

AUSTRALIAN JOURNAL OF CLINICAL AND EXPERIMENTAL HYPNOSIS

MAY 2003

VOLUME 31 NUMBER 1

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subscriptions should be addressed to the Editor.

EDITORIAL

With this first issue for 2003, I am pleased to advise that David Spiegel, MD, has accepted my invitation to become an Editorial Consultant for our journal.

David is currently Jack, Lulu and Sam Willson Professor in the School of Medicine and Associate Chair, Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine. He is an internationally renowned psychiatrist, clinician, researcher, and academic, with an extensive publications record across many applications of medicine, psychiatry, and hypnosis. David runs a major Center on Stress and Health at Stanford University, as well as having many current research activities in stress, health, and his Supportive/Expressive Group Psychotherapy.

David kindly contributed a manuscript titled "Acute Stress Disorder and Dissociation" (with his colleagues Cheryl Koopman and Catherine Classen, *AJCEH*, 22) to my first edition as editor in May 1994. I am happy to formalise his collegial relationship with the *Australian Journal of Clinical and Experimental Hypnosis* and the Australian Society of Hypnosis by welcoming him to the position of Editorial Consultant.

Barry Evans
May 2003

HYPNOSIS WITH TREATMENT FOR THE ANXIETY DISORDERS

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This paper describes the research and clinical literature relating to the anxiety disorders. It begins with a review of the general nature, classification, and aetiology of anxiety disorders, using DSM-IV criteria. Approaches to the treatment of each anxiety disorder are then discussed, including information-giving, cognitive-behavioural techniques, and pharmacological interventions. The broad range of suggestions for effective management highlight the need for an eclectic approach to client management. The particular relevance of hypnosis as an adjunct to the range of therapeutic approaches suitable for these disorders is then discussed, focusing on the evidence for the higher hypnotisability of at least some types of anxiety disorder sufferers. The clinical material suggests that hypnosis has a range of applications in anxiety disorder management.

In lay terminology, people are said to “feel anxious” in situations which represent demands on their coping ability. These might include situations of danger or being faced with important events. We prefer not to use the word “anxiety” to describe what is essentially a state of arousal which, while it may be unpleasant and increase discomfort, is not debilitating in the sense conveyed by the use of the term: “to feel anxious.” Some level of arousal or what others term “normal anxiety” is part of a natural reaction to stressful demands which can be helpful in assisting the individual marshal the energy and activity required to cope with daily life (Bootzin, Bower, Crocker, & Hall,

This paper was originally published in a longer version in *Hypnosis in Australia*, The Australian Society of Hypnosis, Melbourne, 1998.

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1991). However, as arousal increases, and anxiety is felt, they can begin to interfere with the individual's concentration, attention, and performance, limiting overall ability to cope (Bootzin et al., 1991). At very high levels of arousal, people may feel so anxious they cannot perform to a usual or required standard.

Such feelings of arousal, through to mild and elevated anxiety, should be distinguished from the term "anxiety state," which is a continual and, often, irrational feeling of discomfort and tension, in the absence of any justifiable cause (Bootzin et al., 1991; Dally & Watkins, 1986). Such an anxiety state characterises those who suffer from the anxiety disorders.

Our aim in this paper is to describe the range of anxiety disorders, to review treatment approaches and focus specifically on the use of hypnosis as an adjunct to therapy.

The anxiety disorders are the most frequent psychiatric diagnoses (Rickels, Case, & Schweizer, 1988), with an estimated incidence of around 9.0% of the adult population (Goldberg & Huxley, 1980; Schapiro et al., 1984). In certain populations, such as medical patients and those suffering from specific medical conditions, the incidence can rise as high as 25–28% of patients (Dally & Watkins, 1986).

Jackson (1995) commented that therapists often experience great difficulty addressing the issue of anxiety with clients. Clients may fail to understand their feelings of generalised anxiety, which, from their point of view, are not related to what is happening in their lives. They find it difficult to accept that their problems, whether physically or psychologically oriented, are occurring as the result of anxiety. It is interesting that although most clients are aware of the terms "anxious" and "anxiety," few understand clearly what the terms mean. Part of the therapist's task is an educational role: to view anxiety from the standpoint of a generic term for a variety of conditions, which vary markedly in their classification, aetiology, presenting symptomatology, and treatment approaches. Viewing the anxieties from this standpoint, as Jackson argued, has a significant impact on the range of therapeutic approaches one can consider and makes it far easier for the therapist to offer the client a satisfactory treatment rationale.

With this view of the anxieties in mind, the therapist can then help the client distinguish between arousal or "normal" anxiety and abnormal or pathological anxiety. As we commented above, clients can identify with the idea that mild to moderate levels of arousal help them cope more effectively

with the stresses and demands of life. When aroused, their reactions become faster, their concentration improves, there is greater stimulation to get things done, and, overall, an increased sense of mastery. On the other hand, when the person experiences heightened anxiety or feels constantly anxious, there is a reduced capacity to plan, make accurate or logical decisions, carry out skilled tasks, or cope in general with everyday life events. Helping the client understand the relationship between their feelings of anxiety and subsequent effects of this on their coping and self-esteem may be an important first step in helping them learn control over their anxiety.

THE CLASSIFICATION OF ANXIETY DISORDERS

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV: American Psychiatric Association [APA], 1994), provides a suitable classification system for the anxiety disorders. It divides the anxieties into the following clinically recognisable groups:

1. Panic Disorder (with and without agoraphobia).
 2. Specific Phobia (replacing Simple Phobia).
 3. Social Phobia.
 4. Obsessive–Compulsive Disorder.
 5. Generalised Anxiety Disorder.
 6. Substance-induced Anxiety Disorder or that resulting from a medical condition.
 7. Anxiety Disorder not otherwise specified.
- (Note: this paper does not include Post-Traumatic Stress Disorder or Acute Stress Disorder).

The essential characteristic of most anxiety disorders is the occurrence of panic attacks, the sudden onset of a discrete period of intense fear or discomfort accompanied by a range of somatic or cognitive symptoms, and the fear that such attacks may recur. DSM-IV provides information on the specific diagnostic features of each of these disorders and the frequency, severity, and associated requirements for a formal diagnosis. Our approach here is to discuss the general features of the disorders, at both a clinical and sub-clinical level, for which the treatment approaches and hypnosis techniques described in this paper are equally applicable.

THE NATURE OF THE ANXIETIES

Panic Disorder and Agoraphobia

Those suffering from panic disorder and agoraphobia experience a constant sense of apprehension, which they often describe as a "fear of fear." Their initial panic attack can "come out of the blue" and can encompass a terrifying fear they are about to die, lose control, have a stroke, or "go crazy." The accompanying heightened response of the sympathetic nervous system in turn produces an increased release of adrenalin into the circulatory system, causing systemic over-arousal (Murphy, Siever, & Insel, 1985). Many of the distressing symptoms of panic disorder, including chest pains, shortness of breath, dizziness, faintness, sweating, nausea, paraesthesia, and flushes or chills are the result of this sympathetic nervous system over-arousal. Panic attacks can last from minutes to hours and can vary significantly in their frequency and severity.

Sufferers often report depersonalisation and describe feeling as "as though I'm looking at things through a frosted glass window" or "as if I'm on another planet." Once a person has experienced that first attack, there is a likelihood of further attacks recurring in that situation. This fear of panic attacks can become so intense that, in many people, it leads to avoidance behaviour. Sufferers are disinclined to move away from places they perceive to be safe unless accompanied by a trusted, supportive figure. "It's like living on the edge of a precipice" is the way that many clients describe their feelings at this stage of the disorder.

Despite the relatively common incidence of both agoraphobia and panic disorder in the general community, there is little firm research and clinical evidence to suggest an invariable relationship between the two disorders. Clinically, it is known that a small group of sufferers develop panic disorder without progressing to full-blown agoraphobia. Similarly, agoraphobia can occur in the absence of panic attacks. DSM-IV classifies agoraphobia as a more severe form of panic disorder, and avoidance arises from a reluctance on the part of sufferers to put themselves in the position where they might panic.

It is not at all clear why some people who suffer from panic disorder go on to become agoraphobic, while others do not. Jackson (1995) argued that clients most likely to develop panic disorder and agoraphobia were those who were expert at what he termed cognitive distortions and who "catastrophise" situations and events, especially where they face the likelihood of having to leave their perceived place of safety. The role of such cognitive distortions and

irrational thought processes have an important bearing on therapeutic management for, unless due recognition is given to cognitive factors and the person is shown ways of effectively dealing with them, progress is likely to be slow.

Specific Phobia

The category of specific phobia introduced into DSM-IV replaced the category of Simple Phobia used in DSM-III-R (APA, 1987). The defining feature of a specific phobia is a marked and persistent fear of a clearly delineated and circumscribed stimulus, exposure to which provokes an immediate anxiety response. This response may comprise a situationally bound or situationally disposed panic attack. The list of stimuli which could precipitate a phobic reaction is extensive, with the most common involving animals (including fear of dogs, snakes, insects, and mice), flying, heights, closed spaces, thunderstorms, and blood or tissue injury. Anything, in fact, has the potential to trigger a fear response. Adults typically understand their fear is excessive and unreasonable but this may not apply in the case of children suffering from the disorder. For a formal diagnosis, the anxiety reaction must be so severe as to result in marked distress and cause significant interference with daily life. Whether or not a formal diagnosis can be made in any particular case, the treatment approaches and management strategies discussed below will be appropriate. In this context, it is worth noting that DSM-IV reports that, although phobias are common in the general population, they rarely are serious enough to warrant a formal diagnosis of specific phobia.

The sufferer from a specific phobia experiences a marked anxiety response when exposed to the feared situation or even when anticipating such exposure. Generally, the intensity of their reaction is determined by the proximity of the feared stimulus and the severity of previous exposures to the stimulus. It is important to discuss with the client their anticipatory anxiety and self-talk in relation to the feared stimulus, as these may be contributory factors in the development and maintenance of the phobic reaction.

Jackson (1995) argued that the specific phobia for which a person seeks treatment is usually apparent to both therapist and client, but it is important to clarify the validity of what the client believes to be the problem. To safeguard against selecting the wrong anxiety theme or dimension, there are two important questions the therapist can ask. Having sketched out a scene based *closely* on the client's description of an anxiety-provoking situation, ask:

“What would make this even more anxiety-provoking?” and “If you could not get away from this situation, what could you do to make things better?”

These questions help to clarify the correct dimensions of the phobia and ensure the appropriateness of the treatment approach then used (Clarke & Jackson, 1983).

Jackson (1995) concluded that specific phobias are a “*special* form of fear which: (1) are out of proportion to the demands of the situation; (2) cannot be explained or reasoned away; (3) are beyond voluntary control; and (4) lead to avoidance of the feared situation” (Marks, 1969, p. 3). Modelling may also play a part in the development of fears in an individual, and most therapists are familiar with cases in which children exhibit similar fears to a parent.

Social Phobia

Those who suffer social phobia have a marked and persistent fear of social or performance situations in which they may experience embarrassment or ridicule from others. The performance anxiety may be very specific, such as a fear of one’s hands trembling when writing in front of others, being unable to think of what to say when speaking in public, or a fear of choking when eating in a public place. Alternately, the anxiety may be of a more general nature, such as saying foolish things or not being able to answer questions in social situations. Both varieties of social phobia are usually accompanied by a great deal of anticipatory anxiety and result in cognitive dysfunction, typified by negative self-talk.

Social phobias often develop in the mid-teens, usually developing out of a history of childhood inhibition or shyness (DSM-IV, 1994; Marks, 1970; Turner, Beidel, & Larkin, 1986). Epidemiological studies suggest a lifetime prevalence of 3% to 13% (DSM-IV, 1994), but the incidence of performance anxiety related to public speaking and social situations may be much higher, given that the strict criteria for a formal diagnosis may not be met. Again, we make the point that treatment may be required to manage what is a distressing concern for the client, whether or not a formal diagnosis may apply in any given case.

Social phobics show evidence of significant general anxiety, and mild depression can often be a defining characteristic (Jackson, 1995). The severe distress which occurs when the person is no longer able to avoid the feared situation often drives them to seek treatment. Epidemiological studies suggest social phobia is more common in women than in men but, in most clinical

samples, the sexes are equally represented or the majority are males (DSM-IV, 1994).

Jackson (1995) reviewed the evidence which suggests clients with high levels of emotional arousal are more susceptible to acquiring phobias than those with low arousal (Asso & Beech, 1975; Hugdahl, Fredrikson, & Ohman, 1977) and arousal levels (anxiety) are excessive in social phobics preceding the onset of the phobia (Hall & Goldberg, 1977). Personality factors, such as shyness and introversion, may be contributing factors to the social interaction difficulties these people often experience (DSM-IV, 1994). Low self-esteem and lack of assertiveness are commonly associated with social phobia and may play a significant role in aetiology (Kagan, Reznick, & Snidman, 1988; Orenstein, Orenstein, & Carr, 1975).

An important factor in the onset and maintenance of social phobias may be the cognitive processes which precede and follow performance situations. As a group, sufferers of phobic disorders are more inclined to irrational beliefs than non-phobics (Rimm, Janda, Lancaster, Nahl, & Dittman, 1977) and this is particularly the case with social phobia sufferers. The importance of cognitive factors in the aetiology of social phobia is hard to determine but, together with low self-esteem, it would appear on clinical grounds alone that both are important contributing factors.

Obsessive-Compulsive Disorder

Sufferers of obsessive-compulsive disorder are characterised by the presence of recurrent, anxiety-provoking, intrusive thoughts, and compulsive acts aimed at trying to reduce anxiety and control the intrusive thoughts. Common obsessions are persistent thoughts of violence (killing one's child), contamination (becoming infected through touching someone), and doubt (repeatedly wondering if one has hurt another person when driving a car).

Compulsions, on the other hand, are repetitive, purposeful, and intentional behaviours that are performed either in response to an obsession, according to set rules, or in a stereotyped fashion. The sufferer realises their behaviour is irrational but has to perform the rituals as a means of relieving anxiety and tension. The most common compulsions are hand-washing, counting objects (e.g., bricks on a wall), checking (e.g., locks, electrical switches), and touching. These compulsive acts also have the effect of producing anxiety, because the sufferer realises the behaviours are irrational, but is unable to resist them (Dadds & Powell, 1992; DSM-IV, 1994).

The disorder can start in childhood, when obsessions tend to centre on dirt, germs, or concerns that something terrible will happen. The age of onset for the great majority of obsessive-compulsive disorder sufferers is generally between 10 and 24 years of age. The illness usually fluctuates in intensity, but the client is rarely entirely free of symptoms at any stage. In about two-thirds of adult clients, it is associated with significant depressive episodes, and panic attacks, social phobia, and generalised anxiety which frequently complicate the clinical picture (Jackson, 1995).

Obsessive-compulsive disorder may result from dysregulations in serotonin (5HT) neural transmission (Jackson, 1995), or disturbances of the basal ganglia and associated circuits, with a consequent effect on behaviours, such as checking and cleaning (Rapoport, 1990). Support for the involvement of biological processes also comes from studies showing a genetic component, some evidence for cerebral dysfunction in those with the disorder, the beneficial effects of brain surgery for a subpopulation of sufferers, and the successful use of medication for the disorder (Dadds & Powell, 1992). At the present time, however, there are no clearly defined biological markers for obsessive-compulsive disorder.

Recently, attempts have been made to explain the aetiology of obsessive-compulsive disorder in terms of learning theory, emphasising the role of classical conditioning, social learning, and modelling processes in the maintenance of obsessive thoughts and actions. As Dadds and Powell (1992) conclude, however, while these models can explain how the thoughts and behaviours are reinforced, they cannot explain what caused the obsessive cycle in the first place. There is also a suggestion that the disorder may be perpetuated by the cognitive processes characteristic of sufferers, who typically appear to have little confidence in their checking ability, hence they repeat the process (Dadds & Powell, 1992).

Generalised Anxiety Disorder

Generalised anxiety disorder is the most common form of anxiety presenting to medical practitioners and therapists. It is a significant clinical problem, affecting up to 12 % of the general population (DSM-IV, 1994; Marks, 1987).

The disorder is characterised by excessive anxiety and anticipatory concern about a range of activities the person might have to carry out. This anxiety is difficult to control and results in a number of physical and psychological symptoms. These include: restlessness, fatigue, lack of concentration, irritability, muscle tension, and sleep disturbance. Although three or more of

these are required for the formal diagnosis of generalised anxiety disorder, a client experiencing one or more of these symptoms at a sub-clinical level could still be suffering the significant distress and impairment of daily living that is also part of a formal diagnosis.

Global anxiety and worry are the core factors in generalised anxiety disorder (Borkovec & Inz, 1990). Some of these centre on anticipations of coping difficulties, especially in social situations. They may also be precipitated by the sudden onset of illness, injury, surgery (Beck & Emery, 1985), or by a variety of life events that are outside the person's control.

Generalised anxiety disorder can become chronic if not adequately treated. In spite of its relative frequency in the general population, only an estimated 23% of sufferers receive treatment (Schapiro et al., 1984). An estimated two-thirds of sufferers are women (DSM-IV, 1994).

Anxiety Disorder Due to a General Medical Condition or Substance Use

The essential feature of both these conditions is clinically significant anxiety caused by the medical condition or substance use. In determining whether the anxiety condition is due to a medical condition, the therapist needs to establish the presence of a medical condition and determine that the anxiety is physiologically caused by the condition. If this relationship cannot be established, a formal diagnosis cannot be made and a diagnosis of primary anxiety disorder may be appropriate (DSM-IV, 1994).

For a formal diagnosis of anxiety disorder caused by substance abuse, there must be direct evidence of intoxication or withdrawal. DSM-IV (1994) makes the point that primary anxiety disorders may precede the onset of substance abuse or occur during times of sustained abstinence.

Anxiety Disorder (not Otherwise Specified)

This general category covers prominent anxiety or phobic avoidance which do not meet the criteria for any specific anxiety disorder. DSM-IV (1994) gives such examples as mixed anxiety-depressive symptoms which do not meet diagnostic criteria for either anxiety or mood disorder; clinically significant social phobic symptoms that are related to having a general medical or psychiatric condition; and cases where the therapist or clinician cannot meaningfully conclude whether the anxiety disorder is primary, or due to a medical condition or substance use.

HYPNOSIS IN THE TREATMENT OF THE ANXIETY DISORDERS

A number of research and clinical studies have suggested that phobic patients show greater hypnotic susceptibility than other groups (Frankel, 1974, 1988; Frankel & Orne, 1976; Frischolz, Spiegel, Spiegel, Balma, & Markell, 1982; John, Hollander, & Perry, 1983; Kelly, 1984; Rodney, Hollander, & Campbell, 1983), although this has not been universally found (Owens, Bliss, Koester, & Jeppsen, 1989).

