks you "How are you feeling?" that sense of comfort and well-being will increase. You can feel pleased and perhaps surprised by how good you feel after the surgery.

In the days following the operation you will be delighted by your rapid improvement. Your body will regain its normal functions including digestive function, appetite, and bowel function at just the right time and at just the right rate. When you need to use your bowels you will find you are able to relax and let your body take over. You know that, ever since you were a child, this was a function that your body performed without conscious effort. Your unconscious mind learnt to control it many years ago. With this knowledge you will be able to let that deep part of your mind take control, just as it is controlling your rapid and complete healing.

Now imagine yourself going home from hospital. You have had a brief but pleasant stay and have impressed your surgeon, the staff, and yourself by your rapid recovery. You know this recovery will continue over the next few days and weeks and that you can help by resting when your body tells you to and by eating healthy foods. You will find it a pleasant task, as you will find yourself feeling better and better each day.

Several of the suggestions, including the post-hypnotic suggestion linking the phrase "How are you feeling?" to a greater sense of comfort, were repeated and then the trance was terminated. Amanda found the experience pleasant and said she was feeling more positive towards the surgery as it drew closer. I suggested she repeat the rehearsal several times under self-hypnosis in the days before the operation. I also arranged to visit her in hospital after the surgery to assist her recovery.

Session 4

This session occurred in hospital on the day after Amanda's surgery. The procedure had been uncomplicated and she was impressed by how she felt. She was on a morphine infusion but was requiring very low doses and was keen to change to oral analgesia. She had no nausea.

In this session I concentrated on healing and recovery, while still emphasising comfort. After the usual induction and deepening, I praised Amanda for her success so far and stressed that she was progressing very well. I described again her innate ability to heal, emphasising that her body knew just what to do at just the right rate. I suggested her healing would be rapid, complete, and comfortable. Suggestions for rapid return of normal body

functions were also given, proposing that she could relax and let her body take control of the tasks it knew so well. These messages were repeated several times, then the trance was terminated with the suggestion that the comfort she was currently experiencing would continue.

RESULTS

Amanda was discharged on the fourth post-operative day and had a rapid recovery. This was much shorter than with the previous two operations, which required almost two weeks in hospital each time. She was surprised and pleased to have normal, comfortable bowel action on the day prior to discharge. At her post-operative review, her surgeon discovered some haemorrhoids which might require minor surgery, but was otherwise very pleased with her progress. Amanda said she had regained some of her lost self-confidence and felt she was losing her "sick" self-image. She was still very conscious and protective of anything involving her perineum (for instance she was reluctant for any doctor other than her surgeon to examine her there), and had not resumed sexual activity with her husband. We decided these could be issues to address in future work together. Overall, she felt certain the hypnotherapy, along with other preparation, including prayer and aromatherapy, greatly assisted her in her positive attitude towards surgery and her good outcome.

COMMENT

I used a direct approach to address Amanda's problems rather than adopting an analytical approach. I did this for several reasons. I lack experience in psychotherapy and therefore did not feel confident in adopting this approach. I had also discussed ways in which we could approach the problem with Amanda and she felt most comfortable tackling the problem directly. We agreed that, should a problem arise that required deeper exploration, I would refer her to a suitably qualified colleague. We had limited time available to prepare for the surgery and direct methods were likely to be rapidly effective.

Throughout the therapy general counselling was also performed. We discussed many issues such as coping with motherhood and illness, dealing with accompanying feelings of guilt and adjusting to changes in self-image.

My experience with Amanda taught me several things. She adjusted her self-hypnosis induction to suit her imagery. In the future, I will tell my patients that this is an acceptable option and suggest that they can rely on their subconscious mind to find the best practice for them. This gives a further opportunity for ego-strengthening and introduces an expectancy to "wait and see what your subconscious will come up with." Amanda's spontaneous "religious experience" early in therapy reminded me that the inclusion of a person's religious beliefs may aid therapy, although it should be carefully discussed beforehand (the patient may blame their predicament on God, who then would be a most

unwelcome presence in the special place). Amanda's success with hypnotherapy for this problem can act as a basis for future therapy. She will be able to draw on skills already learned and be strengthened by what she has already achieved.

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HYPNOSIS IN THE TREATMENT OF SOCIAL PHOBIA

Lachlan Lipsett

Medical Practitioner

This case report illustrates the use of hypnosis in the treatment of a 26-year-old client with social phobia. A specific goal was nominated and some cognitive therapy was first employed, followed by a trial of desensitisation (both in hypnosis and in vivo with hypnotically conditioned relaxation) which proved insufficient to allow comfortable attainment of the selected goal. The client's contradictory messages manifesting as ambivalence were then sorted and a "somatic bridge" was employed to trace the feelings of anxiety back to a sensitising event which was re-experienced and resolved in hypnosis. Further desensitisation allowed attainment of the specific goal, but the client has requested further assistance for problems with dating.

DIAGNOSTIC INTERVIEW

Eric, 180 cm tall and weighing 70 kg, was 26 years old and unmarried. He had collar-length fair hair and was dressed in his blue work clothes and running shoes, as he had just come from his place of employment, where he was a computer repair technician.

Eric was born in Australia of Australian parents. He was the elder of two children, having a younger sister. His father was an accountant and his mother attended to home duties. Eric had completed his schooling at a state school and trained as a computer technician at a TAFE college where he had done well. He enjoyed his work, saying that he liked working with computers. He still lived at home and felt he had a good relationship with each of his parents. His sister, three years younger, had married and was living with her husband nearby. Eric was a keen bicycle rider and would often go for long rides on his own at the weekend.

Eric's general health was good. He had not needed to see a doctor since his pre-employment check-up four years earlier, which he had passed with no problems.

Requests for reprints should be sent to Lachlan Lipsett, The Cottage, 22 Rous Road, Goonellabah, N.S.W. 2480.

Presenting Complaint

Eric felt uncomfortable in "unstructured" social situations and found himself avoiding going to places where he had to relate to people spontaneously. He appeared confident in this first consultation until he began to describe how he had trouble relating to other people when his anxiety and some embarrassment became evident. When I pointed out how well he had been coping with the consultation, he explained that our roles were defined and he knew what was expected of him. Similarly, he coped well in his job when dealing with customers because he knew what was expected of him in that situation.

He explained how he found himself avoiding others in unstructured social situations because he held a very strong conviction that they would not want to associate with him when all he had to offer them was his company. He felt that he had very little to give, he did not know what to give in an unstructured setting, and that anyone who was happy to have him as a friend would have to be hard-up for friends. In his next sentence he contradicted himself when he described how he had a number of very good friends who were interesting people. They had initiated friendships with Eric and they valued him as a friend. He felt handicapped by his inability to initiate social interactions with others. Eric regretted not having a girlfriend.

Eric also described how he had always needed to be in control. He had never been drunk, never touched any unprescribed medications, and never taken any recreational drugs even though some of his friends used marijuana. Eric felt "at sea" and out of control in unstructured social situations. He appeared ambivalent about hypnosis, hoping it would be helpful but anxious about the idea of handing over control to another. The need to be in constant control can be referred to as a posture of "exaggerated independence" (Boyne, 1989), and while the need to be independent is a normal part of growing up, this posture is handicapping if too rigidly maintained — especially if trying to maintain a relationship when a healthy degree of dependence is important.

He said he hoped that I would be able to help him as he had tried everything he could think of to overcome his problem.

DIAGNOSIS

The following criteria under 300.23 Social Phobia specified in DSM-IV (American Psychiatric Association, 1994) applied to Eric's case:

1. A marked and persistent fear of one or more social situations in which the person is exposed to unfamiliar people and fears that he will act in a way that will be humiliating.
2. Exposure to the feared social situation almost invariably provokes anxiety which may take the form of a situationally predisposed panic attack.
3. The person recognises that the fear is excessive.
4. The feared social situations are avoided or else are endured with intense anxiety or distress.

5. The avoidance or distress in the feared social situations interferes significantly with the person's normal social activities or relationships.
6. Over 18 years old (therefore no minimum duration of symptoms required).
7. Not drug related/medical condition related/other psychiatric condition. Not generalised to work, study, medical consultation situations.

GOALS

I asked Eric what he would like to be able to do that would satisfy him after he had finished seeing me. He said that if I could help him be able to comfortably approach anyone socially and make friends with them, that would be enough! When pressed to nominate a specific goal that we could first work towards, he suggested that being able to comfortably enter a hotel and strike up a conversation with a stranger would be a good start. I agreed, stating that we could always change the goal later as required.

CLIENT'S UNDERSTANDING OF, AND SUITABILITY FOR, HYPNOSIS

Eric had seen some people on TV "under the control" of a stage hypnotist and found it both frightening and intriguing. As he later said, "I couldn't get over the problem of relating to other people with my best efforts and I just thought that if I could find the right person to tell me what to do like the people on the stage in the show, then that would be the end of the problem." I corrected this belief that hypnosis would work miracles on him without his having to do anything (Erickson, Hershman, & Senter, 1990).

I clarified several other misconceptions about hypnosis that Eric had. He believed that hypnosis was some sort of a force the hypnotist projected onto the subject, who then submitted themselves to this force. I explained how that idea has been held in India, and paralleled Mesmer's ideas about magnetic force in relation to the trance state (Spiegel & Spiegel, 1978). I taught Eric that the medical model of hypnosis holds that "all hypnosis is self-hypnosis" and that while the hypnotist's role is to guide the subject's thoughts, the thoughts remained the subject's at all times.

Eric also thought that hypnosis was itself the therapy. I explained that hypnosis was a state of focused concentration that could facilitate new learning (Spiegel & Spiegel, 1978), and that it gave the client access to a number of abilities (trance phenomena) that increased the leverage that could be brought to bear on managing their problem behaviour (Wolinsky, 1991). Thus, hypnosis could simply be regarded as a tool that could be employed where it would do the most good. As Professor Jack Watkins said in a seminar on ego state therapy during the ASH Congress in Adelaide in 1993: "Good doctors who learn to use hypnosis become better doctors, and doctors who are bad doctors who learn to use hypnosis become worse doctors."

The use of hypnosis was not contraindicated by the presence of psychiatric illness or depression. Eric's stance of "exaggerated independence" was a contraindication to the use of an overly authoritarian presentation of hypnosis. I therefore explained in considerable detail what I was going to do before employing hypnosis, and allowed Eric to maintain control by having him tell me to use hypnosis on him.

TREATMENT PLAN

1. Gently familiarise Eric with the hypnotic experience.
2. Assess Eric's hypnotisability.
3. Teach Eric "rules" for behaviour in "unstructured" social settings, lending him a copy of Andrew Matthews' *Making Friends* (1990) and mentioning Eric Berne's *Games People Play* (1976) to show him that the social context is not unstructured for most people and that he could learn the rules they play by.
4. Ego-strengthening with positive suggestions for self-worth and effectiveness (Hartland, 1982).
5. Teach Eric self-hypnosis.
6. Employ hypnotic relaxation in desensitisation to imagined stressful situation of entering a hotel and speaking to a stranger.
7. Homework — practise self-hypnosis incorporating relaxation and desensitisation by visualising successful mastery of "hotel homework."
8. Homework — in vivo desensitisation using self-hypnosis for relaxation.
9. Review.

TREATMENT

Session 1

After taking the history and determining to work towards first getting Eric into a hotel, Eric's thoughts and feelings about hypnosis were explored. I explained how I saw hypnosis being employed to reduce Eric's feelings of anxiety and hypnosis was demonstrated with suggestions for progressive relaxation. Suggestions for feelings of well-being were then made and ideomotor communication demonstrated with an emphasis on how hypnosis could provide Eric with even more control over his life. After the hypnosis Eric was questioned about his experience. He had felt safe.

Session 2

More information was gathered and a cognitive approach employed, looking at human communication. Eric's hypnotisability was assessed with the Hypnotic Induction Profile (HIP; Spiegel & Spiegel, 1978), on which he proved to be a grade 4–5 subject (grade 4 on the basis of the basic HIP and upgraded on the basis of a later demonstrated ability to experience some aspects of age regression). The Hartland ego-strengthening script (Hartland, 1982), was read to Eric while he was in hypnosis and post-hypnotic suggestions made that Eric would rapidly re-enter trance whenever I directed him to do so with his consent, and I would teach him self-hypnosis which he could practise twice daily so he could benefit from the deep physical and mental relaxation it would bring him. Eric was then taught self-hypnosis, based on the Spiegel induction. I gave him a card with the instructions typed on it and asked Eric to practise twice daily, concentrating on the deep sense of relaxation the hypnosis would bring — conditioning this sense of relaxation to exhalation of a deep breath. I also had Eric read Andrew Matthews' *Making Friends* (1990).

Session 3

In this session, unstructured social settings were reframed as structured by consensus amongst the participants — that is, Eric could define some of the parameters in the settings he previously saw as unstructured (e.g., talk about the weather, work, something topical in the news). Trance was induced and Eric visualised entering a hotel, buying a drink, and striking up a conversation while at the same time feeling a deep sense of relaxation. Ideomotor signals were employed to signal any increase in tension and this was allowed to ease before continuing. Eric was then asked to visualise himself standing outside a hotel. An image of Eric feeling confident was built up with accompanying sounds. Then, while visualising himself thinking about entering the hotel, Eric used hypnosis until he felt relaxed. Then he visualised himself actually entering the hotel, buying a drink, and comfortably conversing with the people drinking there. I suggested Eric look forward to a time in the future when he could readily walk into a hotel. I had him create a vivid mental representation of the experience involving all five senses and, when he had a clear picture of himself successfully doing all that, I had him step into the picture and experience how good it felt to have got over that problem; to enjoy knowing how easy it is to meet new people. Eric was then directed to look back at all the steps he had taken in making this dream come true as he felt good about his achievement. This approach is frequently described, for example, central self-image work in Langton & Langton (1983). For homework, Eric was to continue his self-hypnosis and visualise entering the hotel and, on one day, to actually choose a hotel, buy a drink, and speak to someone about the weather or some other topic of his choice.