To explain this phenomenon, Frankel (1974) speculated that an individual's heightened hypnotic susceptibility may be implicated in the development and maintenance of phobic conditions, a view supported by Evans (1991) and Spiegel, Koopman, and Classen (1994). Higher hypnotisability has also been associated with diagnoses of hysteria and multiple personality (Bliss, 1983, 1984), anorexia and bulimia (Pettinati, Kogan, Margolis, Shrier, & Wade, 1989), and post-traumatic stress disorder (Spiegel, Hunt, & Dondershine, 1988; Stutman & Bliss, 1985), the latter, of course, now categorised as a form of anxiety disorder.

The available research and clinical data have shown that hypnosis can be used very effectively as an adjunct to other treatment approaches for each of the anxiety disorders. This occurs, not only because of the possible higher hypnotisability of some sufferers but also because many of the specific phenomena of trance, such as the client's inward focus of attention, reduced capacity for critical reasoning, heightened imagery, and distortions of memory can be used by the therapist as part of many anxiety management interventions (Stanley, Burrows, & Judd, 1990). In addition to these uses for hypnosis, there are a number of specific ways in which hypnosis can contribute to other therapeutic modalities.

Using Hypnosis to Enhance Rapport, Client Expectations, and Motivation

As Coman (1997) noted, the introduction of hypnosis into therapy can have a constructive effect on the relationship established between therapist and client. This has been demonstrated with a variety of client groups, including post-traumatic stress disorder, phobic and weight management clients (Evans, 1991; Goldstein, 1981). Hypnosis strengthens non-specific therapeutic factors in the client-therapist relationship, increasing the client's expectation of change and improvement (Goldstein, 1981; Vanderlinden & Vandereycken,

1990). Clients have made an effort to deal with their anxiety problems and hypnosis can have the profound effect of fostering a sense of hope that the problem can be overcome.

Changes in clients' capacity for critical thinking and alterations to information processing, memory distortions, and heightened imagery capacity (defining characteristics of trance), can also be used in conjunction with hypnotic suggestions to help maintain clients' motivation for treatment and reduce therapeutic resistance (Edgette & Edgette, 1995). Clients' experiences of involuntary muscle movements and other changes in conjunction with hypnotic suggestions provide a powerful motivation to continue with therapy and enhance their beliefs the therapy will work (Golden, 1994; Goldstein, 1981).

Improving Communication in Therapy

Clients' reduced capacity for critical thinking in hypnosis is well documented (Clarke & Jackson, 1983; Shor, 1969). In therapy, the effect of this is to make the client more responsive to the communication of the therapist (McConkey, 1984).

Alterations to cognitive processing in trance also help the client create alternative interpretations of life events, including the significance of these, effectiveness of coping, and what the person expects will be the outcome (Edgette & Edgette, 1995). Such processes of reinterpretation are particularly important in anxiety disorder management, wherein the major goals of therapy are twofold: (a) restructuring cognitive processes which, in the past, have helped maintain the client's anxiety state; and (b) substituting alternative, more effective, cognitions (Jackson, 1995).

Enhancing Imagery and Feelings of Control in Hypnosis

The increased suggestibility and enhanced imagery capacity shown by clients in trance can be used in conjunction with imagery-based therapies to increase the efficacy of treatment. This applies particularly to systematic desensitisation, one imagery-based therapy which is very effective in the treatment of phobias (Golden, 1994; Lang, 1979; Wolpe, 1969). Its use with anxiety-disordered clients is described later in this paper. Those clients who appear to benefit most from systematic desensitisation are those who experience heightened emotional responses to the mental imagery of their feared situations (Lang, 1979). The more realistically clients are able to experience the imagery of

their feared situation in trance, the more rapid and effective treatment becomes (Golden, 1994).

Hypnosis may also be used to help clients not only imagine anxiety-provoking situations but to help them rehearse effective coping in those situations, without the emotional response which normally accompanies such imagery and rehearsal. Even though the client is experiencing with increased realism the feared situation, they are, at the same time, receiving the message that the event can be experienced without the usual emotional response. This quickly helps clients develop new cognitions in relation to their ability to endure the situation in real life, without anxiety (Beck & Emery, 1985; Edmonston, 1981; Evans, 1991), enhancing feelings of control. Changes in perceived ability to deal with anxiety-provoking situations can be effected through behavioural or cognitive control (Bandura, 1988). Behavioural control may take the form of doing things to reduce anxiety, while cognitive control is heightened by instilling the belief that the client can manage anxiety-provoking situations.

Absorption in, and Dissociation From, Feared Situations

The anxiety disorders are characterised by sufferers' absorption in their fear state, which begins with exposure to a specific anxiety-provoking situation and then often generalises to coping in general. The anxiety this causes becomes reinforced in clients' negative cognitions about their ability to cope in general, and contributes to the distress and fear these clients have about the world and their ability to cope with it. This absorption in the fear state is similar to the intense absorption in the focal experience shown by hypnotised subjects (Tellegen & Atkinson, 1974). One result of intense absorption is usually a state of dissociation from one's immediate surroundings and conscious experience and, in the case of the anxiety sufferer, an inability to lead a "normal life," feeling constantly overwhelmed by their "fear of fear."

Anxiety sufferers' dissociative capacity is also an important dimension to the effectiveness of hypnosis. The research and clinical literature has shown that many anxiety disorder subjects, particularly those with post-traumatic and phobic disorders, have high dissociative ability. Subjects frequently report dissociation during traumatic experiences (Spiegel, 1989), with many reporting a feeling of floating above their bodies, remaining detached from what is taking place. Such reports are particularly common in rape cases (Rose, 1986; Spiegel, 1989). Dissociation during the stressful event is a

defence against the powerful negative affect associated with the experience they are enduring (Brende, 1985; Spiegel et al., 1988). This dissociative capacity can be used very effectively in therapy. Given that the trance state intensifies the client's focus of attention on reliving the traumatic event and reduces peripheral awareness, hypnotic techniques are useful in helping them regain control over their thought processes. As Spiegel (1989) noted, the very discreteness of the hypnotic state helps the client put a boundary around their anxiety-provoking situation or fear syndrome. The therapist, rather than telling the client not to mull over the details of the experience, instructs the individual to imagine the event, without experiencing the emotional reactions that usually accompany this imaginative experience. Hypnosis is thus used to teach the client to reduce their emotional reactivity to anxiety-provoking situations.

TREATMENT FOR THE ANXIETY DISORDERS

The primary goals of all psychological therapies for anxiety states are:

1. Educating the client about the nature of their anxiety disorder and the relationship between anxiety and feelings of arousal.
2. Teaching the client relaxation techniques, to help them master feelings of anxiety.
3. Exposing the client (via imagery or reality) to the situation provoking their anxiety, thereby allowing deconditioning, habituation, or desensitisation.
4. Assisting them to cognitively re-evaluate these situations to alter the perception of threat.
5. Giving the person the insight to evaluate the personal, symbolic significance of the anxiety provocation.
6. Increasing the individual's sense of self-efficacy, both behaviourally and cognitively, thus improving their ability to deal with anxiety eliciting situations and the symptoms which then result.
7. The rehearsal and practice of new coping strategies. (Jackson, 1995)

The therapist needs to complete a full investigation of each presenting client's problems, concerns, and reasons for these, and then develop a treatment approach tailored to the particular client.

The major therapeutic approach for the anxiety disorders is behaviour therapy, or more commonly, cognitive-behaviour therapy, which has been shown to be of value to over 70% of clients (Marks, 1981). The components

of therapy are typically relaxation training, imaginal and exposure techniques, and cognitive restructuring. Other techniques useful for each of the disorders include: provision of appropriate information about the disorders, providing a rationale for treatment procedures to be used, behavioural techniques to control hyperventilation, pharmacological treatment, and hypnosis. Our approach in this section of the paper is to review general treatment approaches, and to highlight specific aspects of therapy for individual anxiety disorders.

Presenting the Correct Information

Many anxiety sufferers have a poor understanding of their condition. As we said above, they do not understand what is happening within their bodies to produce their distressing symptoms, and the role of their negative cognitions in exacerbating their disorder. The first aspect of treatment, therefore, should be to discuss all aspects of the disorder and its physiological, psychological, and social effects on the sufferer.

One approach to this information role reported by Jackson (1995) is to describe to the client how their body normally reacts to stress. When faced with psychological or physical stress, the body produces catecholamines, like adrenalin, to help the individual face the stressor or run away (the fight-flight mechanism; Selye, 1976). Jackson described how this approach provides a format for describing to the client the way in which their body releases excessive amounts of these chemicals during anxiety and panic disorder. The analogy may well be extended, describing how the body, faced with constant stress, eventually uses up its coping reserves and depletes its ability to cope with the current and future stress. In the same way, panic disorder sufferers spend all their energy simply trying to cope with the anxiety they feel and do not have the reserves to cope in other areas of life.

Another technique for describing to a client how anxiety overwhelms them is to describe anxiety as being an overload situation of the mind. Each of us has a particular coping threshold when faced with stress, beyond which we find our coping reserves taxed. Any individual's coping threshold is, in part, inherited and, in part, the outcome of our life experiences. Clients can find this appealing because it suggests their problems are not necessarily of their own making. If the pressures of life are such that the threshold level is exceeded, this results in overload and the individual responds with the typical physiological and psychological signs of distress. This explanation may seem

simplistic but it can help the client come to a far better understanding of the mind-body relationship. At the same time, it encourages a greater degree of involvement in the use of self-help procedures. A basic rule of therapy is that you will be unable to get full client cooperation unless they are able to understand the nature of their problem (Jackson, 1995)

Clients are often reassured and feel comfortable with the knowledge that their arousal and anxiety symptoms stem from changes within their body and are not the result of them "having gone crazy." Having described how our bodies respond to stress and arousal, it is then important in therapy to openly discuss with the individual their beliefs and feelings about their mental status. Jackson (1995) commented that most clients are reluctant to discuss their panic feelings and often fail to mention them unless directly questioned. They believe they are the only persons who suffer these problems and are embarrassed about describing them for fear of being thought crazy or stupid.

Providing a Rationale for Treatment

The effectiveness of any therapeutic management plan for the anxiety disorders is, in part, contingent upon explaining to the client the goals of therapy and providing a rationale for the treatment approach (Clarke, 1992; Clarke & Jackson, 1983). Without this, the client may not identify with the therapeutic regime and accept they are ultimately responsible for implementing the treatment and cooperating with the therapist by, for example, completing homework exercises and activities outside the therapeutic setting.

Another important element to therapy is to ensure the client understands the sequencing of therapeutic goals. For example, the client may present to seek help in dealing with the physical symptoms of their panic attacks. The immediate goal of therapy may be to assist the individual to develop relaxation techniques to deal with these symptoms. Over time, as the client achieves success at this level, the goal of therapy may move to developing a sense of mastery and control over the thought processes that contribute to the onset and course of panic attacks. The therapist should assist the client to understand each phase of therapy and the goals and techniques relevant to each.

Explaining the rationale for treatment is particularly important for the client with generalised anxiety disorder. Generally, these sufferers present in the acute phase of the disorder. They are prepared to suffer chronic symptoms until the disorder reaches the point where it seriously interferes with quality

of life or is producing severe physical effects and most believe they can rectify the situation without professional advice. Once the disorder has become chronic, it requires an extensive period of therapy and often calls for the client to practise behavioural and cognitive techniques on their own. For this reason, it is imperative to detail for these clients the aims of, and rationale for, treatment strategies.

Whatever the illness or psychological problem, client cooperation is never easily achieved. Many studies (e.g., Dodd, 1971) have shown that in general psychiatric clinics, 20% to 57% of patients fail to return after the first visit. Where self-help issues are concerned, studies are equally gloomy. Reviews of clinical populations suggest that 20% to 30% of patients fail to follow short-term medication regimens when the regimen is curative and 30% to 40% when the regimen is preventive (Sackett & Snow, 1979). Obviously, client compliance may not be easily achieved and may be especially difficult with an anxious person who is already overwhelmed with health concerns and negative cognitions. Achieving client compliance may well centre on how adequately the therapist explains treatment rationale. This may involve discussing such issues as the type of procedures to be used, the duration of the treatment programme, frequency of consultations, and the nature of the client's involvement in home practice techniques (Jackson, 1995).

Relaxation Procedures

Anxiety disorders are typically accompanied by high levels of generalised anxiety and/or depression. This contributes to sufferers' constant feelings of being unable to cope with life, a feeling reinforced when the person suffers panic attacks. For this reason, most therapeutic programmes incorporate the teaching of relaxation techniques to clients, as part of the treatment methodology.

Relaxation techniques are implemented to help clients control their feelings of tension and anxiety — to “let go” emotions and tension (Goldfried & Davison, 1976). Examples of relaxation techniques include deep breathing, muscular tensing and relaxation, pleasant imagery, and suggestions of relaxation (Golden, 1994). Clarke (1992) reports a relaxation procedure in which the client is asked to physically relax with eyes closed, then increase breathing up to a point where they first become aware of approaching panic. Breathing is then controlled and relaxation again induced.

The ability to learn and use relaxation techniques goes a long way towards breaking down the constant arousal and tension which are a feature of anxiety disorders and agoraphobia. Sufferers find it difficult, at first, to achieve worthwhile levels of disengagement from their constant concerns and it is only persistence in practice and constant reinforcement that finally produce rewards. Achieving a relaxed state helps the client develop the awareness that they can experience feelings other than fear and anxiety. Even if these feelings and thoughts are short-lived at first, they foster a sense of hope that something can be done to alleviate their distress. Increasing morale is an important aspect of treatment, especially in the early stages, and it encourages the client to believe they are able to take responsibility for therapy. This is a valuable aid to counterbalancing some of the feelings of hopelessness and helplessness these people experience (Jackson, 1995).

A defining characteristic of clients with a specific phobia is their physiological and psychological distress whenever they have to confront their fear stimulus. In therapy, this can be of sufficiently high levels as to interfere with desensitisation procedures and can sometimes have the effect of causing the client to drop out of therapy. For these clients, therefore, training in, and mastery of, relaxation techniques as a means of anxiety reduction is useful, irrespective of the type of therapeutic programme being instigated (Morgenstern, 1974). In addition to these considerations, relaxation training helps ensure client compliance with self-help routines (Jackson, 1995).

Relaxation techniques are an integral part of any treatment approach for social phobia clients, to help them reduce excess tension and anxiety, which interferes with functioning away from the social situation. This increases feelings of self-control and, when paired with anxiety management using imaginal techniques for the specific feared situation, contributes to self-esteem.

For obsessive-compulsive clients, with their high levels of arousal and anxiety, relaxation techniques can help reduce these and, in combination with other techniques, enable the individual to take control of their distressing feelings. Relaxation mastery, tied with hypnosis, is especially useful as a counter-anxiety procedure and has the added advantage of reinforcing imagery desensitisation. It provides a valuable way of enhancing positive self-statements designed to reinforce self-esteem. The importance of this lies in the fact that most OCD sufferers exhibit a marked loss of self-esteem and self-worth. They are constantly beset by thoughts that they are quite different from others, and that no one would really wish to befriend them (Jackson, 1995).

Control of high arousal levels is also an important adjunct in the management of generalised anxiety disorder sufferers. Relaxation *per se* plays a small role in the long-term management of the disorder (Andrews, 1990), but it acts as a powerful motivator for change and control in other areas of the client's life.

Relaxation techniques are valuable procedures in reducing high arousal levels, so that cognitive and behavioural approaches can be implemented in therapy. The more relaxed state of mind resulting from relaxation (and hypnosis) enhances the use of positive self-statements (cognitive reframing), intensifies visualisation processes (coping imagery), and enables the individual to more easily challenge their negative cognitions (cognitive restructuring). Having learned to relax, clients feel more capable of challenging negativity and are more responsive to suggestion. Relaxation also intensifies visualisation techniques, thus providing a valuable means of "mentally practising" positive responses in a wide variety of feared scenes (Jackson, 1995).

Behavioural Techniques to Control Hyperventilation

Hyperventilation is a commonly experienced symptom of panic attacks and it is the symptom for which many clients initially seek treatment (Jackson, 1995). One effective way to help clients deal with this problem is through the use of behavioural cues, which can be accessed whenever the individual feels panic feelings developing. One effective technique is to teach the client to say the following words to themselves, immediately upon feeling the onset of anxiety or a panic attack:

This is part of my fear system ...
It will soon pass ...
I'll slow down my breathing ...
Slow it right down ...
Slow down my breathing ...
Slow it right down ...
Slow down my breathing ...
I feel in control again now.

Each line is timed to coincide with each breath, which must be consciously slowed down. This technique works most effectively if the client memorises the words and practises them when free of anxiety and panic. The person can print the words on a card, which they carry at all times so it can be referred to if necessary (Jackson, 1995).

Cognitive Restructuring

Generally speaking, anxiety sufferers are not only disturbed by their excessive physiological arousal symptoms, distressing as these are, but also by the catastrophic interpretations they place on these (Clarke, 1992). An important element to therapy is to help clients deal with emotionally laden thoughts.

The first step is to explore the person's cognitions and then to show how to challenge them. Most cognitive restructuring procedures involve two stages. First, the client is taught how to self-monitor self-defeating thoughts and beliefs which lead to maladaptive emotions; then these thoughts are replaced with more constructive rational ones (Golden, 1994). While it is true many clients are initially not interested in examining how their thoughts and emotions are connected (they are more interested in controlling the latter), they become receptive when they learn to control emotions by changing thought processes. To aid in the process of cognitive restructuring, Golden uses what he terms the "two-column method." Clients record their automatic negative thoughts on the left-hand side of a page. Then, together with the therapist, they formulate therapeutic suggestions that can be used to neutralise these automatic thoughts, which are recorded on the right-hand side of the page. For example, the thought: "I'll get sick and vomit" (when flying) might be usefully replaced with: "I'll use anti-nausea medication, self-hypnosis, distraction, and breathing techniques to control nausea" (Golden, 1994).

One of the principal features of social phobia is cognitive dysfunction. The social phobic invariably gets locked into a series of negative self-statements (e.g., "What if I stand up in front of the group and my hands shake and I can't remember my talk?"). Unless this problem is addressed and the client is taught to challenge the validity of this self-talk, it will constantly undermine treatment. It can be difficult to manage, for even if the client realises the self-talk is illogical, they can still find it hard to disprove in the phobic situation. At this point, imaginal and *in vivo* exposure techniques may be useful.

Cognitive restructuring can also be used to help those anxiety clients who develop a chronic form of cognitive dysfunctioning, characterised by those who admit they "worry if they haven't anything to worry about" (Jackson, 1995). Helping the individual break this vicious cycle can prove difficult, but is an essential process if long-term anxiety relief is to be achieved. Cognitive restructuring centres on two aspects: first, helping clients recognise their negative cognitions, and, second, showing them how to prove to themselves their thought processes are not based on logic but on false beliefs. These

techniques may require considerable time and skills, as negative thinking can become so ingrained in an anxious client that it is a way of life and having to constantly challenge it sometimes proves a demanding task (Walen, DiGiuseppe, & Wessler, 1980).

Finally, cognitive techniques can be used to help clients confront their feared stimulus *in situ*. For example, the client can be taught the use of a cue word such as "calm," when confronting their fear. Spoken in time with the exhalation phase of breathing, a cue word can reduce the person's anxiety and enables them to continue confronting the stimulus. The essential feature of this technique is that the cue is practised, at first, in non-fearful situations. Once it has become established as an anxiety circuit-breaker, it reinforces a sense of confidence that they can cope with fear (Jackson, 1995).

Thought stopping and distraction techniques are other useful ways of dealing with clients' anxiety, which can be combined with cognitive therapy. The essential feature of cognitive therapy is to teach the client to challenge their obsessions and prove to themselves there is no rational basis to their thoughts. A recurring question, for example, that can be posed is, "What reason do I have to believe that I must think these thoughts?" or "If I resisted them, would anything terrible happen to me?" Training the person to constantly recognise, challenge, and revise their negative thinking patterns is a core aspect of management with these clients.

Imaginal and In Vivo Exposure

The anxiety sufferer's systematic exposure to their feared environment or stimulus is an integral element of almost all therapy. Although there is an understandable reluctance for a person to enter any situation where panic attacks have occurred, there is clear research and clinical evidence to show that it is vital to get the client to address their phobic situation and to remain exposed until there is a drop in anxiety (Clarke, 1992).

Exposure can take a number of forms: imaginal (either systematic or flooding); and *in vivo*. The differences between types of exposure relate to the amount of anxiety which may be generated and perceptions of control during the procedure. As Clarke (1992) points out, it appears critical that some degree of anxiety must be generated for desensitisation to be successful and he goes on to explain this may be why agoraphobia sufferers respond better to flooding techniques in which anxiety is heightened, compared with systematic desensitisation where anxiety is kept to a minimum.

Imaginal exposure techniques are useful for preparing clients to face their feared situation in the real world, or situations in which it would be difficult to arrange real-life exposure. The most common form of imaginal exposure is systematic desensitisation, in which the client is systematically exposed to their feared stimulus or environment. Together with the therapist, the client draws up a hierarchy of situations associated with their fear, starting with the least and progressing to the most anxiety-provoking. The client's anxiety is rated on a 10-point scale (10 = *extremely anxious*). An anxiety level of 5 or above is excessive and, as part of the therapeutic process, the client is asked to stay with the scene until they feel more comfortable, with an anxiety level below 3. The client cannot progress to the next level on the hierarchy until the previous scene no longer evokes an anxiety response. This systematic desensitisation procedure enables the client to confront each feared situation under ideal conditions, that is, when relaxed.

Jackson (1995) argued one of the shortcomings of imaginal exposure is that the client sometimes feels so distressed by having to "stay in the scene" they unconsciously avoid it by losing attentional focus or going to sleep. This is especially the case when vicarious exposure is carried out in hypnosis. He suggested that, should this problem occur, it could be remedied by allowing the client a means of allaying their anxiety for a short period before having to confront the fear stimulus once more. He termed the procedure "contrast desensitisation," which generally has the effect of creating an even more graduated and gentle confrontation with the fear situation. From a clinical standpoint, it encourages a greater degree of involvement in the exposure process.

The essence of the technique involves the client rating their fear levels in the imagined scene. If these are excessive (e.g., above 5 on a 10-point scale), the therapist suggests the client imagine themselves moving to a place of security (their "inner mental place") in which they can only experience tranquil, pleasant thoughts and feelings. They remain in that scene until they no longer feel anxious, at which stage they return to the original fear situation. If their self-assessment of their anxiety is still excessive, they return once more to their quiet haven. This process is repeated with each level of the fear hierarchy until the client is able to vicariously confront the fear without excessive anxiety. This procedure enables the client to confront each dimension of their fear hierarchy with less distress. Although, as Jackson (1995) suggested, the technique runs against established principles of

desensitisation, in the clinical setting it is a valuable way of treating a variety of simple phobias as well as the more complex picture of agoraphobia.

Systematic desensitisation is one of the most valuable ways of treating social phobia. For these clients, the technique involves eliciting a series of scenes from the least fearful (e.g., "You are at home getting ready to go to the meeting"), to the most feared, which provoke increasingly more affective responses. These can be carried out as real-life exposure or can quite effectively be introduced in hypnosis. It is always important that the client be asked to sketch out the major themes and dimensions, rather than have them arbitrarily set out by the therapist. Only when the client's fear level for any specific scene drops below 3 does the therapist progress to the next scene (Jackson, 1995).

Flooding is another imaginal technique. Keane and Kaloupek (1982) report the case of a veteran who suffered from panic attacks, depression, alcohol abuse, traumatic nightmares, and other intrusive phenomena. The therapist spent 10 minutes relaxing the client, then started the flooding by asking him to imagine the weather conditions, terrain, the locale, the people, and the way he was feeling at the time. The details of the event were then gradually presented by the therapist, who regularly elicited feedback from the client regarding the next event in the sequence. When the man became visibly anxious, especially during the most disturbing aspects of his memory, he was encouraged to retain the image as long as possible until it was no longer anxiety-provoking. All scenes were concluded by eliciting the events and emotions associated with the time immediately following the trauma. Flooding appears to be most effective when there is prolonged exposure to the anxiety-provoking stimulus: Indeed, too short an exposure time can overwhelm and sensitise the client (Golden, 1994). At the same time, the therapist needs to ensure the images used are not frightening to the extent that the client's fear is intensified, so realistic, rather than frightening, images are recommended (Emmelkamp, 1982). Imaginal flooding as an imaginal technique is also very useful for social phobia clients (Turner, Beidel, & Jacob, 1991).

Another approach to imaginal flooding involves the client being asked, during the first session, to recall all the circumstances associated with their feared event. Then, in subsequent sessions, the person concentrates on particular aspects of the situation — for example, fear of bodily injury, dying, aggressive behaviour, rejection, and punishment for wrongdoing. Such an

approach is helpful when the client has created a number of irrational cognitions in relation to the feared event.

Another behavioural technique similar to flooding can be used when the client has developed strongly held fears or exaggerated startle responses (e.g., following a car accident). The client is taught to relax and is then taught behavioural rehearsal — focusing on the image of driving down a section of road similar to that in the event, until the emotional response is controlled. This can then be practised *in vivo*.

Which is the better technique: systematic desensitisation or flooding? The research literature is mixed, with some favouring systematic desensitisation and others flooding (Levis & Hare, 1977; Marks, 1975; Paul, 1969). Some researchers have suggested there are no differences between the two types of exposure (Levis & Hare, 1977), but numerous others have argued flooding is more effective with agoraphobia and obsessive-compulsive disorders (Clarke, 1992; Golden, 1994). It is obviously appropriate to use both, with the choice depending on the type of anxiety or trauma experienced by the client and their subsequent ability to create a fear hierarchy. Whatever the type of approach, most imaginal interventions have four steps:

1. Training in relaxation techniques and pleasant imagery.
2. Imaginal exposure to the anxiety-provoking situation, using systematic desensitisation, flooding, or variations.
3. *In vivo* exposure.
4. Encouraging the client to carry out the systematic desensitisation or flooding outside the therapy situation, in practice or in real life.

Having learned to control their anxiety and emotional arousal using imaginal techniques, it may well be appropriate for the client to practise these new skills in the real-life situation. Having clients confront their fears through *in vivo* exposure is seen by many as being the most effective form of desensitisation (Emmelkamp & Wessels, 1975; Marks, 1975). In the early stages, it may be useful for the therapist to accompany the client, to provide support and to help ensure the client does not resort to avoidance strategies, rather than confronting their fear and its attendant distressing symptoms.

Hypnosis

The general applications for hypnosis have already been discussed. These relate to the enhancement of rapport, expectations, and motivation; increasing

the efficacy of communication; enhancing imaginal techniques; providing the client an increased sense of control; and the role of absorption and dissociation in therapy. The therapist can utilise these applications to:

1. Help the client re-establish a sense of security and coping through a supportive relationship.
2. Help the client establish control over physical symptoms and cognitive anxiety, allowing the introduction of exposure techniques and improving the client's self-esteem.
3. Introduce imaginal rehearsals of coping as a prelude to in vivo exposure.
4. Enhance the client's motivation and determination through the exploration of what freedom from the symptoms means to lifestyle ("Doing what they have always wanted to do").
5. Help the client alter their general self-image.
6. Enhance dissociation from the anxiety situation and self or symptom focus (a healthy dissociative mechanism) (Jackson, 1995).

Generally speaking, it can be argued that hypnosis practitioners typically use anxiety management techniques similar to those used in behaviour therapy and cognitive-behaviour therapy — relaxation techniques, guided imagery, and desensitisation.

Hypnosis can readily be used in conjunction with the range of relaxation techniques described above. Golden (1994) does make the point that therapists need to have a wider range of hypnotic inductions than simply relaxation inductions, as the anxiety and emotional state of the client may be contraindicated for such an approach. Imaginal and desensitisation techniques can also be made much more efficacious when used with hypnosis. As we described earlier, hypnosis allows the client to: (a) experience the feared situation more fully, allowing; (b) more rapid control over anxiety and emotional reactions which normally accompany this exposure, but in a way which; (c) places a boundary around the event. The experience of being able to control, in trance, what was previously an uncontrolled emotional reaction to the feared situation or trauma highlights for the client a sense of growing power and self-esteem.

Cognitive restructuring is often utilised while the client is in trance. The increased suggestibility and reduced cognitive processing capacity of individuals in hypnosis, described above, mean that trance is a rapid means of creating new, rational cognitions and thoughts to replace the old irrational thoughts.

Self-hypnosis is often a part of the therapeutic programme for the management of anxiety, panic attacks, and agoraphobia. The therapist can build self-hypnotic training around the client's relaxation, desensitisation, and in vivo practice. Prior to confronting an anxiety-provoking situation in situ, the client can enter a self-hypnotic state and rehearse their practised coping strategies and cognitive restructuring statements (Golden, 1994).

Hypnosis can also be used as an adjunct to the treatment for specific phobias, to enhance the effectiveness of imaginal desensitisation techniques. This is achieved through the vividness of the imagined stimulus which can be evoked in trance and the covert modelling utilised for the development of effective coping strategies. Hypnosis is also used to ensure more rapid and effective cognitive restructuring and enhanced self-efficacy in coping, as well as enhancing the client's sense of self-control, and increasing self-confidence (Liebowitz, 1987).

Hypnosis also has utility as a means of helping the client dissociate from their feared stimulus, allowing them to experience the situation without the usual absorption in their anxiety reaction, the latter explaining why these clients develop such an extreme phobic response. Dissociation from the feared stimulus, in trance, facilitates the effectiveness of the client's exposure in imaginal or real-life situations (Jackson, 1995).

Age regression techniques in hypnosis may be used to help the client and therapist explore the symbolism of feared objects and situations, or the uncovering of traumatic experiences which may be related to the object (Clarke & Jackson, 1983). Both these aspects to therapy are illustrated in the case of Paul, on whom hypnotic age regression was used to explore the aetiology of the client's panic attacks.

Regression was initiated by suggesting to Paul that: "In this trance, your mind is very clear and you can remember things very clearly, like this morning, when you were home . . . Where are you?" As he was taken back in time, Paul was asked: "You are able to remember things when you are in a trance that you have repressed . . . memories, events, feelings that are related to your problem . . . And you can tell me about them now . . . as you remember them." (Golden, 1994, p. 272). Upon elicitation of the fear stimulus, the client showed an extreme anxiety response, which was brought under control with hypnotic relaxation and suggestions he would "feel confident" and could "master" these feelings and overcome his fear. Before terminating trance, Paul was taught self-hypnosis, to continue the therapeutic process in his own time.

Hypnotic techniques described for the treatment of other anxiety disorders are equally applicable as an adjunct in the treatment of social phobias. Here, hypnosis is used to reduce anxiety, increase self-esteem, and enhance the effectiveness and rapidity of cognitive restructuring. Altering the client's cognitions by highlighting their positive characteristics and successes is an important technique with these sufferers. The therapist can also help alter cognitions about the possibility of projected social disasters not occurring, and that, even if these do occur, the individual can cope with the resulting anxiety and embarrassment. When the client has been taught self-hypnosis, this can be used in situ to help the person develop control over anxiety and bodily processes, in situations where they fear loss of control.

Hypnosis may also be used to teach clients to dissociate to a tranquil and relaxed state, whenever an anxiety situation occurs. This dissociated state is best achieved by teaching the client a cue word specific to their feared social situations. The client rehearses and develops this dissociated state using the cue word as part of imaginal rehearsal in trance and can use the technique in real-life situations.

Social Skills Training

Later in therapy, when clients have learned to control their anxiety and emotional arousal through the use of imaginal techniques, many can benefit from social skills training. There is research and clinical evidence to suggest that at least some forms of mental disorder, primarily social phobia, are caused or exacerbated by a lack of social competence, which can be cured or alleviated by social skills training (Trower, Bryant, & Argyle, 1978).

Like systematic desensitisation, social skills training is a counterconditioning procedure, designed to improve the client's general social competency and ability to deal with specified fear-provoking social situations. The client is taught general social skills and practises these in imaginal rehearsal, followed by implementation in the anxiety-provoking situations. The aim of this technique is to enable the person to enter a feared scene with far less distress. One way of improving the client's social competency is by practising different ways of dealing with a number of possible scenarios. The principal aim is to provide a variety of behavioural techniques, designed to improve the person's coping abilities in general social settings, as well as the fear situation (Jackson, 1995; Trower et al., 1978).

Support Groups

Clients suffering from obsessive-compulsive disorder can find comfort and support from attending meetings of similarly afflicted people. The realisation that they are not alone in their distress can prove to be very reassuring, for they often hold the belief that they are alone in their symptoms and feelings. Discussing their problems with others in a group forum allays these concerns and often helps to reinforce the person's commitment to continue in treatment. As is the case with most psychological disorders, the drop-out rate from therapy can be high, especially if the rate of progress does not match the patient's expectations. Anything which encourages persistence in treatment must be viewed as of great benefit in long-term management (Jackson, 1995).

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USING HYPNOSIS IN THE PAEDIATRIC ONCOLOGY SETTING

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Despite the fact that research on clinical hypnosis with children is still in an early stage of development and the child hypnosis literature is predominantly comprised of anecdotal case histories and uncontrolled research studies, one of the best documented uses of hypnosis is in the treatment of children with cancer. Hypnosis has established a successful record in the paediatric oncology setting mainly in the management of chemotherapy-related nausea and vomiting and procedure-related pain where it has achieved status as an empirically supported intervention. This paper summarises the current literature and the author's clinical experience of the efficacy and usefulness of hypnosis in the paediatric oncology setting.

Psychological approaches to symptom management are among the oldest and are an intrinsic part of medical practice in every culture. Suggestive therapy is probably the oldest of all therapeutic methods and hypnosis under various names has been used for as long as records have been kept. Using hypnotic techniques with children also dates back to ancient times. Despite the fact that research on clinical hypnosis with children is still in an early stage of development and the child hypnosis literature is predominantly composed of anecdotal case histories and uncontrolled research studies, one of the best documented uses of hypnosis is in the treatment of children with cancer.

Hypnosis has established a successful record in the paediatric oncology setting mainly in the management of chemotherapy-related nausea and vomiting (NV) and procedure-related pain where it has achieved status as an empirically supported intervention (Liossi, 1999, 2000). Moreover, hypnosis

has been successfully utilised for the management of other cancer-related symptoms such as chronic and phantom limb pain, needle phobia, generalised anxiety, dysphasia for pills, and insomnia.

In this paper, the current literature about the uses of hypnosis in the paediatric oncology setting will be briefly reviewed. The first section examines the research evidence for the efficacy of hypnosis in the control of procedure-related cancer pain and the management of chemotherapy-related nausea and vomiting. This is followed by a discussion of the uses of hypnosis in the treatment of other symptoms and the evidence presented in this section is primarily drawn from the author's clinical work with this population. The next section provides a brief description of the current body of knowledge regarding hypnotic responsiveness, together with a review of clinical hypnotic interventions used with children with cancer. In the final section an attempt is made to summarise and evaluate the existing literature regarding the use of hypnosis with the paediatric cancer population.

Hypnotic Intervention Studies for Paediatric Procedure-Related Cancer Pain

Children and adolescents in treatment for cancer undergo numerous painful procedures, including venepunctures, lumbar punctures, bone marrow aspirations, and biopsies. There is now a growing body of scientific evidence which suggests that a cancer diagnosis itself, in combination with associated invasive procedures and treatment protocols, renders patients at risk for long-term psychological distress, sometimes manifesting itself in compromised treatment compliance.

Hypnosis interventions have been found to be of significant help in reducing pain and anxiety during painful medical procedures in all studies conducted thus far (Katz, Kellerman, & Ellenberg 1987; Kuttner, Bowman, & Teasdale, 1988; Wall & Womack, 1989; Zeltzer & LeBaron, 1982). The consistency of the findings and methodological considerations of current studies indicates the usefulness of hypnosis as an effective intervention for helping children and adolescents control pain and anxiety associated with medical procedures. It renders hypnosis as an empirically validated intervention in procedure-related pain management (Liossi, 2002) according to the criteria developed by Chambliss and Hollon (1998) and endorsed by the American Psychological Association.

The two most recent studies conducted in the area have provided compelling evidence for the significant role that hypnosis can play in the management of procedure-related pain in children with cancer. In the first, Lioessi and Hatira (1999) conducted a controlled trial to compare the efficacy of clinical hypnosis versus cognitive-behavioural (CB) training in alleviating the pain and distress of 30 paediatric cancer patients (age 5–15 years) undergoing bone marrow aspirations. Patients were randomised to one of three groups: hypnosis, a package of CB coping skills, and no intervention. In the hypnosis group, children received hypnotic analgesic suggestions (i.e., request for numbness; and topical, local, and glove anaesthesia) and were given posthypnotic suggestions. In the CB group, children were taught relaxation training, breathing exercises, and cognitive restructuring. In the control group, children received a standard lidocaine injection (as did children in both other groups). Results demonstrated that patients who received either hypnosis or CB reported less pain and pain-related anxiety than did control patients and less pain and anxiety than at their own baseline. Hypnosis and CB were similarly effective in the relief of pain. Results also indicated that children reported more anxiety and exhibited more behavioural distress in the CB group than in the hypnosis group.