Session 4

Upon Eric's return from holidays, he reported he had practised his self-hypnosis and visualisation exercises. He had even entered a hotel, bought a drink, and spoken to a coach driver for over an hour. The coach driver had bought him a drink and, when he left, thanked Eric for talking to him. Eric described the feeling of tightness in his chest as he walked past the hotel, his use of the self-hypnosis to ease the feeling of dread, and his decision to get his committed homework over so he could enjoy the rest of his holiday.

I was aware that while Eric was still saying that he really wanted to be able to enter hotels comfortably, he did not sound or look convincing — even with his success behind him. I decided to take his simultaneously incongruent (contradictory) verbal and body-language messages and have him fully identify with each contradictory position sequentially. I had Eric re-enter trance and took him back to when he was standing in the car park outside the hotel debating whether to go in or not. With Eric seated in a chair, I asked him what he saw when he said he wanted to be able to comfortably enter the hotel. He described a clear picture of the desired behaviour with him looking relaxed and confident. I then asked him to move into another chair and tell me what he heard when he thought about entering the hotel. He reported a commentary describing the picture and then a statement in his father's voice: "You're not going in there." I then asked Eric to sit in a third chair and report what he felt when he thought about entering the hotel. He described the tightness in his chest and slightly nauseated feeling in his stomach that were all too familiar to him.

By moving from chair to chair, Eric found that he visualised what he wanted to do with a commentary of his visualised images, followed by his father's voice saying "No!" and his feeling paralysed.

Eric was then instructed to follow the paralysed feeling back in time (somatic bridge — if I had labelled the paralysed feeling "fear" and followed the feeling back, then it would be called an affect bridge) to sequentially earlier and earlier times. Eric eventually identified a time when he was about three years of age, in terrible trouble with his father. When asked what he most needed in the recalled situation of feeling so frightened by his father's anger, Eric said: "feel safe." He described the situation in the present tense and was clearly distressed by the memory (age regression — hence, at least 4–5 on HIP). I had the adult Eric tell the little Eric something that he needed to know: "Don't worry, he won't hurt you, he just sounds really mad" and, lifting Eric's arm up horizontally, told Eric to let it drift down only as fast as it took for little Eric to feel safe again.

Each part (visual, auditory, and feeling — spatially associated with a chair each) was then asked to respond to the following questions (derived from Grinder & Bandler, 1976):

1. What, specifically, do you want for yourself (i.e., for Eric)?
2. How, specifically, does each other part stop you from getting what you want for yourself? Tell that part directly.
3. Is there any way that you can see/hear/feel each other part can be of any use to you? Tell each part in turn specifically how it could be of help.
4. What would happen if each of the others went away completely? (Consider each separately.) How would that be of use to you?
5. Do you see/hear/feel what each of the others wants for Eric? Tell them what they want, check that each part understands where each of the other is "coming from."
6. What would happen if you let each of the other parts have what they want? (Consider each separately.)
7. Is there any way that you can each get what you want, that is, is there any way the identified parts can cooperate?

Eric then negotiated a new strategy whereby he would ask for a picture of what he wanted to do. The visual part would create an image. The auditory part which could see the picture that had been created would then describe what was being imagined so the feeling part knew what the visual part was up to. The auditory part would then list consequences which the feeling part would classify under de Bono's (1980) three headings of Plus, Minus, and Interesting (PMI). The auditory part would describe what the feeling part felt about each consequence so the visual part knew how its suggestions were being received. Then, if the consensus was to go ahead and a physical behaviour was required, the feeling function (closest to the muscles) would actually perform the behaviour.

OUTCOME

Eric reported he had continued to use the self-hypnosis with the imagery of a successful future and he had been able to enter a hotel feeling more in control. He was pleased he no longer "froze" as soon as he heard his father's angry disapproving voice. Eric asked to see me again to help him further with his self-consciousness about dating. This has not yet been addressed.

Eric's ability to hear a memory of his father's voice and the consequent arrest of the proscribed behaviour with feelings of intense fear was explained to Eric as being a product of his high hypnotisability, which can be both a gift and a liability. The induction of hypnosis is a ritual that accentuates what goes on all the time for those like Eric. Walker (1994) has written about the damaged highly hypnotisable subject's use of imaginative involvement to generate much of their suffering by creating an imagined negative future which they react to as if it were real. Therapy is aimed at helping the client to reclaim control of their imagination (reclaiming it from emotion-laden "hijackers" like the memory of Eric's father's anger).

COMMENTS IN RETROSPECT

Hypnosis may be employed in symptom removal and in searching for the causes of the client's symptoms. If the client does not readily give up a symptom then it is unlikely to simply be a habit made out of a previously useful behaviour which can be given up with no consequence. Such resistance to giving up an unwanted behaviour frequently indicates that the behaviour is continuing because of its perceived continuing direct benefit for the patient. In Eric's case, he failed to take to his requested new behaviour of being able to enter a hotel comfortably (clinging to the avoidant behaviour) even after successfully completing the task as homework. This suggested to me that Eric likely held a belief that identified that task as being against his best interests. Hypnosis is used to advantage in uncovering the perceived relationship between the problem behaviour and the patient's needs at some time in the past — and allowing a re-evaluation of the problem behaviour in the light of the client's current needs and resources.

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HYPNOSIS IN THE TREATMENT OF LEARNING DIFFICULTIES IN CHILDREN

Timothy Hill

Psychologist

This case describes the use of hypnosis in treatment for learning difficulties in a child. While there is little reference in the literature to the utility of hypnosis in such cases, the report describes the effectiveness with which hypnosis has been used to treat symptoms associated with the condition.

BACKGROUND

My client was an 11-year-old boy who first came to see me in June 1995 because of difficulties he was having at school. At that point, Sam was 8 years old and in a Year 2 class at his local primary school. Sam undertook psycho-educational assessment at that time.

On the Differential Ability Scales, his performance indicated abilities which were equivalent to an overall IQ of 110. The assessment indicated he had reasonably high levels of verbal expressive and receptive abilities, very good visual short-term recall, and good visual spatial abilities. The assessment indicated a mild weakness on tasks which required analytical, sequential, and quantitative reasoning. Diagnostic assessment indicated that Sam had very significant dyslexic problems, with significant weaknesses with regard to both auditory and visual processing. Sam had an auditory short-term memory capacity which was within the bottom percentile for his age. He had visual processing difficulties which affected his ability to track lines when reading. The assessment also indicated that Sam had very significant weaknesses with regard to phonological awareness. At that point, Sam's literacy skills could be described as at an emergent level. He was still not consistently sure of all letters of the alphabet, and was able to recognise or spell very few, if any words. Since that time, Sam had had an individualised tutoring program to help with literacy skills.

Sam came for a review in August 1997. At the time of the review, he was almost 11 years of age. Since the initial assessment, he had undertaken intervention to help with visual processing. His reading program had included a predominantly phonics based approach. Sam's performance at the review indicated he had developed reading and writing skills which are now at approximately the average 6 year level. He could read some simple texts fluently and could spell some single syllable words. He still had significant weaknesses with regard to phonological awareness skills, though he had certainly made some improvement since the time of the initial assessment. Sam's phonological awareness skills were also at an average 6 year level. Thus he was able to identify initial sounds in words and divide words into syllables, however, he still had difficulty on tasks which required the identification of final sounds in words. Overall, Sam was still at a point where he would benefit from an ongoing intensive program using a predominantly phonics-based approach to help develop reading and spelling skills.

One of the most significant concerns at this time related to Sam's discouragement and lack of belief in his own abilities to learn. His tutor indicated that Sam lacked motivation during sessions and she was finding it very difficult to motivate him to continue. Sam's mother was clearly distressed about her son's difficulties and reported she was extremely concerned as she did not know what to do next. She indicated that she was at the end of her tether. Sam gave up and frequently said things such as "I can't do it, I'm dumb." The tutor also reported she was not sure what to do next, as nothing seemed to be working.

My discussion with Sam confirmed impressions gained from his mother and from the tutor. Sam indicated he was sick of trying and nothing seemed to work. He was sick of practising with reading and spelling, and yet, was still one of the worst in the class. Sam reported that, while he would like to read and write, "It is all too hard."

Sam completed a more formal assessment of self-esteem using the Piers-Harris Children's Self-Concept Scale (1984). His responses confirmed very negative self-esteem with regard to intellectual status.

In discussion, both Sam and his mother welcomed an opportunity to try hypnotherapy as an adjunct to his ongoing tutorial program. Sam's mother was informed that, while previous research indicated one could be confident about the benefits of hypnotherapy, it would be misleading to think this was going to lead to any quick, magical, or miraculous solution to Sam's learning problems. Hypnotherapy would be primarily aimed at treating his emotional problems relating to self-esteem, lack of motivation, and his ability to concentrate as it was clear at this point that these were factors representing significant impediments to ongoing progress.

HYPNOSIS AS AN INTERVENTION FOR CHILDREN WITH READING DIFFICULTIES

Illovsy (1963) studied the effect of group hypnotherapy with adolescents. All subjects were non-readers with reading skills at or below first grade level at the beginning of the study. The study included experimental and control groups. Every day, before class began, the experimental group listened to a hypnotic induction, followed by several suggestions for increased motivation, concentration, and performance in reading. After six months, four of the five boys in the hypnotherapy group gained an average of 2 years and 3 months in reading skills, while the no-treatment controls gained an average of 9 months. The author concluded this provided evidence for the benefits of hypnosis in maintaining and enhancing reading abilities.

Olness and Kohen (1996) described a study which was presented at a conference by Jampolsky, who worked with a small group of third and fourth grade students having difficulty learning to read. In order to overcome the negative messages to which such children were repeatedly subjected, the students were encouraged to visualise themselves as successful readers. The research included a control group of poor readers who apparently received no treatment but who were tested at the beginning and end of the study. The experimental group participated in three training sessions which included visualisations, ridding themselves of negative feelings associated with reading, and imagining themselves as successful readers. They were asked to repeat the process daily for 5–10 minutes before going to school and before going to sleep. Over a one-month period, the experimental group averaged an increase in reading skill of 18 months, whereas the control group gained only one month. Self-esteem was markedly increased in the experimental group and parents and teachers reported decreased tension and increased energy. A further assessment at 12 months indicated that progress continued to be excellent, compared to the control group.

Krippner (1966) studied 49 children aged 8–17 with average intelligence who were enrolled in a five-week remedial reading program. Krippner compared a group using hypnosis and another group that did not include this as part of their training. While the difference between the two groups was statistically significant in favour of the hypnosis group, the difference was too small to be of practical value.

In their review, Crasilneck and Hall (1985) reported that clinical results using hypnotherapy were very optimistic, yielding moderate to marked improvement in nearly three-quarters of their child clients who presented with dyslexia, although the length of treatment required for each child was not reported.

TREATMENT PLAN

Having decided to proceed with hypnotherapy as an adjunct to ongoing intervention, I planned the following treatment approach. In session 1, I planned

to explain the nature of hypnosis and how beneficial it could be for learning and then test for hypnotisability using the Stanford Hypnotic Clinical Scales for Children (Standard Form for Children Aged 6–16; Morgan & Hilgard, 1979).

At a second session Sam was to be induced using a progressive relaxation technique. Suggestions would follow those provided by Jampolsky (Olness & Kohen, 1996). Jampolsky's intervention emphasises a holistic approach to learning rather than a bit-by-bit process that is often employed. The hypnosis session was to be audio-taped and Sam would be instructed to take the tape with him, to practise self-hypnosis using this tape twice a day.

At the third session, any difficulties were to be discussed, along with feedback from Sam. Feedback would also provide some indication regarding his motivation to continue with this form of intervention. It was my intention to suggest the ongoing use of his self-hypnosis tape on a daily basis.

Finally, it was intended, at a later session, to introduce the idea that self-hypnosis could be used prior to tutorial sessions and also as part of each night's homework. Here the suggestions were to emphasise specific skills such as abilities to relax, concentrate, and focus while undertaking studies.

Further sessions were then to be planned according to need.

TREATMENT AND OUTCOME

Session 1

Discussions had already taken place with Sam and his mother regarding the use of hypnotherapy to help with learning difficulties. There had been prior discussion about the possible benefits and limitations of hypnotherapy. In the initial session, we also discussed any preconceived ideas that mother and child may have had about hypnosis. During this session, Sam was tested for hypnotisability using the Stanford Hypnotic Clinical Scales for Children (Ages 6–16). He responded positively to all seven items: hand lowering, arm rigidity, visual and auditory hallucination, dream experience, age regression, and response to post-hypnotic suggestion.

Given that relaxation was an important outcome relating to Sam's ability to work and concentrate, I was of the view that a progressive relaxation technique for induction would be appropriate.

One of the main differences in response to hypnosis between children and adults is that children often respond very quickly with total body relaxation. Given this, it is generally not necessary to provide lengthy details about specific muscle groups for relaxation. Hypnosis was induced using a progressive relaxation technique and then suggestions were provided.