In the second study, the same investigators (Lioessi & Hatira, in press) conducted a prospective controlled trial to investigate the efficacy of a manual-based clinical hypnosis intervention in alleviating the pain of 80 paediatric cancer patients (6–16 years of age) undergoing regular lumbar punctures. Patients were randomly assigned to one of four groups: direct hypnosis with standard medical treatment; indirect hypnosis with standard medical treatment; attention control with standard medical treatment; and standard medical treatment alone. Results confirmed that patients in the hypnosis groups reported less pain and anxiety and were rated as demonstrating less behavioural distress than patients in the control groups. Direct and indirect suggestions were equally effective. The level of hypnotisability was significantly associated with the magnitude of treatment benefit in the hypnosis groups. For both hypnosis groups the therapeutic benefit degraded when patients were switched to self-hypnosis. The investigators concluded that hypnosis is effective in preparing paediatric oncology patients for lumbar puncture but the presence of the therapist may be critical for success.

Nausea and Vomiting Management

Nausea and vomiting are the most frequently reported and debilitating adverse effects of cancer chemotherapy and radiotherapy and have remained prevalent despite the use of increasingly potent antiemetic medications (i.e., 5-HT₃ receptor antagonists). These side effects are sometimes so serious that they compromise compliance with therapy, a problem most prevalent in the adolescent population. Patients may postpone, refuse completely or be unwilling to complete a full course of potentially curative or palliative chemotherapy because of the unpleasantness of these symptoms (Morrow & Hickok, 1993).

Initial reports on the use of hypnosis to treat NV were in the form of case studies. Subsequently several controlled studies (Cotanch, Hockenberry, & Herman, 1985; Jacknow, Tschann, Link, & Boyce, 1994; Zeltzer, Dolgin, LeBaron, & LeBaron, 1991; Zeltzer, Kellerman, Ellenberg, & Dash, 1983; Zeltzer, LeBaron, & Zeltzer, 1984) have assessed and supported the efficacy of hypnotherapy in alleviating chemotherapy-related NV. The most recent study (Hawkins et al., 1995) demonstrated the effectiveness of hypnosis for the reduction of anticipatory NV in a randomised controlled-design study that assessed the possible therapeutic gains that may be derived from hypnosis while controlling for gains that may be derived from non-specific therapeutic factors. Following baseline assessment, 30 paediatric oncology patients (5–17 years of age) undergoing an identical chemotherapy course were randomly assigned to one of three groups: "treatment as usual" control group; therapist contact group; and a hypnosis training group. Hypnosis was effective in reducing both anticipatory nausea and vomiting. Therapist contact alone was also found to be effective in reducing anticipatory nausea but this was a statistical rather than a clinical effect.

Hypnosis and the Child with Cancer

Reports from several centres agree that hypnotherapy can be sometimes valuable in dramatic ways for a vast array of physical and psychological problems that arise in children with cancer. The present author has successfully used hypnosis for the treatment of a number of physical and psychological symptoms including: depression, anxiety, passivity and helplessness, phantom limb and mucositis pain, insomnia, and to enhance ego function and help the child to experience feelings of safety, trust, hope,

autonomy, competence, self-esteem, and dignity, and to increase the child's ability to relate positively to their family and health care professionals.

However, in the light of a lack of controlled studies it is important not to over-emphasise the role of hypnosis. Hypnosis is one of many therapeutic options (psychological and pharmacological) which combined can act together to bring about the desired effect — the best possible quality of life for the child with cancer and his family.

Childhood Hypnotic Responsiveness and Treatment Outcome

Children have long been regarded as good respondents to hypnosis and hypnotic interventions with hypnotic-like states common to their experience. Antecedent conditions are found in childhood play, fantasy, and imaginary playmates. Hypnotic ability is limited in children below the age of 3, achieves its apex during the middle childhood years of 7–14, and then decreases somewhat in adolescence, remaining stable through midlife before decreasing again in the older population. There are no significant differences in hypnotic responsiveness between boys and girls at any age. Children's natural desire for mastery of skills and for understanding of, and participation in, their environment is directly related to responsiveness to hypnosis (Olness & Gardner, 1988). Clinicians capitalise on these qualities when they introduce hypnosis to a child as "something new you can learn how to do — not everybody knows how to do it, just as not everybody knows how to ride a bike" (Wester & O'Grady, 1991).

Although there are inconsistent clinical and laboratory reports on who is a good or not good candidate for hypnosis, clinical experience attests that almost any patient can benefit from individualised treatment, as long as the patient wants to use hypnosis. With some motivation on the part of the patient and with individualisation of the methods, nearly any child with cancer can benefit from these techniques, although the patient with more responsiveness will probably respond more readily to any approach.

Apart from specific correlates of hypnotic responsiveness in childhood, such as age and hypnotisability, several variables not directly related to hypnotic talent may enhance or impede hypnotic responsiveness in a clinical setting. These include the child's parents', and health care professionals' attitudes towards hypnosis. When preparing a child to learn hypnosis and self-hypnosis, it is vital to assess the parents' expectations and to clarify why hypnosis is being

used. Usually, children look to their parents for guidance and assurance when facing new situations, and if the parents communicate a confident attitude toward hypnosis the child is much more likely to be trusting and cooperative. Hypnotherapy can be undermined by opponents of its use, so it is therefore essential to secure the cooperation of all those concerned in the child's care.

Overall Plan of Hypnotic Interventions

The process of clinical hypnosis with children can be divided conceptually into six phases:

1. preparation,
2. induction,
3. deepening,
4. therapeutic suggestions,
5. post-hypnotic suggestions, and
6. termination.

The hypnotist develops an overall plan of the hypnotic session by choosing tasks for each phase and arranging the suggestions for the task in a sequence.

Depending on the needs of the child, the pre-induction interview can be quite brief or more extensive. Preparation usually includes discussion of the reasons for utilising hypnosis, clarification of misconceptions, and full reply to questions. Details of the child's likes and dislikes, significant experiences, fears, hopes, and comfort areas are discussed. It is essential that the child forms a comfortable, trusting relationship with the therapist and feels safe with him or her (Olness & Gardner, 1988). Hypnotic treatment does not require passive submission but instead emphasises the child's involvement and control of the situation and is permissive enough to allow the child to participate actively and enthusiastically in his or her own treatment. Children respond to a large number of hypnotic induction techniques (e.g., visual imagery, auditory imagery, movement imagery, story-telling, ideomotor, progressive relaxation, eye fixation, distraction), each with countless variations. Any induction method may also be used as a deepening method, and methods may be combined in almost any order. The choice of an appropriate induction for any child depends on the age, needs and preferences of the child, and the skills and the training of the therapist. Compared with adults, children are more likely to wriggle and move about, open their eyes or refuse to close them and make spontaneous comments during hypnosis. Positive feedback should be given to

the child's responses, and expectations of success should be communicated by focusing on possibilities and avoiding words such as "try" that imply that failure may be the outcome.

The specific therapeutic suggestions used are obviously relevant to the physical or psychological symptoms that the child is experiencing. As a general rule they should emphasise children's involvement and control, and encourage their active participation in the process of experiencing and utilising hypnosis. The purpose of therapy is always to increase the child's control of desired feeling or behaviour, and any suggestion that emphasises loss of control can only inhibit therapeutic progress. Direct and indirect hypnotic suggestions have been proven equally effective in the treatment of children and this means that the clinician can utilise them both, depending on the preferences of the child. The therapist can also teach the patient self-hypnosis as a way for them to participate actively (in a motivated and purposeful way) in the treatment process, and to reinforce self-mastery.

CONCLUSION

Apart from its proven efficacy in actual symptom management, hypnosis has several other attractive features. It is safe and does not produce adverse effects or drug interactions. Children enjoy the hypnotic experience. They obtain relief without destructive or unpleasant effects. There is no reduction of normal functioning or mental capacity and no development of tolerance to the hypnotic effect. It is a skill which children can easily learn, that provides a personal sense of mastery and control over their problems and counters feelings of helplessness and powerlessness. An additional benefit is that hypnosis can be generalised to many circumstances. The child who learns hypnosis for management of pain or nausea and vomiting may apply their skills to lessen the distress of insomnia and anxiety or to enhance their performance in their favourite sport. For the clinician, hypnosis is an opportunity to be inventive, spontaneous and playful, and to build a stronger therapeutic relationship with a child while providing symptom relief (Liossi, 1999).

Clearly hypnosis has been shown in a number of studies to reduce the distress of children with cancer undergoing a variety of stressful procedures and chemotherapy. These studies have been conducted by a number of investigators using various experimental designs. There is also significant clinical experience that supports the use of hypnosis for the management of

other symptoms in every stage of the disease, including the terminal, and future research should provide the necessary empirical evidence.

It is believed that children with cancer would benefit tremendously from the wider application of hypnosis in paediatric oncology centres. In terms of clinical practice, the optimal control of children's symptoms (both physical and psychological) requires an integrated psychological and medical approach. Hypnosis is well suited to become an integral part of a comprehensive multidisciplinary cancer treatment approach.

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HYPNOSIS IN A CASE OF PRIMARY ENURESIS

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This case study describes the treatment of a 13-year-old boy for enuresis using hypnosis. The referring psychiatrist specifically requested hypnosis after physical causes had been eliminated and previous behavioural interventions had not resulted in a successful outcome. Intervention was based around that described by Kohen (1990) and Olness and Kohen (1996). Promising progress was shown over the three sessions. Issues associated with the intervention are discussed.

William, the younger of two brothers in a single-parent family, was referred by a child and adolescent psychiatrist for treatment of primary enuresis. At the age of 13, William had never had a prolonged period of consecutive dry beds.

William had been seeing a psychiatrist for several years for attentional difficulties and social issues, which were reported to have greatly improved. The psychiatrist noted, however, that the boy's enuresis remained intractable and had not been resolved using behavioural strategies (including a bell and pad), or pharmacotherapy. At the time of referral William was rarely having a dry night. Wetting only occurred at night and there was no soiling, although William's mother noted that he had trouble maintaining complete bowel control, only achieving this at 10 years of age. William was also reported to have had night terrors as a child, his mother reporting that he "hardly slept." William's older brother had no significant problems with toilet training or bed-wetting.

William had a history of asthma but, at the time of referral, the only medication he was taking was dexamphetamine for ADHD, which had been prescribed since he was eight years of age. He rarely drank caffeinated

I thank Nada Murphy for her helpful comments after reading a draft of the manuscript. Requests for reprints should be sent to Trevor Mazzucchelli, Clinical and Applied Psychological Services, PO Box 7017, Shenton Park, W.A. 6008. trevorm@iinet.net.au

beverages, just the occasional hot-chocolate. His mother noted, however, that he drank a lot of milk and lots of water.

William had no allergies, but it was reported that if he had too much sugar he became hyperactive. It used to be the boy's responsibility to put wet bedclothes in the washing machine but his mother reported that this resulted in arguments between herself and the boy when he did not do so. At the time of intervention, William was wearing incontinence pants during the night.

TREATMENT FOR ENURESIS

Two controlled studies suggest that hypnosis may be an effective intervention for enuresis and preferable to the most commonly used medication for this problem (Milling & Costantino, 2000).

Edwards and van der Spuy (1985) evaluated the effectiveness of hypnosis in treating 24 primary (i.e., never dry) and 24 secondary enuretic boys between the ages of 8 and 12. Following a baseline period in which the number of wet nights per week were tallied, children were randomly assigned to one of four conditions: no intervention, induction plus suggestions, suggestions without induction, and induction alone without suggestions. Suggestions were aimed at general tension reduction and enhancement of self-confidence and contained "dry night" suggestions for: (a) increased bladder capacity, (b) reduction of fluids before bedtime, (c) visiting the toilet before bedtime, and (d) awakening at night to go to the toilet if the bladder was full.

Results showed that by the end of the 6-week treatment period the number of wet nights per week for the "induction plus suggestion" and "suggestion only" groups had significantly decreased relative to the other conditions. Furthermore, at 6-month follow-up, all three treatment groups averaged between four and five dry nights per week which represented significantly greater reductions in wet nights than the non-treatment group, which averaged three dry nights per week. Overall, this study indicated that suggestions for dry nights, provided in or out of hypnosis, might be a useful intervention for enuresis.

Banerjee, Srivastav, and Palan (1993) treated 50 enuretic children, ranging from 5 to 16, with either hypnosis or imipramine, the most common drug therapy for this problem. Children in the hypnosis condition attended three sessions in which they were taught the anatomy and physiology of the bladder. Thereafter, these children listened to a hypnotic induction followed by suggestions for appropriate use of the toilet during the night. The children

were encouraged to practise self-hypnosis before going to sleep. Children assigned to the imipramine condition were treated with 25 mg every night for the first week. Doses were increased an additional 25 mg each week as necessary to produce dry nights. Comparable results were found between groups after three months of treatment, with 76% of the imipramine group and 72% of the hypnosis group achieving positive responses (as defined by all dry beds or decreased frequency of wetting). After three months of treatment and reinforcement, imipramine was discontinued, and active follow-up visits were discontinued for both groups, while the hypnosis group was encouraged to continue self-hypnosis practice. At follow-up six months later, only 24% of the imipramine group had maintained a positive response whereas 68% in the hypnosis group had maintained a positive response without clinical reinforcement. This difference between the two treatments was largely accounted for by the substantial number of youngsters in the medication group who had relapsed without the medication. The results of this study parallel those of other investigations of enuresis treated with imipramine; initially the medication produces a positive response followed by a high relapse rate when it is withdrawn (Blackwell & Currah, 1973).

A number of behavioural interventions have proven to be effective for enuresis including "enuresis alarm" and "Dry Bed Training" (Walker, Kenning & Faust, 1989). Hypnosis for enuresis was provided in this instance because it was specifically requested by the referring psychiatrist after physical causes had been eliminated and previous behavioural interventions had not resulted in a successful outcome. There were no contra-indications for the use of hypnosis.

TREATMENT PLAN

The agreed aim of therapy was to achieve dry beds and to accomplish this through hypnosis.

Session 1

William and his mother were seen together at the beginning of the session. I noted that interactions between them suggested a relationship affected by conflict. William's mother appeared tense and taciturn. William attempted to avoid interacting with either myself or his mother by focusing on a fantasy novel. His mother gave him instructions to "pay attention," "put the book

down,” and “concentrate.” I attempted to build rapport with William by asking about his book.

A brief history of the problem was obtained and statistics about the incidence of enuresis were presented. When asked what he wondered might be the reason for the problem, William indicated that he didn’t know. His mother answered that she didn’t know either. I explained that while the specific cause cannot always be discovered, and although many things had been tried in the past that “didn’t work,” the method I was going to teach would help William help himself, as long as he didn’t mind having dry beds.

Anatomy was discussed with the aid of a simplified diagram of the physiology and anatomy of urination drawn on a whiteboard. Suggested explanations provided by Kohen (1990) and Olness and Kohen (1996) were used. A drawing of the heart, kidneys, bladder, a “gate” or “door” on the bladder, a urethra, a brain, and a toilet were made while teaching about the function of each. The heart was described as a pump muscle that sends blood all over the body. The kidneys were described as a washing machine for the blood. The bladder was described as a place where the “pee” is stored. William was asked how he would know if he had to pee right at that moment. He answered that he “didn’t know.” I explained that the bladder would say something to the brain like, “hey brain, I’m full.” Arrows were drawn going back and forth between the brain and the bladder. I explained that the brain and the bladder communicate with each other. As the bladder tells the brain when it is full, the brain tells the bladder to keep the gate or door closed, and sends messages to other parts of the body so that it can get to the toilet to pee. The brain might have to send messages to the mouth and tongue to ask where the bathroom is, to the ears to listen to the answer, to the legs to walk to the bathroom, and to the hands to close the door. *Then* the brain sends a message to the bladder to open the gate and let the pee out in the toilet where it belongs, and then to close the gate again. William was told that since the brain and bladder have been communicating with each other for a long time in the daytime, it would be relatively easy to remind them to communicate with each other at night too.

Using suggestions provided by Kohen (1990), I explained to William that the brain is the boss of the body. Even when we are asleep the brain may be resting, but it is paying attention, taking care of us, dreaming, keeping our heart pumping, our lungs breathing, telling us how to kick the covers off if we’re too hot and so on. Sometimes the brain and the bladder get in the bad

habit of not talking to each other at night, and they need some reminders and some training.

Using this metaphor of the problem potentially served a number of purposes. The reference to "the brain" and "the bladder" is a dissociative suggestion to distance William from responsibility and guilt. It provided a useful way of thinking about the problem and a positive response expectation that the problem could be resolved.

William was instructed to make his own version of the diagram of the body and study this before going to sleep at night and "just think about what we talked about."

Explanation of hypnosis William was told that now that he knew how the body works I was going to show him how to use a relaxation and imagination exercise to help teach the brain and bladder to talk to each other during the night. I explained that the success of this exercise would depend on how involved he became in it, and how regularly he practised it. We discussed the best time to practise the exercise and mutually agreed that the best time would be when he first got to his bed, before reading his novel, so he wasn't too tired. We also agreed that William's mother would place a card on his pillow to remind him to do his exercise, but would provide no other reminders.

At this point, William's mother was given a description of enuresis and I explained her part in the self-hypnosis treatment program and then I asked her to leave the room. I noted that William become more responsive when he was on his own.

I asked William to draw the layout of his house, then asked him to describe his likes and dislikes. He explained that he loved eating and told me some of his favourite foods. He also stated that he really enjoyed reading Terry Pratchett books and inventing fanciful machines.

Hypnotic induction I used an imagery induction in which William was asked to imagine himself in his favourite place — an imaginary warehouse with tables laden with his favourite foods, his favourite characters from Terry Pratchett and with several of his inventions in corners of the building. William spontaneously closed his eyes and verbalised that he was imagining trying out one of his inventions — a machine that was able to simulate the experience of skiing snow slopes. During the induction William conversed naturally, describing in detail the contents of the warehouse. At times he opened his eyes to tell me what he was doing or to explain one of his inventions.

Deepening To deepen the experience and provide some ego-strengthening suggestions provided by Kohen (1990) were used.

You've probably already noticed that your face muscles are relaxed and that your breathing is slower than it was before. That's because you are doing this exactly the right way, and since you and your brain are the boss of your body, you can even make your relaxation even more than it already is, because our bodies already know how to relax, and we even relax a little bit each time we breathe out. Just notice how your shoulders go down every time you breathe out . . . that's right. So, to help relax even more, take a slow, deep breath, in and out, and when you breathe out, say "relax" to yourself, and just notice what happens as your shoulders go down and relax. Floppy and relaxed.

With each exhalation the muscle groups from the feet up to the head were labelled, and William was given suggestions for the muscles to get loose and floppy.