Sam was asked to imagine being in a pleasant place of his own choosing. He was encouraged to get rid of painful associations with learning by mentally washing such bad feelings, dirt, and grime out of his brain. He imagined himself writing a small book about his favourite subject. Suggestions were then

introduced which included tactile, auditory, and visual imagery to help Sam picture himself on a motion picture screen where he was reading a book with fluency, success, confidence, and joy. (In theory, this creates an ego ideal.) Sam then imagined he was climbing into his own image on the screen and merging with his ideal self. He imagined this new self permeating all his body tissues.

After this hypnosis session, and after gaining feedback from Sam, he was again induced into hypnosis and the session was audiotaped. The suggestions included post-hypnotic suggestions regarding his ability to utilise hypnosis and the ongoing effectiveness of treatment. Trance state was terminated by counting from 5 back to 1 in the usual way. Sam was instructed in the process of self-hypnosis and asked to repeat this process twice daily, once before going to school and in the evening before going to bed.

An appointment was made for Sam to return in a fortnight, to provide feedback and to arrange ongoing treatment.

Session 2

Both Sam and his mother reported very positive outcomes. He described the tape as his "feel good" tape. Both Sam and his mother independently reported he was taking his self-hypnosis sessions twice a day. In fact, Sam's mother indicated he actually enjoyed and looked forward to doing the sessions. Thus, there was every indication that he was well motivated to continue with treatment. Sam's mother believed there were also some very positive changes to his attitude to work and his willingness to be involved in school work. I suggested it would be ideal for Sam to continue using the tape at least on a daily basis but that, if he wished to use it more often, that was okay.

I then suggested that, in addition to this hypnosis which focused more on a holistic view, it would also be worthwhile to include self-hypnosis prior to doing work with the tutor in reading and writing and also prior to doing homework at night. Sam and his mother both indicated that they would be very willing to do this. He was provided with the following suggestions.

Following a brief induction, Sam's attention was directed to relaxing as he breathed deeply. He imagined breathing IN: relaxation, energy, and confidence; and breathing OUT: tension, tiredness, and fear. Sam focused on this process for five or six breaths. I suggested that with this relaxation, energy, and confidence, Sam would find he could channel his mind — just as a funnel can direct and concentrate water flowing into it. In the same way, he could find his mind channelling and focusing on words he was reading and writing.

Post-hypnotic suggestions were also included relating to Sam's ability to utilise hypnosis and positive outcomes for learning. This session was audiotaped and he was given a copy of the tape to use in ways described above. We made arrangements to keep in touch by phone and to have a follow-up session one month later.

I discussed with Sam's tutor the use of hypnosis and the possible benefits for learning. She was very keen to include my suggestions as part of her tutorial

program. She had become exasperated by Sam's lack of motivation, but indicated she had noticed a definite change in his attitude toward work in the past couple of weeks. He was much keener to get down to work and she was not having to struggle with him to work as she had previously.

A phone conversation with Sam's tutor approximately four weeks after the session described above indicated ongoing positive outcomes. Sam's attitude to work had changed dramatically. He was participating in study, was more relaxed, and concentrating on work far better than he had been. She believed there had been significant changes to Sam's self-esteem and confidence. Even though this change had only taken place over a short time, the tutor felt it was already having a significant impact on his academic progress with respect to reading and writing.

Session 3

A follow-up session with Sam and his mother provided further confirmation regarding the tutor's comments. Sam indicated a far more positive attitude to learning and his mother reported Sam was undertaking his homework and that many of the battles that they had previously were now not taking place. I undertook formal assessment of his reading and spelling using the DAS word reading and spelling scales, together with the Neale Analysis of Reading Ability (1988). Sam's performance indicated approximately a six-month improvement in reading and spelling ability on these formal scales over the one-month period.

Both Sam and his mother indicated they were keen to continue using hypnosis. Arrangements were made for a further follow-up session in two months time. It is my intention to monitor progress every two months. At a later date, I also intend to re-administer the Piers-Harris Children's Self-Concept Scale.

CONCLUSIONS

Early indications are that the treatment provided in this case was very successful. Clearly, it is impossible to specify which aspect of the treatment was of most benefit: treatment is likely to have impacted upon the attitudes of the client, his mother, and the tutor and all of these things are likely to have had some impact upon the outcome. There was certainly evidence that the treatment produced a very significant change in Sam's perceptions of himself and positive outcomes relating to abilities to relax, concentrate, and to take part in academic work. There was certainly some evidence that hypnotherapy can be helpful for learning and performance problems in children. This case study certainly supports the use of this form of intervention for children with learning problems who seem to have given up on themselves and who lack self-esteem and motivation.

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CASE NOTES

The aim of Case Notes is to enable readers to contribute brief items and case material drawn from their own experience. These may be case situations in which hypnosis has been used in treatment or a description of specific hypnotherapeutic techniques used within treatment contexts. The contributor is asked to supply as much information as is needed to ensure the reader has an understanding of the situation, the therapeutic aims of the hypnosis, and outcomes. It may also be appropriate for the contributor to review the relevant research and clinical literature to justify and explain their use of hypnosis. While the standard criteria for publications in the Journal will not apply to Case Notes, a clear exposition of the ethical professional practice of hypnosis will be required if the material is to be published.

HYPNOSIS IN A CASE OF ACQUAINTANCE RAPE

Elliott H. Schreiber

Professor Emeritus of Psychology

This is a forensic investigation of a 20-year-old female who was allegedly raped at a party. This individual had psychogenic amnesia relative to the alleged rape. She was enthusiastic about the possibility of recalling the traumatic experience through the use of hypnosis for memory refreshment, and she was willing to help the police apprehend the alleged rapist. The woman had fears and guilt with regard to the alleged rape. Hypnosis was used to relax the client, and the technique of hypnotic time regression revealed the identity of the rapist. The standard legal procedures (Hammond, 1994) for criminal interrogation with hypnosis were followed with this client.

The objective of this paper was to investigate the influence of hypnosis in producing recall in a female who experienced psychogenic amnesia relative to

an alleged rape pursuant to a social party. Erickson (1968), Orne (1961), Weitzenhoffer (1989), and Kroger (1977) each indicate that hypnosis can be very useful in rape cases. The work of these authors helped to motivate this paper.

The literature in court decisions with regard to hypnosis has been both positive and negative. Judicial treatment of hypnosis as admissible evidence has varied. State courts have used one of three approaches in determining admissibility of hypnotically induced testimony. 37 Cath. U.L. Rev. 1177. The first approach is "per-se admissibility" where the view is that hypnosis only affects credibility, which is determined by the fact-finder. *Harding v. State*, 246 A.2d 302 (Md. App., 1968), *cert. den'd*, 395 U.S. 949 (1969). Under this approach, the contention is that hypnosis falls within traditional methods of refreshing a witness' present recollection, whereby the jury can weigh the credibility of the hypnotised witness. *State v. Peoples*, 319 S.E. 2d 177 (N.C., 1984); *Harding*, *Supra*.