Ideomotor signalling William was told that while he continued to enjoy his imagination, I was going to ask him a number of questions. I asked him to show me a "yes" finger and a "no" finger. After this he was asked a series of questions: "Do you like the colour purple?" "Do you like to eat doughnuts?" "Would you like to have all dry beds?" To this last question, William's "no" finger raised, but then he quickly verbalised that he had made a mistake and raised his "yes" finger. His correction was accepted and he was asked to signal a "yes" when he was ready to have instructions to his bladder.

Trance utilisation Various therapeutic suggestions from Kohen (1990) and Olness and Kohen (1996) were then made, including:

1. "Before you go to sleep you can remind them to be sure to talk to each other tonight, just the same way they talk to each other so well during the day, because your brain is the boss of your body and the main computer. And when you practise this way, the way you are doing so well, you are really programming the computer, just the same way you teach your brain to teach you to do so many of those other things you do so well: riding your bike, reading, inventing amazing machines. So, the more you practise, the better you get." [metaphor for control]
2. "If your bladder fills up with pee, it will send a message to your brain to let it know. And I don't know what instructions you will give the brain and

bladder about how to talk to each other. Maybe you will tell them to have the brain wake up so that you can walk to the bathroom, open the gate, pee in the toilet and walk back to your nice warm, comfortable dry bed, or maybe you'll have the brain simply tell the bladder to keep the gate closed through the night. I don't know which." [presupposition, double-bind, positive expectancy, expectancy of control]

3. "Think of yourself awakening in a dry bed, knowing you will have a good day." [positive expectancy]
4. "Enjoy knowing your bed is dry because of your efforts, because you're the boss of your bladder muscle. Enjoy the good feeling of waking up in a dry bed as long as you like." [positive expectancy, expectancy of control]
5. "I don't know who is going to be the most proud of you when you have given yourself a dry bed every morning, whether yourself, or mum, or me, or who." [positive expectancy, expectancy of control]

Self-hypnosis instruction While in trance, William was given instruction in self-hypnosis:

It's nice before you finish to remind yourself of what you did to help give yourself the good feelings you have now, so that when you practise this each day for 10 or 15 minutes, you'll know exactly how to do it. So, just picture in your mind where you might sit at home when you practise, and then see yourself closing your eyes and thinking of something fun to start off your special thinking practice. Great . . . now notice that as your eyes close and you start to get comfortable that you can imagine anything you want . . . perhaps it will be your warehouse with all your incredible inventions and favourite foods . . . and you can notice everything about it . . . and when you practise this at home in this same way, you'll be able to notice, just as you have today, and even right now, the way your muscles relax as you breathe out. And you can allow the relaxation feeling to move up your body all the way . . . that's right . . . and then, just like today, as soon as the relaxation has gotten all the way to your head, then you can let your finger lift, and that will be the signal to yourself that you are as comfortable as you want to be for that practice time. And then when you're ready, be sure to give instructions to the bladder and brain about how you want them to talk to each during the night. And when you're finished, then you'll be done. When you're practising at night you can then just fall asleep, and if you're practising in the day, you can just gradually come back to

where you were at the start, but be sure to bring your proud and relaxed feelings with you.

Posthypnotic suggestions William was given the posthypnotic suggestion that, "whenever you practise this thinking exercise, it will get easier and easier to do, and you will get better and better at teaching yourself to wake up every day in a nice, dry bed." He was then given the instruction, "When you're ready, you can open your eyes and enjoy the rest of the day."

Debriefing William was told that he did a great job. When asked what he noticed that he liked the most, he told me that he enjoyed trying out some of his inventions.

Homework William was engaged in a commitment to practise this relaxation/imagination exercise daily. I also asked him to keep track of numbers of dry beds at home, to bring his own rendition of the diagram of the body to the next session, and to "just think about" the communication between the brain and bladder prior to his next visit. This initial session took 60 minutes.

Session 2

William's mother reported that he was dry on one out of the five nights since the previous session. Although William had refused to let his mother participate in the reminder system and his mother was sceptical that he was practising his hypnosis exercise, the boy stated that he had practised on all but one night.

William was seen alone for the first part of the session. He had not completed his own rendition of the diagram of the bladder and the brain and needed assistance to draw his own version as part of the session.

Assessment of hypnotic capacity Despite verbalisations suggesting strong visual imagery, because William had fidgeted, opened his eyes and made comments, and his responses to the ideomotor signalling appeared volitional, I had doubts as to whether he had achieved hypnosis in the previous session. I used the Stanford Clinical Scale for Children (SHCS-C: Morgan & Hilgard, 1979) to assess his hypnotic capacity. William was responsive to all of the test items except the posthypnotic suggestion. Interestingly, he did not respond immediately to the cue to exhibit the posthypnotic response, but then demonstrated recognition as to why I had clapped by stating, "Oh, I forgot [to

do what you wanted me to]." William's responses on the SHCS-C indicated a willingness to cooperate with suggestions, if not his hypnotic capacity.

Hypnosis A similar induction and suggestions were used as in session 1. When given the double bind suggestion that, "if your bladder should fill up with pee, I don't know whether your brain will send a message to your body to wake up and go to the toilet or send a message to the bladder to keep the gate firmly shut until the morning," William said that he would keep the gate shut.

Debriefing I praised William for his efforts. When asked what he liked the most, William said that he enjoyed eating foods that he's not normally allowed to have.

Homework William was again engaged in a commitment to practise his self-hypnosis exercise on a daily basis and keep track of dry beds. He was asked to "think about how the brain and bladder are communicating with each other" when he went to the toilet at other times during the day.

Consultation with mother William's mother was seen alone for a short period of time. She indicated that she did not believe that William was practising and found it difficult not to remind him. I explained that the more she tried to encourage William to practise, the more he may resist. Self-hypnosis is not something that can be forced. Instead, we discussed ways to increase William's motivation to achieve dry nights. She decided to reward William with a chocolate frog for each dry night and give him permission to skip his dreaded morning shower.

She expressed concern that William was having a friend to sleep over on Friday night. He did not want to wear his incontinence pants, and mother felt that, if he did not, she should cancel the visit. She was concerned that if William wet the bed, his friend would gossip about him. It was agreed to alert him of the risks and leave the decision to him. William was called back into the room and the situation was discussed.

He confirmed his decision not to wear incontinence pants. When asked what he could do to make it more likely he would be dry, he said that he could have fewer drinks in the evening. I explained that this might help in the short-term, but may not be helpful in the longer term because it would mean that his bladder would get smaller and get full more quickly. William was reminded that he needed to keep practising his imagination/relaxation exercise. This session took 60 minutes.

Session 3

William's mother prompted him to report that he had been dry on four out of seven nights. Although he reported that he had been practising his relaxation/imagination exercise, he attributed some of his success to restricting drinks in the evening. As it turned out, William's friend could not come around on the Friday night, thus avoiding the dilemma.

Hypnosis A similar induction and suggestions were used as in the first two sessions.

Homework William was again engaged in a commitment to practise his self-hypnosis exercise on a daily basis and keep track of dry beds.

Consultation with William and his mother Since William had demonstrated his competence in the strategy, it was agreed to suspend further contact. This session took 45 minutes.

OUTCOME

Twelve months after intervention, I made phone contact with William's mother. She informed me that although William had made progress in the weeks after receiving instruction in hypnosis, this was not maintained. Four months after the last session, however, William's father resumed regular contact with him. Soon after this time William stopped wetting, and has mostly remained dry ever since.

William's mother reiterated her belief that the hypnotic approach did not have a fair trial. She expressed her belief that William did not practise his self-hypnosis exercises, commenting that she used to check up on him by looking through his bedroom window when he was supposed to be doing his exercise. At these times, she noted, he would be reading a book or playing on a computer game.

DISCUSSION

This case study describes the hypnotic treatment of enuresis in a 13-year-old boy. At 12 month follow-up William was reported to have been having dry nights for about eight months. It is impossible to know what to attribute this improvement to, although it seems plausible that the resumption of contact with his father is related. It is also possible that the instruction outlined in this paper contributed to his subsequent success. Promising progress was shown

over the course of the intervention, despite several factors that may have impacted on the intervention's success. These issues are discussed below

First, it was apparent that the relationship between William and his mother was affected by conflict. Olness and Kohen (1996) observed that the process tends to go less well if parents teach, reinforce, or are otherwise involved in the process. Although I did not have a mandate to work on the parent-child relationship, a number of steps were taken to reduce mother's involvement and reinforce the idea that dry beds were primarily William's responsibility. The boy was seen on his own for hypnosis, his mother was encouraged not to provide verbal reminders, and she was encouraged to allow William to make his own decisions in relation to risks with his friends. Despite this, there were signs that William's mother remained very much involved in the boy's progress. It was William's mother who would spontaneously report on his progress at the beginning of sessions, and she remained sceptical that he was actually "trying" or doing his homework.

Kohen, Colwell, Heimel, and Olness (1984) identified that lack of motivation on the part of the child is another major reason for the failure of hypnotic treatment for enuresis. Concerns about William's level of motivation were raised by his spontaneous response to the question, "Would you like to have all dry beds?" To increase the boy's motivation, I encouraged his mother to reinforce dry nights with small rewards and permission to escape the "dreaded" morning shower. Although parents have been involved in providing rewards in other studies (e.g., Baumann & Hinman, 1974), this strategy would certainly have reinforced mum's involvement. Other attempts to build William's motivation could have been usefully employed. For instance, self-monitoring his success on a calendar or a cumulative graph could have potentially led to the self-reinforcement of both William's increased bladder control and his efforts to change his behaviour. Achieving increased self-efficacy would have been an important accomplishment given his tendency to attribute his dry nights not to his own ability, but to the restriction of fluids.

Squirming, moving about, opening eyes and making spontaneous comments during hypnotic inductions and throughout the hypnotic procedure are reported to be more common in children than in adults (Olness & Kohen, 1996). Despite this, some of William's behaviour left me with some doubts as to whether or not he achieved hypnosis. I nevertheless continued with the suggestions given his willingness to cooperate and the fact that

formal trance induction is not essential for suggestions to be effective (Edwards & van der Spuy, 1985).

The literature suggests that most of the gains from hypnosis occur in the first three sessions. Olness (1975) found that most children resolved their bedwetting within the first month of treatment and Stanton (1979) reported that the majority of children in his sample stopped wetting after one to three sessions. Hypnosis with William was concluded after three sessions since it was judged at the time that prolonged treatment would not produce gains commensurate with the investment of time and money involved. In retrospect, however, it could be argued that the marked improvement over the three sessions could have been consolidated with additional contact. This seems even more relevant given his mother's insistence that he was not practising his self-hypnosis exercise. Phone contact might have been a productive compromise.

Olness and Kohen (1996) mention offering suggestions for integrating the alarm and hypnotic approach by asking the child to give him or herself a challenging message during self-hypnosis, such as "Tonight while I'm sleeping, bladder, when you fill up with urine be sure and send the message to the brain that you're full and, brain, be sure to keep the gate on the bladder shut until you wake me so I can beat the buzzer" (p. 144). William had some short-term success with the bell and pad. Given this, it would have been of interest if the two treatments could have combined to provide a successful outcome.

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HYPNOSIS FOR POST-TRAUMATIC STRESS DISORDERS

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This paper describes the research and clinical literature relating to post-traumatic stress disorders (PTSD) and acute stress disorders (ASD). It begins with a review of the general nature, classification and aetiology of the disorder, using DSM-IV criteria. The particular relevance of hypnosis as an adjunct to the range of therapeutic approaches suitable for the disorder is then discussed, focusing on the evidence for the higher hypnotisability of many PTSD sufferers. The paper concludes with detailed suggestions for the use of hypnosis as an adjunct in the treatment of post-traumatic stress reactions.

POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder is defined as a cluster of symptoms precipitated by a person's exposure to a severe stressor that is outside the range of usual human experience, and which involves a threat to life or wellbeing. It can result from a severe stressor that could be expected to create anxiety in almost any person, such as physical attack, rape, natural disasters, war experiences, or traumatic accidents (DSM-IV: American Psychiatric Association, 1994).

These symptoms provide for the formal diagnosis of post-traumatic stress disorder, but at the sub-clinical level, many other reactions can follow one's experience of a severe stressor which do not result in the person being formally diagnosed as suffering from the disorder. These minor reactions include shock (disbelief, numbness); fear (of the event recurring); anger (at the causal agent and the injustice of it all); sadness (human, material or safety

This paper is adapted and updated from that originally published in *Hypnosis in Australia*, The Australian Society of Hypnosis, Melbourne, 1998.

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losses); and shame. The sufferer may also experience sleep disorders, physical problems, social isolation, work disruption, loss of appetite, and changes in alcohol and drug usage. Cognitions may be affected, with dreams, nightmares, confusion, and persistent recollections of the event.

Following their traumatic exposure, many PTSD sufferers experience distressing flashbacks to the event (Horowitz, 1976). PTSD sufferers from Vietnam have reported auditory hallucinations of dying comrades (Mueser & Butler, 1987), innocent participants in the Queen Street incident in Melbourne in 1987 reported frequent intrusive thoughts and memories of the incident including dreams and vivid images (Creamer, Burgess, Buckingham, & Pattison, 1989), as have patients who have undergone stressful experiences during surgery (Peebles, 1989). Intrusive ruminations may also take the form of disturbing dreams or nightmares, and/or daydreams (flashbacks). There is often a sense of numbness or detachment from everyday events and an inability to focus on here-and-now things in life. Instead, the person tends to dwell constantly on the past and this is usually linked to a great deal of cognitive dysfunction.

These components of PTSD suggest a "psychic numbing" (Brende, 1985), which helps sufferers avoid conscious traumatic memories of the event. Many patients with PTSD experience a polarisation in which they alternate between intense, vivid, and painful memories and images associated with the traumatic experience, and a kind of pseudonormality in which the victims avoid such painful memories, using traumatic amnesia, other forms of dissociation, and repression, with associated reduction in adaptive capacity and loss of affective responsiveness (Spiegel, Hunt, & Dondershine, 1988).

Other symptoms of the disorder include an exaggerated startle reflex, sleep difficulties, survivor guilt, poor concentration and memory impairment, and an avoidance of situations or thoughts and feelings that remind the person of the event. Anxiety and depression often form part of the clinical picture and some clients describe a diminished responsiveness to the outside world, referred to as "psychic numbing" or "emotional anaesthesia." Clients feel a sense of detachment from many aspects of their life and often find difficulty enjoying or feeling emotions such as intimacy, tenderness, or sexuality.

The epidemiology of the disorder is estimated from 1% to 14% (DSM-IV, 1994). Helzer, Robins, and McEvoy (1987) suggested a prevalence rate of 0.5% for males and 1.2% for females, compared with an estimated 6% of Vietnam veterans with combat-related PTSD. These figures compare

favourably with the estimate by Kidson, Douglas, and Holwill (1993) that 45% of Australian World War II veterans suffer from active symptomatology. Rather than address the prevalence issue, it can be agreed that many clients suffer from degrees of symptomatology, without fulfilling precise post-traumatic stress disorder criteria. In these terms, understanding of the problem and treatment considerations apply over the range of symptoms from mild anxiety symptomatology to those sufferers who meet DSM-IV criteria.

There are a number of theoretical formulations which attempt to explain the development of post-traumatic stress disorder syndromes.

The personality-type approach suggests that these stress reactions derive from an interaction between a certain personality type and traumatic events. The post-traumatic syndrome reflects the individual's personality and social environment, and provides a common pathway to the disorder, reached through a wide variety of relatively severe stressors (Kaplan & Sadock, 1991).

Freud (1914) argued that the initial trauma overwhelms the ego and the defence mechanisms of *repression* and *undoing* (in dreams and compulsive repetition of the trauma) are the ego's attempts to drain off excess libidinal energy. A chronic course leads to ego exhaustion and changes in the ego-superego boundary as a result of overwhelming guilt and shame. On the other hand, Pavlov argued that the emotional response of *fear* becomes conditioned to the sights and sounds of the traumatic event and that the defensive reaction continues to be elicited by stimuli reminiscent of the initial trauma (Pavlov, 1927).

Information processing models have also been developed to explain trauma reactions. These argue post-traumatic stress reactions result from cognitive re-processing of the events to which people are exposed (Horowitz, 1976). Horowitz argued that traumatic experiences affect our "schemas" — our world views. The stimulus event occurs to the individual, who then responds physiologically, emotionally, and behaviourally to the event. The individual has to interpret these events and responses. Typically, the sufferer may say "I'm going crazy" or "I'm vulnerable." Thus, the individual's schemas have been changed to reflect the experience he or she has been through and their interpretation of the events. New situations are processed to see if they fit in with the changed schema. The victim's responses affect all levels of functioning, because of the powerful and pervasive nature of the event. The meaning given to the event (in terms of the victim's schema) may be to say: "If I'm vulnerable in this [trauma] situation, is anywhere safe?" or "If I couldn't cope in this [trauma] situation, can I cope in any situation?"

The person's appraisal of the trauma and interpretation of the event is influenced by characteristics of the situation, its degree of threat, the unpredictability of the experience, and how rare an event it is — together with such personal characteristics as locus of control, anxiety proneness, and "schemas" or world view.

The greater the appraisal of threat, the more powerful and pervasive is the trauma-related memory network which is formed. This memory network can be reactivated whenever the individual is reminded of the trauma event — even by very superficial reminders, such as clothing similar to that which they were wearing on the occasion. Where there is unsuccessful processing of the memory network, associated with avoidance behaviour and high anxiety, then a post-traumatic stress reaction is likely to develop.

Hodgkinson and Stewart (1991) argued that information-processing models of post-traumatic stress disorder aetiology only partially explain sufferers' behaviour. They argue that the disorder is a "fear structure" — a schema the victim uses to escape danger, which contains information about the feared situation, behavioural and emotional responses to it, and information about the meaning of the event. Of course, many fear structures exist in everyday life, but what distinguishes this reaction from other anxiety disorders is that the traumatic event is of monumental significance and violates previously held basic concepts of safety. Thus, we can view post-traumatic stress disorder as primarily a loss of faith in the world which affects every aspect of the individual's day-to-day life. In a cyclic process that develops from the individual's personality and beliefs and the experience of the traumatic event, the person's ruminations about what has happened cause frequent intrusive memories and attempts to suppress these, resulting in cognitive reappraisals of the world, the self, and what has occurred. These changes result in emotional distress and arousal, with subsequent avoidance and withdrawal behaviour. Thus, a fear structure is set up (Hodgkinson & Stewart, 1991). The importance of this approach to understanding symptoms lies in the recognition by the therapist that different therapeutic goals, with subsequent differing techniques, will apply depending upon the particular symptoms displayed by the client when commencing therapy.