The second, and most widely applied, judicial approach is "conditional admissibility" whereby hypnotically induced testimony may be admitted provided procedural safeguards are employed in the hypnotic process. *State v. Hurd*, 432 A.2d 86 (N.J., 1981). Relevant considerations for the court under the conditional approach are whether: (a) procedural safeguards were employed, (b) hypnosis was appropriate for the type of psychogenic memory loss involved, and (c) there is any corroborating evidence. *Sprynczynatyk v. General Motors Corp.*, 771 F.2d 1112 (8th Cir., 1985), *cert. den'd* 106 S.Ct. 1263 (1986).¹

This investigation was made of a 20-year-old female college undergraduate student. The student possessed a B-average in her courses. She was involved in numerous organisations on the campus and held several executive positions in such clubs. The student also had close friends on the campus.

During the spring 1995 semester, a friend invited the student to attend a stag party which was held in an off-campus apartment. According to the client, there were approximately 15 people in attendance. She recalled there were seven male students and eight female students at the social. Food and alcohol, in the form of beer, were served during the course of the party. The client was already acquainted with three of the female students and two of the male students at the party. Upon her arrival, she reported that the people at the party were talkative and the client enjoyed the conversation she engaged in with other students.

The students began to leave the party at 1 a.m., according to the client. About an hour later there were six students, including the client, still remaining at the party. She indicated that she was dancing and drinking beer with several students. She knew one of the remaining girls very well. The client knew the other remaining three male and one female students by their first names only. The client reported that the last thing she recalled from the party was talking to some male students. She then woke up later that morning at 11 a.m. in a bedroom at the apartment where the party was held. She recalled being nude and

having experienced some pain in her vagina. There was no-one in the apartment at the time the client awoke. Evidently since it was Monday morning, the other students were attending classes.

Later that week, the client visited a gynaecologist who indicated finding evidence of penetration and abrasions in the vaginal area. She received medical attention for her condition but chose not to inform the police department at that time because of her fear that the incident might be placed in the newspaper. The client had psychogenic amnesia with respect to the apparent rape and she was not then able to identify who did this to her. Two months after the alleged rape, she decided to contact the police and also seek psychological help to deal with the feeling she was experiencing.

This woman was previously evaluated by another psychologist. A colleague referred the client to this psychologist for hypnosis. She gave permission for hypnosis and was seen for four sessions. The first session was used to gather case history information and to develop rapport. During the second session, an orientation and induction of hypnosis using sensory relaxation techniques (Erickson, Rossi, & Rossi, 1976) were made. In the third session, the client was placed in a medium state of hypnosis (Hilgard, 1992) and hypnotic time regression was used. She revealed glove anesthesia through suggestion in a medium state of hypnosis, and she responded to questions.

The client moved into hypnotic time regression very slowly. She was told to relax and to describe her experiences over the past few weeks. She was asked to talk freely about anything that came into her mind. About one half-hour into the hypnosis session, the client was able to picture the individual who raped her and described him in detail. The patient recalled that the student had hit her on the face and body, and then he raped her in the apartment bedroom. At this point in the hypnosis, the patient began to cry, and she expressed feelings of guilt and dysphoria with regard to the incident.

The fourth session was utilised to deal with the client's feelings and conflicts. This session served as a catharsis for the client and was held three days after the third session. She was given ego reinforcement and encouragement to seek an individual psychotherapy program. The student who committed the rape had left the college at the end of the semester. Nevertheless, the client filed a criminal complaint against the student with the police department. The student was not arrested because the client ultimately decided against pursuing the case primarily to avoid publicity and in deference to her school studies. Several weeks later, the client attended a psychotherapy program with this psychologist and a co-therapist colleague.

This case supports the use and value of hypnosis (Schreiber, 1988, 1991) in rape cases. More investigation is needed in this area (Fromm & Nash, 1992; Lynn & Rhue, 1991), which the author of this paper is currently conducting.

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¹ The third approach is "per-se admissibility" of hypnotically induced testimony. This older, infrequently applied approach, held that hypnotically induced testimony was a scientific process where no general acceptance existed as to the reliability of hypnosis. See, *State v. Mack*, 292 N.W. 2d 764 (Minn., 1980) (applying general rule in *Frye v. U.S.*, 293 F. 1013 (1923)).

BOOK REVIEWS

Handbook of Dissociation: Theoretical, Empirical and Clinical Perspectives. Larry K. Michelson and William J. Ray (Eds.). Pennsylvania: Plenum Press. 1996. xviii + 645. US\$95.

The *Shorter Oxford English Dictionary* (Onions, 1978) states a handbook is a small book or treatise, such as may be held in the hand. The *Oxford Advanced Learner's Dictionary* (Cowie, 1993) has a handbook as a small book giving useful facts (cf., manual). Back to the big brother *Shorter Oxford*, where a manual is a small book for handy use. Flip some more pages. Handy in the *Shorter Oxford* is ready to hand, near at hand, ready for use, convenient to handle, easy to be manipulated or managed.

Weighting 1.5 kilograms and 645 pages long, Michelson and Ray's volume somewhat exceeds the criteria for handiness. One last try, what about treatise? This, our *Shorter Oxford* says, is a book or writing which treats of some particular subject; now always containing a methodological discussion or exposition of the principles of the subject.

I think this is what Michelson and Ray have produced, a treatise. And for the most part, they have succeeded. Organised into seven sections, the reader is taken through foundations, developmental perspectives, theoretical models, assessment, diagnostic classifications, therapeutic interventions, and finally special topics.

If I had read this last section first, I might well have been put off reading the rest. Respectively, the last two chapters, numbers 27 and 28, are entitled "Clinical Aspects of Sadistic Ritual Abuse" and, "Legal and Ethical Issues in the Treatment of Dissociative Disorders." These pages sound a chilling warning to therapists of all persuasions. From the summary to chapter 27: "The extremes of human cruelty . . . are bound to affect the therapist in profound ways . . . it can bring into question many of the therapist's previous beliefs about people and about life in general. It is an easy area in which to lose objectivity . . . The therapist must not be seduced by his or her own needs or by the compelling material and the intensely projected affects to give up the therapeutic role." In other words, this field of clinical practice is not for the faint-hearted.

The theme of chapter 28 is equally frightening, although American law may not be completely applicable or transferable to Australian practice. The

essential element is that a therapist may him or herself become a defendant in an indefensible investigation, especially if the matter is raised through a complaint to the therapist's professional licensing or registration board. To quote from the last paragraph: "It is in the nature of kangaroo courts . . . they are meant to be expeditious, not fair . . . meant to make a quick end to some perceived trouble forthwith . . . based on power plays, not equanimity. Yet this is where practitioners are at highest risk. Lose a lawsuit, you lose money, perhaps some degree of reputation. Lose your license and it is catastrophic to all of a purely material nature one has built, as well as having to shelve years of finely honed skills." The danger comes not from outside the profession, but within. "Paul Dell . . . was the first to systematically study . . . not the patients' hostilities toward their therapists, but colleagues' hostilities toward MPD therapists."

Fortunately I had read the earlier chapters in order and found them to be more straightforward, although I was a little surprised that a formal definition was not given at the start of the book. I suppose, this being a multi-authored book, everyone thought someone else had already done it! Anyway, in essence, dissociation is the splitting off or splitting between, what are ordinarily the very closely connected functions forming the personality. That is, thoughts, emotions, and behaviour such that there is a lack of integration into the normal stream of consciousness and memory. When this process of integration is sufficiently disturbed, clinical disorders can occur, characterised by symptoms such as distorted or altered sensory and time perception, variably impaired memory, derealisation and depersonalisation. In the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; 1994), there are criteria for classifying five conditions: dissociative amnesia; dissociative fugue; dissociative identity disorder; depersonalisation disorder; and dissociative disorder not otherwise specified.

The first four sections of *Handbook of Dissociation* — entitled "Foundations," "Developmental Perspectives," "Theoretical models" and "Assessment" — make up a total of 13 chapters. For obvious reasons, chapter 9 in the "Theoretical Models" section, "Hypnosis and Dissociation," was the most interesting of these, if only for the conclusion reached and stated in the first sentence of the summary. "If there is any relationship between the constructs of dissociation and hypnosis, it is complex and indirect." I would wager that quite a few readers have thought the connection simple and direct. But a perusal of this chapter is likely to challenge their degree of conviction.

Sections Four and Five are assessment and diagnostic classifications. Both are short, consisting of only three and five chapters respectively. Section Six, "Therapeutic Interventions," is the longest, with eight chapters and likely to be the most widely read part of the whole book.

Two themes occur in all the therapies. First, safety in the therapeutic relationships needs to be established. By this is meant psychological safety, but occasionally physical safety may also need to be arranged. Second, therapists

are advised to allow experiences and memories to emerge at their own pace.

All the chapters in this section are interesting, some more familiar than others. The one most likely to be least familiar to readers is chapter 25, "Art and the Dissociative Paracosm: Uncommon Realities." Chapter 21, "Overt-Covert Dissociation and Hypnotic Ego-State Therapy," is a warm reminder for those of us who have done workshops with the Watkins. Chapter 21, "Hypnotherapeutic Techniques . . ." is very much a "how to do it" set of instructions. For those readers with a little clinical hypnotic experience, the words/suggestions will read with a more than faintly condescending and patronising tone. Finally, the last chapter in this section, number 26, "Psychopharmacology," is perhaps the most informative for the non-medically/psychiatrically qualified clinicians because it describes an area that tends to be neglected in the training of, and in the references available to, psychological practitioners.

There are a couple of minor criticisms. The referencing might be a little inaccurate. For instance, with chapter 22, the red covered, well-known and recognisable Cory Hammond *Handbook of Hypnotic Suggestions and Metaphors* is cited as being published in 1992 and 1991 several times, whereas it was actually published in 1990. One wonders whether one can trust the referencing in all the other chapters. Second, and this is probably an idiosyncratic preference, the degrees and qualifications of the contributors are not stated. I like to know the professional background of my authors so I can put them in perspective and know what framework they are "coming from."

Notwithstanding these minor criticisms, overall this "treatise" provides a comprehensive addition to other literature discussing dissociation as a phenomenon or a clinical disorder either directly or indirectly (e.g., Spiegel, 1994; Schumaker, 1995), and can be recommended as a useful addition to any clinician's library.

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- NORMAN SHUM, Consultant physician in psychological medicine, private practice, Eastwood, S.A.

Dangerous Persuaders: An Exposé of Gurus, Personal Development Courses and Cults, and How They Operate in Australia. Louise Samways. Melbourne: Penguin Books. 1994. xi + 148. \$12.95.

Samways is enthusiastically involved at the cutting edge of issues such as allergies and informed consumer self-awareness in the field of psychological healing and health. Her aim in this work is to expose the way people are psychologically exploited, not only by gurus, cults, and in personal development courses, but in multi-level marketing and fundamentalist sects of various kinds. She also touches on the current trend of healers to the potential detriment of clients.

Samways has found, through responses to her previous book, *Your Mindbody Energy* (1992), that many people wanted to learn how to recognise the traps and lures of groups taking control of people's lives. She found that these groups did not provide rules or guides for higher level functioning, but instead tended to subtly entrap people. Her work highlights the continuing problem of group membership of sects (Galanter, 1982), and the issue of unfounded and metaphysical methods in therapy (Singer & Lalich, 1996). Essentially, she is concerned with those cults and groups that attempt to control people by adopting "new therapeutic psychological techniques for their own purposes." She highlights the exclusion of recruits to these groups from the general informed consumer economy, and their deprivation of outlets that enable them to make free choices — in particular to leave the group.

A short book with a comprehensive detailed index, it covers techniques used by the "dangerous persuaders"; a small sample of offending groups (Samways believes that there are at least 100 in Australia and over 1,000 in the U.S.A.); explanations of group manipulating mechanisms; examples of victims of these groups; and how people may protect themselves, obtain help or complain about their experiences with these groups.

Hypnosis has received notorious publicity recently, especially in regard to regression therapies and the veracity of recovered memories (Singer & Lalich, 1996; see also the *International Journal of Clinical Hypnosis*, Vol 42, No. 4, October 1994). Samways points out that the use of hypnosis by groups is often without reference to hypnosis protocol, or information on the effects of hypnosis. She contends that if a person knew that they were to be hypnotised they would respond appropriately, by having free choice to accept or reject the method. As it is, many of these organisations use hypnotic styles of influence, incorporating behaviour modification, obedience to authority and conformity to group expectations.

She also points out that waking suggestion and waking hypnosis is easy to impart with or without confusional techniques in groups or individually. Indeed, using combinations of treatment with structured groups for depression, Geary (1989) found it difficult to distinguish between hypnotic and non-hypnotic strategies and effects. In group hypnosis treatments, inter alia, knowledge of the

group dynamics is needed to avoid distortion of the therapeutic process. Samways echoes this concern, especially in relation to groups run by non-psychologists becoming too business-focused with stylised approaches. Her main concern, however, is that the approach of persuasive groups is structured to obtain poorly informed commitment by recruits to another way of life without responsibility for them as people. Her guide reflects the presence of social isolation and disconnectedness in our society. People who are isolated and disconnected need information to protect themselves from being exploited.