It is worthwhile drawing attention to so-called psychobiological explanations of post-traumatic stress disorders, because they make sense of sufferers' physical symptoms. These hypothesise that the disorder is a hyperarousal state associated with excessive sympathetic activity. Exposure to

a stressor leads to a massive sympathetic discharge (heart rate, respiratory rate, sweating, muscle tension, blood pressure, and skin conductance) which may persist for days, weeks, or months. If the individual cannot desensitise themselves to the traumatic event or forget it, then the acute arousal becomes chronic as the person remembers or re-experiences the event with repeated accompanying arousal. Sufferers report frequent sleep disturbance, have poor tolerance for arousal, and react in an "all or none" manner. They lose the capacity to make an appropriate assessment of stimuli and continue to react with an emergency response to minor stimuli.

Depletions in noradrenaline and increased production of endogenous opiates have also been related to the disorder. Animal studies have shown that, when faced with inescapable shock, animals show a subsequent helplessness syndrome — deficits in learning, motivational decrease, distress, and immunosuppression. These changes are due to noradrenaline and dopamine depletion. PTSD sufferers show similar depletions in noradrenaline, compared with other psychiatric groups. Animals exposed to inescapable shock also develop analgesia, mediated by endogenous opioids and reversed by naxolone. There is a striking similarity between the symptoms of opiate withdrawal and hyperactive symptoms of the PTSD. It is now hypothesised that these opiates may be produced as part of the traumatic response and reproduced when the individual suffers re-exposure to the event (Kihlstrom, 1985; Krantz, Grunberg, & Baum, 1985). These biochemical changes may have implications for treatment.

From a clinical perspective, it would not seem unreasonable for a person to experience marked physiological and behavioural disturbances following a severe and unexpected trauma which might have threatened life and limb. Our concern with some of the theories advanced so far is that there is a degree of circularity in them, in that they use the responses to the trauma as a means of explaining away why they occurred. From the therapist's viewpoint, we think it important to understand the nature, intensity, and importance of the trauma as the primary aetiological factor in evaluating the individual's response to their stressful event (Evans, 1995; Green, Wilson, & Lindy, 1985).

Acute Stress Disorder

Acute stress disorder (ASD) was first introduced with DSM-IV (1994). Its defining characteristic is the development of anxiety, dissociative, and other symptoms of post-traumatic stress disorder within one month following

exposure to the stressor. In all other respects the disorder is the same as PTSD; indeed, symptoms of acute stress disorder are predictive of the later development of post-traumatic stress disorder, unless treatment is effected (Spiegel, Koopman, & Classen, 1994).

GENERAL TREATMENT CONSIDERATIONS FOR ACUTE STRESS DISORDER AND POST-TRAUMATIC STRESS DISORDER

Given the conceptual and aetiological similarities between acute stress disorder and post-traumatic stress disorder, the treatment considerations for each are the same. Indeed, as we outlined earlier, there is clear research and clinical evidence to show that untreated ASD will likely become PTSD.

The overall aim of treatment is, of course, the reduction of target symptoms, prevention of chronic disability, and occupational and social rehabilitation. Typically, treatment interventions involve behavioural techniques, medication, and various forms of psychotherapy, including hypnosis.

Commencement of Treatment, Client Evaluation, and Information Giving

Treatment commenced as soon as possible after the onset of symptoms is usually the most effective (Evans, 1991; McFarlane, 1989; Spiegel et al., 1994). The client must understand their emotional reactions to the anxiety-provoking event and its after-effects are common responses to trauma and that it is normal to experience such reactions. They are not going mad or losing control.

Information about the incident and its sequelae helps fill in the client's information gaps and assists in the exploration of the event from their perspective so the therapist gets a feel for what has occurred. Information and support provide a rationale for the client regarding the symptom constellation they are experiencing and gives them an understanding about treatment and its goals of self-control and personal empowerment.

In the early stages of treatment, the therapist should:

1. Emphasise the normality of PTSD symptoms, following a major trauma.
2. Teach the client to contain intrusive imagery, rather than simply trying to stop the imagery, which may heighten anxiety.

3. Focus the client's attention on what he or she has achieved in the way of overcoming avoided situations, rather than on the discomfort involved.
4. Assess the client's irritability and the reasonableness of their expectations of others. In particular, check whether they are expecting others to be mind-readers.
5. Remember that the event that triggered the onset of the PTSD may not itself have been particularly traumatic, but may have served to rekindle earlier traumas that had been denied for many years. Both recent and previous traumas will need addressing (Scott & Stradling, 1992).

Talking About, and Re-Exposure to, the Traumatic Event

Most therapeutic regimes for these disorders involve the client, at some stage during therapy, talking about their traumatic incidents and use of regression techniques to take the client back to that event.

Typically, clients resist talking about what has happened to them and the initial retelling will usually be like a reporter describing the event, without any emotional tone. Over time, the repeating of the event and exposure results in the situation becoming more affect-laden. The aim of exposure is to help the person reintegrate the trauma event. In general, any exposure is graded, prolonged, repeated, and functional.

Normally clients are gradually exposed to what they fear (as in systematic desensitisation), but this may be difficult when the trauma was experienced as one single event. The therapist needs to uncover the details of the trauma and the sequence of events leading up to it, with a view to working with the client to create a hierarchy from least to most anxiety-provoking. The graded exposure should then follow this hierarchical form. Re-exposure to the trauma normally results in increased anxiety. The session should continue until the client's anxiety level has dropped by 50%. If the session is terminated too early, the client's anxiety level may be higher than when the session commenced, conditioning high anxiety to the re-exposure, deepening the disorder. Exposure is repeated until minimal anxiety is evoked by the client. Such re-exposure should be functional, in that moderately high levels of anxiety evoked during re-exposure is optimal, helping the client learn control over anxiety.

After exposure, the client is helped to reintegrate the trauma and its memories and cognitions, using a range of therapeutic strategies including anxiety management, physical changes (exercise, reducing stimulants),

cognitive reframing (coping statements), behavioural changes (daily activities and scheduling to avoid social isolation and return to normal routine), and such cognitive restructuring techniques as changing depressive cognitions, reducing self-blame and guilt, changing feelings of vulnerability and insecurity, and increasing personal control.

Cognitive-Behaviour Therapy

The therapeutic purpose of cognitive-behaviour therapy is cognitive restructuring, helping the client realise their trauma does not exist in reality but in their construction of it. Cognitive restructuring helps them describe the trauma *as it was* — not seeking to minimise the negative aspects or negating the positive aspects but balancing negative and positive aspects. Common cognitive dysfunctions include: intrusive thoughts and imagery, avoidance reactions, anger, irritability, detachment and withdrawal, and feelings of guilt. A number of cognitive-behaviour strategies may be used to help the individual cope with these.

Anger and Irritability Clients' anger and irritability derive from their typically unreasonable expectations about their environment and people around them. When these expectations are not met, the client reacts with anger and irritability (which, often, they cannot explain and feel guilty about). Clients make such statements as: "You can't talk about it unless you were part of it — what do you know about what really happened?" or "After all I've been through, other people should just leave me alone or try to understand."

Detachment and Withdrawal PTSD sufferers become detached and withdrawn from social contact for two reasons. First, their view of the world as a safe place (in a natural disaster) or their perception of other people as caring (as in rape or personal injury) has been destroyed. Retreat is seen as the best defence mechanism to use. Alternatively, they may develop irrational beliefs about their impact on the lives of others.

Guilt. This is one of the hardest cognitions to alter in PTSD. Typical statements may be: "I didn't do enough — maybe I should have dived back into the water," "I shouldn't have walked down that street in the dark," or "Maybe it was my fault, because I looked at the person."

All irrational statements made by the client need to be reality tested — the reality of the traumatic situation and the range of possible reactions of the client in the circumstances have to be made explicit. The specific aim of all

cognitive restructuring is to prevent the client from overgeneralising his or her behaviour in the traumatic situation to the real world. For example: "The water was so cold and if I had gone back in I may never have got out again. Perhaps there were more people to be rescued but I might not be here now if I'd tried to do it all myself."

Reality Testing This is another effective cognitive technique. Another is the ABC of *rational emotive therapy* — Activating Event—Beliefs—Consequences. Help the client draw out the link between beliefs and expectations and anger/irritability and develop alternate rational beliefs. For example: "I can't expect people to really understand what happened and I can't always expect them to make allowances for the way I feel from moment to moment."

Distraction Another cognitive technique that is frequently used in the treatment of these disorders. Here the technique is used to help the client escape from, or avoid thinking about, the trauma and its triggering symptoms. Such techniques can be most appropriate early in therapy when one of the presenting features is a preoccupation with what has happened. Distractional techniques (which are used to reduce symptoms by avoidance and/or not thinking about the trauma) must be accompanied by the use of other techniques which promote control and mastery. If this is not done, the client is never able to attend to, and deal with, the emotion of the trauma.

Anger Control This can be achieved through the use of cognitive techniques. The therapist needs to educate the client about the positive elements of anger and try to help them understand the feelings of other people, using role-plays or imagery under trance. The client can be given self-statements during trance which they are taught to recall and repeat when anger-provoking situations occur.

Other Cognitive Techniques

Containment Sufferers often try hard to get rid of their intrusive thoughts or to stop them occurring. With the strategy of containment, the therapist does not seek to stop the memory re-occurring, but to contain it. This can be done by having the person put a rubber band on their arm and each time the intrusive thought occurs, they pull the band and let the thought go. At the same time, they tell themselves that they will watch a mental video of the event for 20 minutes, at some time later in the day. Such controlled re-exposure heightens perceptions of self-control over what were uncontrollable

flashbacks to the trauma. Alternatively, the person is taught to say: *Stop!* to cut out the intrusive memory.

Desensitisation This strategy involves having the client make a short audiotape describing their trauma which they play at least once a day, but not switch the tape off until they have become more relaxed (recall graded exposure earlier). Unless there is decrease in distress during a session there will be no decrease in distress from session to session. The tapes tend to be effective within two to three weeks.

There are some important conditions for the use of desensitisation:

1. PTSD clients tend to be more difficult to engage in counselling than those with disorders such as depression and anxiety. Because of this, great care has to be taken not to prematurely introduce a procedure that is initially likely to amplify the client's distress before reducing it. Use this technique only when other cognitive strategies, such as containment and cognitive restructuring, have proven inadequate.
2. Clients usually do not like the idea of recording their trauma and then listening to it — typically they've spent months trying to forget it. Offer to create the tape with the client and initially, at least, let them listen to the tape in your office.
3. This technique is suited to a trauma that consisted of a single event. There is usually greater reluctance and difficulty making a tape of a series of traumas — for example, childhood sexual abuse. If the trauma was of the client's own making — for example having committed a crime — then making a tape can evoke considerable distress and evidence suggests that this strategy should only be used with in-patients.
4. Having the client write about the trauma for half an hour per day for four consecutive days can help them engage with the material of the trauma. Familiarity with the events can help the person diminish the intensity of their response.

There are numerous examples of systematic desensitisation in the literature. Schindler (1980) was treating a Vietnam veteran suffering from PTSD after seeing a fellow soldier virtually disintegrate after he stepped on a land mine. Schindler taught a progressive relaxation technique followed by systematic exposure to a seven-stage hierarchy that followed the sequence of the client's recurring dream. The client progresses up the hierarchy from least to most disturbing, using relaxation while imagining each scene, and progresses to the next scene when anxiety levels are rated as nil.

Another technique used in cognitive-behaviour therapy frequently reported in the literature is *imaginal flooding*, discussed earlier in the paper on the treatment of all anxiety disorders by Evans and Coman.

Behavioural interventions such as systematic desensitisation and imaginal flooding are frequently the techniques of choice used to allow the client to return to their traumatic experience and achieve mastery over the event, thus reducing their anxiety and the impact of the trauma on their lives. This can be done in a graded hierarchical way (as in systematic desensitisation) or without a graded approach (as in flooding). Whatever approach is used, it should follow the general proscription — the exposure should be graded, prolonged, repeated, and functional.

Pharmacological Interventions

Drug therapy has received relatively little attention, but we do know that drug treatment *alone* is rarely sufficient to provide complete symptom remission. By the same token, symptom relief through medication may enable the individual to participate in the various psychotherapies.

The benzodiazepines reduce the symptoms of autonomic arousal and anxious mood. However, the significant abuse potential of these limit their use. Studies suggest that low-dose, time-limited benzodiazepines can be very helpful (especially if there is no history of alcohol/drug abuse, or personality disorder).

MAOIs reportedly decrease nightmares, startle reactions, and flashbacks, possibly as a result of suppression of rapid eye movement sleep processes. They are powerful inhibitors of REM sleep.

The tricyclic antidepressants (Phenelzine, Imipramine) dampen arousal through their anti-panic action, reduce intrusive recollections and nightmares, and suppress flashbacks. They may also enhance endogenous opioids through stimulation of synergistic serotonergic mechanisms. They may also moderate fluctuations in endogenous opioids.

Antipsychotics should be used only for psychotic symptoms, including brief reactive psychoses, severe agitation, anger and/or paranoia.

Lithium and Carbamazepine have been used with limited success, primarily in patients who report constantly feeling on the verge of exploding and with feelings of being out of control.

The current state of knowledge regarding pharmacological interventions is extremely limited, with few carefully controlled studies.

Hypnosis

A number of researchers and clinicians have reported the use of hypnotic techniques with PTSD sufferers. These have included cases of PTSD following surgery (Peebles, 1989), combat (Brende, 1985; Grigsby, 1987), accidents (Mutter, 1987), burns injuries (Dobkin de Rios & Friedmann, 1987), rape (Spiegel, 1989), bereavement (McFarlane, 1989), and child abuse (Havens, 1990). Since many people mobilise what is akin to the hypnotic state during traumatic experiences, it seems sensible to use hypnosis as a means of helping PTSD sufferers retrieve their repressed or dissociated memories of the event and emotional reactions to the experience they have endured. However, the therapist should ensure that the hypnotisability of the client is assessed, as many PTSD sufferers show high hypnotisability. Hypnotic interventions should be used judiciously, to avoid the possibility of hypnosis contributing to, rather than minimising, the client's emotional and psychological problems.

Hypnotic interventions can be used in a number of ways. These are: as a supportive technique when the client requires help in controlling and minimising anxiety; as a means of uncovering repressed or dissociated thoughts and memories of the traumatic event; and as a means of reintegrating the experience into the client's consciousness (Brende, 1985).

Therapists treating clients with PTSD should be attuned to the particular needs of these sufferers. Clients tend to show low compliance behaviour and a tendency to drop out of therapy (Burnstein, 1986). They are typically difficult individuals with whom to establish effective communication because of their reluctance to enter into therapeutic relationships and their perception that the majority of therapists will not be able to comprehend the enormity of their traumatic experience (Lindy, Grace, & Green, 1981; Lindy, Green, Grace, & Titchener, 1983). The therapist should be experienced in dealing with PTSD in the therapeutic setting and needs to give careful consideration to these aspects of therapy.

An important element early in the therapeutic relationship is that the client has made a decision to challenge their isolation by seeking help. The therapist needs to provide both a sense of hope to the client and information explaining the reasons for the emotional distress and anxiety that the person is likely to be experiencing at the time (McFarlane, 1989). Hypnotic suggestions for relaxation and control may be very useful at this stage of the therapy to help the client understand their feelings and reactions, to reduce anxiety, and to increase motivation to continue with therapy (Brende, 1985). A progressive

relaxation induction may be appropriate, utilising the visualisation of the client moving "energy" into his/her body (Dobkin de Rios & Friedmann, 1987).

Many sufferers seek out treatment as a means of obtaining relief from their heightened emotional reactions to their intense absorption of reliving the stressful experience, and their commitment to treatment may be enhanced if these distressing symptoms can be controlled (McFarlane, 1989). The therapist should utilise techniques which help maintain a sense of calmness and control for the client, contributing to the effectiveness of therapy.

The therapist should bear in mind the research finding that over 50% of PTSD clients have some form of psychiatric illness associated with post-traumatic stress symptoms, with panic disorder and major depressive symptoms being the most common diagnoses (Davidson, Swartz, Storck, Krishnan, & Hammett, 1985). Hypnosis can be used quite effectively for treatment of phobic and anxiety conditions (Frankel, 1988) but its use for the treatment of depression needs to be carefully considered. It is important to ensure that any psychiatric symptomatology can be treated concurrently with the PTSD symptoms, given that the onset or increased severity of the psychiatric symptoms can increase symptoms and associated anxiety (McFarlane, 1989).

Hypnosis may also be used in the early phases of treatment to help build trust between the client and therapist. For example, you may use the following suggestion: "I would like you to relax and imagine that I am helping you with the burden that you are carrying. It's been there ever since your [include exact type of trauma experienced by patient] and has contributed to all the pain/emotion you are feeling. Imagine that I am right here with you now, helping you hold up the burden. As you let me share that burden with you, it will be easier for you in the future to talk about what is bothering you and to share your feelings with me" (adapted from Brende, 1985, p. 203).

With the client in a hypnotically induced state of relaxation, the therapist can explore the aetiology of the post-traumatic stress disorder. You should ask about the type of traumatic event to which the client has been subjected and consider whether the person is experiencing acute or chronic PTSD. For example, there are considerable cognitive and emotional differences between involvement in a combat situation, being the victim of rape, and being caught in a natural disaster (McFarlane, 1989; Spiegel, 1989). These different traumatic situations cause a range of feelings regarding the possibility

of one maintaining or establishing control over the situation and trust in others, factors which will also vary depending on the severity of the traumatic experience and the closeness of death experienced by the client (McFarlane, 1989). Additionally, the therapist must be aware of the time period between the traumatic event and the client's presentation for therapy. With acute PTSD disorders, the majority of clients will have developed the early stages of social and personal dysfunction and these will still be amenable to treatment. In cases of chronic PTSD, the therapist's attention will be focused on remedying the client's reduced affect and social withdrawal (McFarlane, 1988, 1989).

As Brende (1985) noted, reliving events in one's life is a common experience for most people. Such reliving helps ensure control over one's life and the maintenance of a sense of personal identity and continuity with the past. However, PTSD sufferers may exhibit the symptoms of amnesia for the traumatic events, thereby lacking the sense of continuity needed to establish mastery over their situations (Horowitz, 1976). This amnesia may result from the psychic numbing PTSD sufferers experience in their attempts to keep traumatic experience from consciousness. However, the resultant instability gives rise to repetitive re-enactments of the traumatic event, which are unconscious and potentially uncontrollable attempts by the person to achieve a resolution of the intrapsychic split caused by the alternate repression and recall of the trauma (Horowitz, 1976). Hypnosis may assist in the opening up of the client's repressed memories of the traumatic event.

In the process of helping the client "uncover" repressed memories, it is important the therapist achieves a greater understanding of what the person experienced, as a means of comprehending the nature of reported intrusive cognitions and associated feelings (Horowitz, 1976; McFarlane, 1989). This may not only be of therapeutic value to the client but may also reduce their feelings that the therapist is distant from the traumatic event and, therefore, unable to comprehend its magnitude (Lindy et al., 1981; Lindy et al., 1983).

It is also important for the therapist to separate out the client's intrusive memories and reliving of the traumatic experience (cognitions) from feelings of loss, anxiety, or depression (emotions). As McFarlane (1989) noted, there are quite different therapeutic goals between helping the client accept that the traumatic event has occurred and helping the person deal with the range of painful emotional states evoked by the event.

Hypnotic regression can be a successful hypnotic technique for helping clients retrieve repressed memories of their traumatic experiences (Mutter,

1987; Spiegel, 1989). The most important aspect to the use of any technique which may enable clients to re-live their trauma is to ensure the individual is taught how to dissociate the mental experience from the physical experience. This serves two purposes. First, it reminds the client that the traumatic event is not physically recurring. Second, it may prevent the subject from experiencing an anxiety or panic reaction in response to the reliving of the event. Metaphors which suggests physical relaxation, as in a bath or pool, and a sense that the subject is floating, can be useful for this purpose. The traumatic event may then be re-experienced by having the subject picture the event occurring on an imaginary screen (Spiegel, 1989). The client divides the screen into two halves. On one side there is a re-creation of the traumatic event, while, on the other, the individual visualises any action he or she took at the time to control what was happening or to escape the situation. The negative picture on the one side is then balanced, to some extent, by the client's attempts to provide protection, maintain dignity, and, in some way, to exert mastery over the situation, as revealed on the other side of the screen (Spiegel, 1989).

PTSD sufferers are likely to experience strong emotional reactions to the reliving of their traumatic experience, despite efforts to control for this possibility. The goal for the clinician is to help the client understand that these emotional reactions are possible and that their controlled expression is more therapeutic than their repression (Brende, 1985; Mutter, 1987; Spiegel, 1989). Many people express the fear that, if they attempt to recall their experiences, they will become victim to greater anxiety and fear (Brende & Benedict, 1980). Suggestions for control and relaxation can be used to help the client recall the repressed event and then consolidate the memory in a therapeutic way (Grigsby, 1987; Spiegel, 1989). Suggestions for personal mastery and control are very therapeutic for PTSD clients, given they have feelings of low control and perceived low ability to cope with the traumatic event and current stressors (Hyer, Boudewyns, & O'Leary, 1987). Ebert (1990) uses the following suggestion: "Take your time with this growing sense of power, control, and comfort because you will discover that, the more you relax with the techniques, the more the fears will simply fade away." Another technique is to have the client imagine a person whom he or she sees as having the strength to deal with the trauma and then tell them to: "Take the strength you need from this person, store it deeply inside you, and utilise it whenever you choose by recalling the image when you need to feel strong and in control" (adapted from Ebert, 1990).

Hypnotic suggestions can be used to explore the client's social withdrawal (Spiegel, 1989). Encouragement of renewed involvement with others who may provide social support and re-engagement in relationships may be difficult with PTSD sufferers, given their sense of vulnerability and lack of trust in others (Kelly & Reddy, 1989; Strupp, 1972). Suggestions for anxiety reduction, ego-strengthening, and cognitive reframing can be used as ways of reducing fear and anxiety and instilling the belief that social re-engagement is possible, desirable, and under the client's control. Cognitive reframing suggestions can be used to help the client re-evaluate the importance of social relationships in stress management, re-establish in the person's mind their ability to restore social contacts, and help them re-establish trust in other people.

It will always be pertinent to explore the client's fears regarding the recurrence of the traumatic event (Horowitz, 1976). Those who exhibit an intense fear of the event recurring often show an inability to develop effective coping strategies to help them deal with stressful events, which may result in intense feelings of vulnerability and hypervigilance (McFarlane, 1989). Feelings of vulnerability can be reduced with trance-induced suggestions of control, power, and strength. Hypervigilance may be reduced using hypnotic suggestions for anxiety reduction and other cognitive techniques, such as thought-stopping and cognitive reframing. One perpetuating factor important in the morbidity and treatment of PTSD is the possibility of re-exposure to the traumatic experience. Combat veterans are returned home so that the trauma is focused in their memories and imagination, while victims of natural disasters, accidents, and personal attacks may be often and involuntarily re-exposed to their trauma. For clients who may be faced with the scene of their traumatic experience, the therapist can utilise such coupling techniques: "Whenever a thought about this event occurs or you are faced with the scene of the event, you will add to your thoughts the idea that you can control your emotional response and that, each time it happens, you feel greater and greater control over your feelings." This can be coupled with a posthypnotic suggestion to the effect that anytime a flashback occurs or the person is confronted by the trauma, the imagery would immediately be coupled with the above suggestion.

Summary: Spiegel's 8 'Cs'

The treatment approach to PTSD, whether using hypnotic techniques or not, can be summarised with Spiegel's 8 'Cs.'

1. *Confront* trauma.
2. Find a *condensation* to the traumatic experience. This allows a finite series of memories to symbolise the trauma, making the memories finite and manageable.
3. Allow for *confession*. Many trauma victims find their memories degrading and humiliating. The very act of admitting them to someone else makes them feel less isolated and unacceptable.
4. Provide *consolation*. Appropriate expressions of empathy go a long way towards acknowledging the normality of extreme reactions to an extreme experience. Detachment or disinterest conveys rejection. Trauma victims need to feel acceptable, even with their burden of uncomfortable recollections and experiences.
5. Make *conscious* previously dissociated material. The need to keep important events out of conscious awareness exacts an emotional and cognitive toll, interfering with normal functioning. Furthermore, making the material conscious facilitates working through the traumatic memories.
6. Utilise focused *concentration* in the working through of traumatic memories. The process of psychotherapy provides ceremonial boundaries around the accessing of traumatic memories, conveying the message that they may be put aside once the therapy session is over.
7. Enhance the client's sense of *control* over the traumatic memories. The process of therapy must reinforce the content by giving the victim a greater sense of control over traumatic memories and in the relationship with the therapist.
8. Facilitate the development of *congruence*, the incorporation of traumatic memories into an integrated and acceptable view of the self. Psychotherapy and other forms of support can enhance adjustment to trauma and mitigate both acute and chronic stress response syndromes (Spiegel, 1989).

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INDUCTION OF LABOUR USING SWITCHBOX IMAGERY DURING HYPNOSIS

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We report seven consecutive cases of attempted induction of labour (IOL) using hypnosis and switchbox imagery. All seven women had an unfavourable cervix for labour and medical indications for delivery. During hypnosis, these women independently experienced, unprompted, similar colours when looking for the switch to turn on their labour. Red to green colour changes were experienced by five women. Two women experienced visual hallucinations of these images during the hours preceding childbirth. The women who did not see a colour change experienced a uterine contraction or an increase in the strength and frequency of contractions during or immediately after hypnosis. We believe hypnosis contributed to the establishment of labour in two patients and early labour in another. Hypnosis is likely to have made a useful contribution to the successful outcomes in a further two women who may have had their labour accelerated after a limited response to prostaglandin vaginal pessaries.

Induction of labour aims to stimulate uterine contractions and cervical dilatation so as to promote birth at a time when the baby is thought to be safer outside the uterus than in it (Chamberlain & Zander, 1999). It may be considered beneficial when there is fetal growth restriction (or other states of potential fetal compromise), spontaneous rupture of membranes, pre-eclampsia, and post-term pregnancy (Hofmeyr et al., 2002). Medical

We thank the midwives at Adelaide Women's and Children's Hospital for their support, and the women in this report, for their permission to publish the details of their cases. We are grateful to Drs Graham Wicks and Jodie Dodds for their helpful comments on the draft manuscript. Requests for reprints should be sent to Allan M. Cyna, Department of Women's Anaesthesia, Women's and Children's Hospital, Adelaide, S.A. 5006. cynaa@wch.sa.gov.au

induction of labour is usually initiated by one or more methods including: the administration of vaginal or intracervical prostaglandins, intravenous oxytocin and/or amniotomy. These methods may be associated with increased requirements for pain relief, introduction of infection, hyperstimulation of the uterus, uterine rupture, and fetal distress. In addition, the need for caesarean section due to failed induction is more likely if the cervix is unfavourable (Chamberlain & Zander, 1999). Some women perceive induction of labour to interfere with the natural process of pregnancy and are reluctant to change their expected birth plan. Many women therefore seek alternative therapies to induce labour.

We have increasingly used hypnosis as part of our everyday anaesthetic practice as an adjunct to analgesic or anaesthetic techniques and in the provision of improving maternal control and analgesia during childbirth. More recently we have been asked by midwives and patients about the possibility of using hypnosis to stimulate the onset of labour. The use of control switch visualisation for pain control has been described as a means of providing analgesia and modulation of various pain states (Garver, 1990). We have adapted this technique to attempt to induce labour in seven consecutive women presenting at or near term with obstetric indications for delivery. In the hypnotic trance state suggestions are made for the mother to visualise a lead or wire running from the uterus that controls when labour starts. The woman then uses a head nod or ideomotor finger signal to indicate when the lead is visualised. She is then requested to follow the lead, tubing or wire to the control box where she will see switches, buttons, or levers. When visualising the switch to turn on labour she is asked to pull, push, or press the switch. When she has noticed a change, she is asked to signal that this has occurred. The trance is then terminated and the woman questioned on what exactly was visualised.

Case Report 1

A 29-year-old multiparous woman at 37 weeks and 4 days gestation requested referral for hypnosis in order to attempt to induce the spontaneous onset of labour. She had been in hospital since 32 weeks and 4 days gestation following spontaneous rupture of membranes and had requested hypnosis previously to prepare herself for childbirth. The woman had two previous pregnancies, the first an uneventful vaginal birth after a long labour at term. Her second child was delivered by elective caesarean section under spinal anaesthesia for a low

lying placenta. During the current pregnancy the woman had expressed a strong wish to labour and deliver vaginally if possible. However, there was no sign of her labour starting and the baby was in a breech presentation. The obstetric team felt that a caesarean section at 38 weeks gestation was indicated but agreed that if uterine contractions commenced spontaneously, labour would be allowed to proceed unless intervention was deemed necessary for maternal or fetal wellbeing. Three days before the patient's planned caesarean at 38 weeks gestation, we attempted to induce spontaneous labour using hypnosis and switchbox imagery. Following a modified Chiasson induction, suggestions were given regarding relaxation and comfort post-caesarean as requested by the patient prior to hypnotic induction. We then used the switchbox imagery suggestions as described above. Using head nods the patient indicated when she could visualise the wire and switch or lever to turn on her labour. It was suggested that this may be associated with an indicator light which could be turned on or off. Twenty-five seconds after being asked to signal when she could see the switch and the light indicator she nodded her head. She was then asked to turn/press or pull the switch and confirm when the light had changed. On her indicating that a change had occurred the trance was terminated. After hypnosis the patient reported that the wire running from the uterus was like cream coloured telephone cable with red truncated lines running longitudinally through its centre but interspaced along its length. Alongside the insertion of the wire at the switchbox was a red indicator light. On turning the switch near where this wire was attached, the indicator light changed colour from red to green. In the early hours of the morning the next day, the patient reported experiencing slight tightenings of the uterus beginning approximately seven hours after trance termination. In addition, she began experiencing recurrent images of the indicator light which she stated was now a brighter green than when she first turned on the switch. The following day she had images of the cable running from the uterus. The red truncated lines running longitudinally through the centre of this wire had changed colour from red to green. Uterine contractions were also noted to have become stronger and were occurring every 30 minutes. On vaginal examination by the obstetric registrar the cervix was only 1 cm dilated and was uneffaced. The following night the recurrent images of the indicator light continued and the tubing truncated red lines which had turned green were now joined as a single bright green line. Over the next few hours the images of the green tubing became more frequent and the light became

brighter with the tubing turning a fluorescent green. The contractions had become more frequent and stronger. By 0800 hours on the day of scheduled surgery, vaginal examination by the obstetric registrar noted the cervix to be thin, fully effaced and 3 cm dilated. Labour proceeded uneventfully and the woman gave birth vaginally to a healthy male infant at approximately the time of her scheduled caesarean section, 68 hours after her hypnosis. Apart from inhalational 50% nitrous oxide in oxygen used in the second stage of labour, no other analgesia was required and the total labour and delivery time was 4 hours 23 minutes. The postnatal period was uneventful and she was discharged from hospital with her baby the next day.

Case 2

A 38-year-old primigravida at term was admitted for induction of labour for high blood pressure which settled following 24 hours bed rest. Though the obstetricians suggested proceeding with medical induction of labour the woman was keen to have as little intervention as possible and with their agreement she eventually elected to go home and await spontaneous onset of labour. Prior to her discharge the obstetric consultant anaesthetist (M.I.A.) invited the labour ward midwife to offer hypnosis to this woman as a possible means of spontaneously inducing labour. This was enthusiastically agreed to by the patient. Following our standard preparation and discussion, hypnosis was induced using eye fixation followed by progressive relaxation. The patient was asked to visualise the control panel on which there is a switch which controls a wire going to the uterus that will turn labour on. The woman was told that she may also see a light but no other details were suggested. Following trance termination, she stated afterwards that she had visualised a panel of old-fashioned light switches and a wire passing down to her uterus which she described as greyish. She was instructed while under hypnosis that she could flick the switch to turn her uterus on whenever she felt ready. But no signals of confirmation were made. She was not asked to flick the switch at this time and had not done so. Three days later she returned to the hospital for further assessment and her blood pressure was again raised and she had additional signs of pre-eclampsia. She had been having "niggling" pains over her abdomen during the weekend at home. The obstetricians decided that medical induction of labour should proceed and prostaglandin gels were inserted into the vagina two hours later to facilitate cervical ripening. At this stage the cervix was 1 cm dilated and posterior. Five hours later she was not

in labour and was seen again by M.I.A. with a view to attempting to initiate regular contractions using hypnosis. Under hypnosis she was asked to again visualise the switchbox and wire but this time to actually flick the appropriate switch while under hypnosis. In addition, posthypnotic ego strengthening suggestions were also given to facilitate her ability to cope with the uterine contractions, and relax during her labour. Following emergence from trance she again described the switches she saw as a panel of old-fashioned light switches, only this time they were clearly labelled with the days of the week with a red wire attached. She flicked the switch labelled for that day (Tuesday) and the wire to her uterus immediately changed from red to green. Four hours following this second hypnosis session she commenced contracting regularly. She proceeded to a normal delivery of a healthy baby girl five hours later. She used nitrous oxide and oxygen and a single dose of intramuscular pethidine for analgesia.

Case 3

A 31-year-old primipara who was planning for a vaginal birth at home requested hypnosis to facilitate spontaneous labour at six days post-term. This woman was a midwife and had an uneventful pregnancy but there was no sign of labour starting. She had heard about the use of hypnosis to initiate the labour of the woman described in Case 1 and had experience of hypnosis by a stage hypnotist 10 years previously. Following a modified Chiasson induction and progressive relaxation she was asked to visualise the wire or tube leading to the switch to induce labour as in Case 1. Using ideomotor finger signals with the index finger of the left hand being the "yes" finger, the patient indicated when she could visualise the wire. Twenty seconds later she confirmed visualising the switch and five seconds after being asked to turn/press or pull the switch to induce her labour she confirmed that a change had occurred. Following trance termination, she reported that the wire running from the uterus was "white tubing with dendrites spreading over the uterus." The tubing was connected to a rusty metal box with a lever pointing to a red light situated to the right of the box. On pulling the switch over to the left the red light went off and a green light on the left of the box went on. Regular contractions started to occur every 5 minutes lasting 30 seconds 8 hours after the hypnosis that morning. These contractions continued for five hours and then petered out overnight, occurring only every 30 minutes. Flashes of green light "darting down the middle of both eyes" appeared every

time the woman closed her eyes. This was associated with moderate tightening of the uterus over the next two days. On the morning of the second day after hypnosis, the midwife examined the woman vaginally to assess progress and performed a cervical stretch and sweep. The cervix was noticed to be softer than 48 hours earlier but was only 1–2 cm dilated, 1.5 cm long, minimally effaced and very posterior. Over the next 36 hours there was evidence of early labour which finally became established 79 hours after hypnosis. An episiotomy was performed just prior to the birth of a healthy female infant 10 hours 20 minutes later. Apart from the use of a warm bath and self-hypnosis techniques taught three days earlier, no analgesia was required. The postnatal period was uneventful apart from some difficulty breastfeeding due to mastitis.

Case 4

A 21-year-old primigravida presented at term with spontaneous rupture of membranes. She had experienced hypnosis on one occasion eight weeks previously in preparation for childbirth but had not attended for any further sessions. The woman was requesting hypnosis to assist induction of spontaneous labour. Following a rapid Chiasson induction and progressive relaxation she used head nods to indicate when she could visualise the wire and switch for labour as detailed above. The woman indicated that she could see the switch 35 seconds later. Ten seconds after being asked to turn/press or pull the switch she confirmed that a change had occurred. Following trance termination the woman stated that she visualised a yellow cable like an electric lead going down the back of her neck to her womb. The cable from the uterus was attached to a square switch. She then pressed the toggle switch and noticed a green flash descending down the previously yellow cable to the uterus. Her head was stated as being filled with light on pushing the switch. The cable remained "a bright white/green and stayed bright." Further suggestions regarding labour and childbirth were given prior to trance termination. Four hours after the hypnosis some slight tightenings were experienced but these were not regular or strong. Intravenous oxytocin augmentation was commenced at this time as there had been meconium staining following the ruptured membranes. Although she was coping with the contractions well, nine hours later, epidural analgesia was requested as the cervix was 3 cm dilated although now 70% effaced. The fetal cardiotachograph (CTG) gave a non-reassuring trace with late decelerations

of the fetal heart and a caesarean section was performed for fetal distress an hour after the epidural catheter was inserted. A male infant weighing 2.87 kg was delivered with Apgar scores of 6 and 8 at one and five minutes respectively.