As a consumer guide for practitioners, *Dangerous Persuaders* is well worth having available to assist clients, as well as a basis for promoting social reform. Although academics may dispute her premises and statements, she is willing to follow her own principles and accept constructive criticism. It is because criticism has been discouraged in these exploitative groups that people come under their control.

Samways has called for tighter controls over the use of psychological techniques. It is ironic that hypnosis in Victoria has become "self-regulating" from the beginning of 1998. At the same time, there is government concern that previously termed alternative therapies now being called complementary therapies need some form of regulation, ensuring professional ethics and expertise to protect the community. Samways' book is a welcome addition to community education and awareness of how techniques to help people can be misused to imprison them, rather than assist them to raise themselves to a higher level of functioning.

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JOHN W. REDMAN, Clinical psychologist in private practice, Morwell, Victoria.

Hypnosis and the Law: Principles and Practice. Barry J. Evans and Robb O. Stanley (Eds.). Heidelberg: Australian Society of Hypnosis. 1994. xv + 289. \$34.95.

This anthology illustrates two propositions that are generally so well known as to be truisms. They are, however, worth restating. First, good interdisciplinary work is very hard to do. Second, valuable insights are derived from considering the viewpoint of someone working in another discipline on any matter of mutual interest. The authors whose works appears in this anthology are qualified in the disciplines of psychology, psychiatry, law and police science, and epidemiology. Taking the subdisciplines of psychology into account expands the list of disciplines represented to include clinical psychology, cognitive psychology, forensic psychology, and industrial and organizational psychology. I should acknowledge, therefore, that my own viewpoint is that of an Australian legal academic.

This anthology contains 27 chapters that consider a number of issues that arise in the relationship between hypnosis and the law. The chapters are presented in five parts, and each part contains an introductory chapter written by Barry J. Evans. Four chapters appear for the first time in this anthology. These were written by Robb O. Stanley (chapters 2 and 16), Alan W. Schefflin (chapter 3), and Edward Ogden (chapter 22). Of the remaining 18 chapters, 17 have appeared earlier in the *Australian Journal of Clinical and Experimental Hypnosis*, and one chapter, by Martin T. Orne (chapter 7), appeared in the *International Journal of Clinical and Experimental Hypnosis*.

Original publication details appear on the first page of each reprinted chapter. Unfortunately, however, in giving these details the editors have omitted the year of original publication. This is an important omission because this anthology will appeal most to those libraries (and those individuals) that do not subscribe to the journals in which the articles initially appeared. In chapter 6 (Judd, Judd, & Burrows), reference is made to the Australian Law Reform Commission's Evidence Report, and the hope is expressed that it might resolve some issues that affect the admissibility of testimony affected by hypnosis in Australian courts. This report has now been implemented by the passage of significant new legislation in the form of the Evidence Acts 1995 (Cth) and (NSW). This legislation, however, offers no specific resolution for any of the problems identified in the Judd et al. chapter. Lawyers reading this anthology should be aware of this fact; psychologists and psychiatrists, however, may not be. The inclusion of original publication dates would alert these readers to the possibility of such problems and avoid the misleading impression that the material presented is current to 1994.

The chapters of the anthology are arranged into five parts. The first, titled "General Issues," contains articles written by authors from a number of different disciplines. It provides information about the control of the use of hypnosis in Australia and the United States. Noteworthy is the excellent chapter by Alan W.

Schefflin (chapter 3), an American legal academic. This section also contains the original article by Martin T. Orne (chapter 7), and his set of guidelines that have been used as a standard by the courts when they have considered the admission of hypnotically refreshed testimony.

Part II contains a number of articles, authored by Kevin M. McConkey and Peter W. Sheehan, that present original experimental studies. Australians can take pride in the fact that McConkey and Sheehan are world leaders in the experimental study of hypnosis and its legal applications. Significant new information about the process of hypnosis and its effects is presented, and the impact of this information on ideas about the nature of memory and suggestibility is explored. The next two parts present, in turn, the clinical viewpoint and the forensic viewpoint. The final part contains relevant case studies.

Although they are not explicitly identified, it is possible to discern four more general themes to which various passages throughout this anthology relate. One of these is expository. A wealth of information about hypnosis – both general and case specific – is presented. There are three normative themes. First, it is repeatedly suggested that the law should restrict the ability to practise hypnosis to professionals; there is no dissent from this proposition in the anthology. Second, there is general, but not unanimous, agreement that the courts should admit hypnotically refreshed testimony, subject to safeguards. The more interesting question apparently is what safeguards should be imposed. Majority opinion is that the Orne guidelines contain necessary but not sufficient safeguards. Third, there is a strong and important difference between clinical and forensic hypnosis. McConkey (chapter 9) points out that the aim of hypnosis in the clinical setting is to reconstruct past events to aid in the treatment of an individual, whereas the aim of hypnosis in the forensic setting is to determine which past events occurred to fix responsibility for these events. The clear recognition that these two aims are to some extent incompatible echoes the proposition that others have advanced.

In what I have said so far, I believe I have supported the idea that valuable insights are to be derived from the interdisciplinary nature of this work. It remains to be seen whether the anthology demonstrates the difficulties of interdisciplinary work. I wish here to point to two instances. The first is trivial: Technical legal terms have been misused. On page 61, for example, the statement is made that a decision of the Minnesota Supreme Court reversed a decision of the Maryland Supreme court. "Reversed," in legal usage, means that the later inconsistent decision was from a court in the same jurisdiction. The Minnesota Supreme Court cannot reverse the Maryland Supreme Court. Much more serious is the unsatisfactory nature of the first substantive article (chapter 2). This article, authored by Robb O. Stanley, presents information about the legal regulation of hypnosis in Australia and leads to an argument supporting the draft Hypnosis Registration Act. The argument is acceptable, but the article is poorly organized. It would have been better to take each point and present

each jurisdiction's provisions on that point in comparison with the draft Act. It would have been even better, however, to start with the concluding paragraphs which, although appearing under the heading Summary, actually present an argument not made earlier. A still greater improvement would have been to consolidate this chapter with chapter 16, also by Stanley, so that the reader knew up-front why the regulation of hypnotists was desirable. On further reflection, and taking into account that Stanley is a psychologist, this might be evidence not that interdisciplinary work is hard to do right, but that it is difficult to work outside one's discipline. It is a pity that a good argument has been weakened to the point of extinction by a poor presentation.

In conclusion, ignoring the precept I have just laid down, I'd like to state that what this anthology's substantive chapters lack in primacy is more than compensated for by recency. The account of the Knibb case (1987), that leaves readers to draw their own conclusions on the basis of the information presented, will haunt me.

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EILIS S. MAGNER, University of New England, Armidale, New South Wales.

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| Robert G. Kunzendorf,
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| Björn Enqvist | <i>Pre-Surgical Hypnosis and Suggestions in Anesthesia</i> . Stockholm: Department of Health Sciences, Karolinska Institute, 1996. |
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