Case 5

A 29-year-old Para 2 presented at two weeks post-term with a closed unfavourable cervix who was scheduled for caesarean section three days later. She had no previous experience of labour or hypnosis but was hoping to deliver in our hospital birthing centre despite having had an elective caesarean section for breech presentation previously. The woman was requesting hypnosis to assist induction of spontaneous labour prior to her scheduled section. Using ideomotor finger signals (index finger of left hand) she indicated that she could visualise the wire to the control box and see a switch or lever or button with which she could turn on her labour. She confirmed a change had occurred thirty-three seconds after being asked to switch on her labour. The woman subsequently stated that she visualised a black-grey cable going down to her uterus. Near this cable at the switchbox she saw a red button which was pressed. No colour change was noted although no direct questions were asked regarding this. In view of the lack of a confirmed change on pressing the button we invited this lady to see if anything else needed to be done in a further hypnosis 20 minutes later. We asked her that when she found the switchbox and lead controlling labour she should do whatever else is necessary to start her labour and confirm this with her yes finger. Following alerting suggestions she confirmed that this time she visualised a large overhanging long lever which she pulled down. This was immediately associated with a uterine contraction. She stated that she could no longer see the red switch. Over the next three days she experienced mild to moderate contractions and when performing self-hypnosis she was able to confirm that the lever was still in the "down" position. She was still not in established labour on the day of her caesarean section 69 hours after the initial hypnosis and was offered and agreed to one further attempt to accelerate labour as described by Fist (1960) and Rice (1961). She had not experienced any uterine contractions that morning but, following suggestions to imagine a contraction, she began experiencing them and suggestions were given that these would continue following trance termination and would become stronger, longer, and more effective. The contractions continued except for

periods when visitors entered the room. On examination prior to her scheduled caesarean section the cervix was still unfavourable. An uneventful caesarean section under spinal anaesthesia was performed and a healthy male infant delivered. Her post-operative course was uneventful.

Case 6

An anxious 33-year-old multiparous woman with a history of gestational diabetes and a prior intra-uterine death at term in her first pregnancy was requesting an early epidural for labour analgesia. She had used epidural pain relief for both previous live births, the labours of which had taken more than 12 hours. A prostaglandin pessary had been given earlier that day but she was only experiencing mild contractions and the cervix was still uneffaced and only 1.5-2 cm dilated. She had some experience of meditation and had used imagery of a safe place previously to allow her to relax. She readily agreed to try hypnosis as an adjunct to labour analgesia and to accelerate her labour. It was explained that she could still have other analgesia including epidural pain relief at any time, should she feel this was required. Our standard suggestions for relaxation, control, and analgesia were given and she was taught self-hypnosis, incorporating her safe place to be used during contractions. Using ideomotor finger signals for confirmation, she was then asked to look for the control box and switch to turn on her labour as described previously. On direct questioning after trance termination she described visualising a black round button which she noted was the switch for her labour. Although the lead to the uterus was red in colour there were no changes noted on pressing the switch. Within a few minutes of trance termination she started experiencing stronger contractions and was noted to be in established labour 23 minutes later following which her membranes were ruptured. The woman did not require analgesia apart from some inhalational Entonox for 20 minutes prior to the vaginal birth of a healthy male infant 5 hours and 10 minutes after her hypnosis.

Case 7

A 31-year-old primiparous woman weighing 139 kg was admitted to labour ward with pre-eclampsia for medical induction of labour. The anaesthetist was called to insert an epidural catheter in order to assist blood pressure control. She had one set of prostaglandin gels two hours prior to her hypnosis, at which time the cervix was noted to be long, closed, and posterior. She had

no experience of meditation/hypnosis or yoga previously although she was very keen to try to use hypnosis for relaxation, analgesia, and to assist in her induction of labour. It was explained that she would still have the epidural catheter inserted for blood pressure control should this prove necessary. Our standard suggestions for relaxation, control and analgesia were given and she was taught self-hypnosis for use during contractions or stressful situations such as epidural insertion or forceps delivery. Using ideomotor finger signals for confirmation, she was asked to look for the control box and switch to turn on her labour as described previously. On direct questioning after trance termination she described visualising a red round button which she noted was the switch for her labour. Immediately after pressing the red button, a green light, situated next to the switch, went on. The lead to the uterus was "covered in white fairy lights" which lit up in progression down to the uterus at the same time as the green light appearing. One attempt was made to induce contractions in hypnosis but only one contraction was experienced. Two hours after the hypnosis irregular contractions were experienced and these became stronger over the next two hours and were timed by the midwife as occurring every 5 minutes and lasting for 20 seconds. The cervix was still closed and the obstetrician was unable to rupture her amniotic membranes. The decision was made to proceed with caesarean section because of the difficulty in monitoring the fetal heart if further oxytocics were required. The epidural anaesthetic was subsequently assessed as inadequate for surgery. General anaesthesia was therefore administered prior to delivery of a live male infant. The post-operative course was otherwise uneventful.

Table 1 shows a summary of this small series of patients' demographic details, description of switchbox imagery, and birth outcomes

DISCUSSION

The induction of labour using hypnosis was first reported in Marseilles by Fanton in 1889 and in 1891 von Schrenck-Notzing claimed that he could initiate uterine contractions using hypnotic suggestions (Bramwell, 1956). Newbold (1956) claimed that the strength of uterine contractions could be increased by direct suggestion. We have found two more recent reports of attempting to accelerate (Fist, 1960) or induce (Rice, 1961) labour in multiparas with a favourable cervix using imagery of uterine contractions. Our case series suggests that switchbox imagery in hypnosis may be of value for the induction or acceleration of labour in primipara women as well. We

Table 1 Summary of Demographic Details, Description of Switchbox Imagery and Birth Outcomes of Seven Consecutive Women Having Hypnosis for Induction of Labour

Case no. days to term age/para	Description of lead switch	Description of switch	Change noted	Time from hypnosis to regular contractions (hrs)	Time from hypnosis to established labour (hr, min.)	Time from hypnosis to birth (hr, min.)	Mode of delivery
1: T - 19 Age 29/Para 3 (Previous LSCS) Cx unfavourable	Cream cable red truncated lines	Turning switch next to red light	Indicator light red to green; red lines on cable turned green and joined together	24	63	68	Vaginal breech
2: T - 1 Age 38/Para 1 Cx unfavourable	Red wire	Old-fashioned light switches labelled by day (Tuesday switch)	Red wire turned by green	4	4	9.12	SVD
3: T + 6 Age 31/Para 1 Cx unfavourable	White tubing with dendrites spreading over the uterus	Lever pointing to a red light	Lever pulled over to the right and red light off/green light on	43	79	89.10	SVD
4: T + 0 Age 21/Para 1 SRM Oxytocin Cx unfavourable	Yellow electric cable going down back of neck to womb	Square toggle switch	Head filled with light; green flash descended down yellow cable to womb	5.1 Oxytocin started 75 minutes prior to regular contractions	6.15	n.a.	LSCS fetal distress

Table 1 (contd)

Case no. days to term age/para	Description of lead switch	Change noted	Time from hypnosis to regular contractions (hrs)	Time from hypnosis to established labour (hr, min.)	Time from hypnosis to birth (hr, min.)	Mode of delivery
5: T + 14 Age 29/Para 2 (previous LSCS) Cx unfavourable	Black-grey cable Red switch and hanging lever	No colour change but felt a contraction on pulling the lever down	Nil after 69 hours	-	n.a.	LSCS 17 days post- term
6: T - 13 Age 33/Para 4 PGs Cx 1 - 2 cm uneffaced	Red lead to the uterus	No colour change but felt stronger contractions almost immediately after trance termination	< 5 minutes	0.23	5.10	SVD
7: T - 31 Age 31/Para 1 PGs Cx unfavourable	Lead to the uterus "covered in fairy lights"	Red round button Green light next to button turned on and fairy lights lit up progressing down to the uterus	1 hour	n.a.	n.a.	LSCS for PET

Note: SVD = Spontaneous vaginal delivery, LSCS = Lower segment caesarean section, T = Term, SRM = Spontaneous rupture of amniotic membranes, PGs = Prostaglandins, PET = Pre-eclamptic toxæmia.

believe this to be the first time induction of labour has been attempted using switchbox visualisation. Unlike previous reports (Fist, 1960; Rice, 1961) all but one woman had a closed extremely unfavourable cervix prior to hypnosis and only two of the seven women had experienced labour previously. Interestingly, all seven women independently experienced similar colours when looking for the switch to turn on labour. Five women experienced independent, unprompted colour changes on switching on their labour and two experienced visual hallucinations of these images during the hours preceding childbirth. The symbolism of the colours and changes that occurred when switching on the labour was apparently not recognised consciously by the women. Whether subconscious imagery of red and green expressing stop and start is a fundamental feature or a result of environmental influence on the subconscious is a question for future research.

The two women who did not see a colour change experienced a uterine contraction or increases in the strength and frequency of contractions associated with hypnosis. We believe hypnosis almost certainly contributed to the induction of early labour in one patient (Case 7) and established labour in two patients (Cases 1 and 3). Hypnosis is likely to have made a useful contribution to the successful outcomes in a further two women (Cases 2 and 6) who might have had their labour accelerated following an apparently limited response to prostaglandin pessaries. Six of the seven women experienced uterine contractions in association with switching on their labour either during or within several hours of hypnosis. Four women (two multipara and two primipara) were in established labour within 79 hours of their hypnosis and gave birth vaginally within 89 hours. Two of the three women having caesarean section had fetal distress within 10 hours of hypnosis while one woman failed to establish labour within 69 hours. This may be considered a failure but in view of Case 3 who was a primipara and who did not establish labour for 79 hours it is not clear whether, given time, vaginal delivery would have been possible.

Case 1 probably gives the most convincing evidence for hypnosis initiating spontaneous labour. The vivid imagery during hypnosis and subsequent visual hallucinations associated with progressively increasing strength and frequency of uterine contractions and dilatation of the cervix within hours of hypnosis are highly suggestive. This lady was still more than two weeks away from her due date and was unlikely to go into labour, given that, at the time of her hypnosis, her cervix was extremely unfavourable being closed, long, and

uneffaced. It appears likely that a successful hypnotic induction with no medical adjuncts takes between three and five days before labour is established, which is considerably longer than conventional methods. This may be acceptable for social inductions and post-dates but not for pre-eclampsia or mothers with spontaneous rupture of amniotic membranes. However, the potential lack of side effects of hypnotic induction of labour may be preferable to medical induction unless one is unable to wait for clinical reasons.

Hypnosis appears to have a therapeutic role in many autonomic systems (Collison, 1980). The mechanism by which hypnosis might induce labour could involve stimulation of the uterus by hormonal changes normally activated by the autonomic or central nervous system at term. Parasympathetic stimulation close to term has been shown to have an influence on the uterus (Bell, 1972). It should therefore not be surprising that the onset of labour might be influenced by hypnotherapy. If proven to be effective, it is likely that hypnosis would represent an improvement in patient safety, with teratogenic and other adverse effects on the fetus being extremely unlikely to be present. There is a need for well-designed controlled clinical trials to assess whether hypnosis can stimulate labour. It may be interesting to assess whether hypnotisability of women (as measured by a scale) is related to their clinical response. Clinically relevant outcomes in future trials should include: the need for other methods of induction such as prostaglandins, oxytocin, and artificial rupture of membranes; whether vaginal birth is achieved over a longer time period than expected with pharmacological agents, as appears in this case series. There may be ways of accelerating induction of labour by using repeat hypnosis on successive days after the first attempt. It would also be important to identify any adverse effects arising from induction of labour utilising hypnosis.

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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.

ZEN AND HYPNOSIS: A PERSONAL EXPERIENCE

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Enforced relative physical inactivity or modification of one's usual routines allows an opportunity to indulge in other pursuits that have been neglected for too long. For example, reflection, contemplation, or other meditative exercises. The Labour Day long weekend (in South Australia) provided me with such an opportunity. After several weekends out of town attending psychiatry update workshops and the ASH Congress in Launceston in September, the October long weekend was the first chance to get back to some physical activities.

On the Saturday I trained in Aikido, my martial art. On Sunday I played tennis and had just begun the second set of another game on the holiday Monday when "thump," I thought I had been hit across the lower left leg from

behind with a cricket bat! For a couple of moments I stood still wondering what had happened but soon realised my Achilles tendon had ruptured.

An emergency visit to a sports clinic doctor confirmed the diagnosis and an appointment with the orthopaedic surgeon was arranged for the next day. Thus, one day after the injury I was wearing a below-knee cast and on crutches, this being the conservative option without surgery. Expected recovery time, vague. Being medically qualified, I knew that a tendon takes much longer to heal than torn muscles or broken bones. I was not happy, as while I could still continue my professional work I would not be able to train in my martial art or play tennis for an indefinite period!

I decided to use some of the clinical skills I teach my patients, but my "self-therapy" led me on an interesting unexpected journey. I accepted that in persistent, sustained vigorous movement in any physical discipline, no matter how conditioned, healthy and fit the performer is, there is always the risk of damage and injury. One only has to observe what happens to professional dancers, elite athletes, and sportspersons.

I wondered how martial arts practitioners coped with inevitable injuries. To find out I began by re-reading a small book I had first read many years ago. It was called *Zen in the Martial Arts* by Joe Hyams. At the same time, as I often do, I also began re-reading another book put aside many years ago, *Zen for Beginners* by Judith Blackstone and Zoran Josipovic. Others soon followed, *Zen Soup* by Laurence Boldt, *Zen Flesh*, *Zen Bones* by Paul Reps, *On Having No Head* by D. E. Harding, and finally *The Way of Zen*, the classic by Alan Watts.

In Hyams' book he described his karate friend, Sam Brodsky, injuring his hand demonstrating a breaking technique to his students. Instead of smashing all nine of the one-inch-thick slabs of concrete stacked in a pile as he had intended, seven broke and so did some bones in Brodsky's hand. Hyams found Brodsky surprised at his injury but not evidencing obvious pain. Later Hyams learned that his friend was more disturbed by his doctor's poor prognosis regarding the time healing and recovery might take after the necessary surgery. Brodsky was apparently told it might take three to six months to heal and then another six months to regain some movement.

Brodsky had studied martial arts in Korea and Japan and believed healing began in the mind, so he started applying the mental techniques he had learned each night to control his pain and enhance his healing. As I re-read the book it became obvious Brodsky was using visualisation and auto-

suggestion, much the same as are used in hypnosis. I began using similar visualisations but with a more medical touch. Instead of Brodsky's team of construction workers with building equipment I envisaged increased blood circulation with healing cells carrying oxygen and collagen fibres to the damaged tendon area. The collagen literally snaked its way in and out of the tendon, knitting it all back together.

Other Zen sayings and comments from the books helped me use the time to ponder while the healing took place. Some of these I reproduce here but do not attempt to explain. Rather, if you let your mind play with the words, they sound very much like what we often do in or out of hypnosis in therapy with our patients and clients. In Zen, you find your own meaning.

"Tell me, I'll forget. Show me, I may remember. But involve me and I'll understand." Chinese proverb. (I believe this is the essence of effective therapy.)

"A man with outward courage dares to die. A man with inward courage dares to live." Lao Tzu. (I used this statement with a suicidal patient recently.)

"We are what we think. All that we are arises with our thoughts. With our thoughts we make our world." Buddha. (Sounds like a good cognitive principle to me.)

Being here now If Zen is telling us anything, it is to be here now, to live in this moment. Simple enough. So what stops us? To live in the moment, we must go out of our minds. The mind, with its guilt and resentment about the past and its fears and hopes for the future, the mind that confuses thoughts about people, things, and events with the people, things, and events themselves — must be transcended. Out of the mind and into direct immediate experience — this is the message of Zen.

Reality Things are not what they seem, including us. As a Zen master put it, "How can you be happy when you spend most of your time worrying about something that doesn't even exist?" The "something" he was referring to is the ego, that confused jumble of thoughts and desires we mistake for the Self. Reality and the true perception of it lie beyond this narrow band of socially conditioned consciousness. From the perspective of Zen, to "get real" is to get out of ourselves, to release the identification with ourselves as a "thing apart." A part is in conflict with other parts, but the whole cannot be against itself.

In reality there is no better, no worse, no difference. There is no loss or gain, nothing old or new. There is nothing to compare with anything else. Everything in the universe is the one same stuff, taking on various forms or disguises. The Zen realisation of "emptiness" comes from the release of the identification with, and attachment to, forms, including the physical form we call the body and the mental form we call the ego and mistake for the Self.

Responsibility One of the great lessons of Zen is to take total responsibility for your own life. Unfortunately, many of us have been conditioned to believe, feel, and act as though the world owes us something. Zen says, why waste time and energy with regrets and whining? We have the gift of life and the opportunities of this moment.

Be yourself Most Western psychological theories confuse the ego with the Self. As a result, we view the self as an object in the need of adaptation or correction. On the other hand, most Eastern philosophies, including Zen, distinguish the ego from the authentic Self. The Self is to be realised, not perfected. It cannot be improved upon or in any way altered, for It remains ever transcendent to time and space and all the changes that transpire within them.

From the perspective of Zen, the ego (or mask of personality) is not to be corrected but released. The ego is the fictional social self we must lose in order to find, or realise, the authentic Self. Losing the ego does not mean despising or annihilating it but, rather, severing our identification with it. In the language of Zen, releasing identification with the ego brings spontaneous realisation of the "original" or "unborn" Self, the True or One Self in all.

Creativity To live is to create. While consciously creating, we move in harmony with life, actively participating with the creative power that is the Universe. There is no conflict between consciously creating your own life and "letting things happen." Indeed, creation is what is happening, and we are consciously creating our own lives. Rather than viewing ourselves as static objects, tossed about by the waves of life, we can identify ourselves with the vast ocean of existence and consciously participate in what it is doing.

So what has happened to my Achilles tendon? The plaster came off one week before Christmas. It is healed but the calf muscle above it is very weak. My surgeon instructed me, no running, jumping, lunging, and definitely *no* tennis or martial arts training, yet! For the time being it is muscle and tendon strengthening only. As I write the end of this story, it is exactly four months

since I tore the tendon. I do not know if I have assisted my own healing or not by my Zen-hypnotic efforts, but as various sages have said, I cannot have done myself any harm.

To close, a quote from a less well-known Chinese philosopher, Mencius. "He who has exhausted all his mental constitution knows his nature. Knowing his nature, he knows heaven."

BOOKS AVAILABLE FOR REVIEW

Full members of the Australian Society of Hypnosis interested in reviewing books should apply to the editor. Reviews are subject to editorial review prior to publication. Reviewers are required to return books to the Board of Education of the Society, for use as part of the Distance Education Program.

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| Rubin Battino | <i>Metaphoria: Metaphor and Guided Metaphor for Psychotherapy and Healing.</i>
Carmarthen, Wales: Crown House Publishing, 2002. |
| Linn F. Cooper &
M. H. Erickson | <i>Time Distortion in Hypnosis.</i>
Carmarthen, Wales: Crown House Publishing, 2002. |
| Joseph Covino | <i>Terror Tales of the City.</i>
Berkeley, CA: New Humanity Press, 2002. |
| Roger Hambleton | <i>Practising Safe Hypnosis.</i>
Carmarthen, Wales: Crown House Publishing, 2002. |
| Clark L. Hull | <i>Hypnosis and Suggestibility.</i>
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