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EDITORIAL

In the November 2003 edition of the journal I announced that I would no longer hold the position of editor and confirmed that Dr Wendy-Louise Walker would act as interim editor for the May 2004 issue, pending the appointment of a new editor.

Circumstances conspired to put me in the position to continue acting in the role of interim editor with Dr Walker. We have worked collaboratively and with our editorial assistant, Carl Harrison-Ford, to ensure the timely publication of the May 2004 journal, with a series of research and clinically focused manuscripts which uphold the consistently high standard of the *Australian Journal of Clinical and Experimental Hypnosis*. We welcome you to this edition and the research reports, case histories, and case notes contained herein.

The Federal Council of the Australian Society of Hypnosis has yet to determine who will take up the position of Chairman of Publications of ASH and editor of *AJCEH*. To ensure that the journal continues its tradition of hypnosis scholarship, clinical excellence, and timely publication, Dr Walker and I have agreed to remain as interim editors for the remainder of 2004. This will also ensure that the new editor, who will assume responsibility for the May 2005 edition, will have sufficient time to take up the reins at that time.

Barry Evans
May 2004

SELF-ESTEEM, HYPNOSIS, AND EGO-ENHANCEMENT

Simon P. Stafrace
Psychiatrist in Private Practice

Self-esteem is a construct underlying many psychological and psychiatric theories. At the same time, despite its integral role in therapy, it is not well articulated in the literature. This paper describes the concepts of self-esteem and self-concept, their role in psychological and emotional wellbeing, and utilisation in a range of therapies. It concludes with a review of hypnosis in ego-strengthening.

Self-esteem is a key concept in accounts of normal personality and mental disorder. It has been said to embody a feeling or a “hedonic” tone that attaches a sense of value to experiences of the self and permits for a personal judgment of worthiness (Coopersmith, 1967). Its clinical significance, however, remains ambiguous and subject to paradoxical assertions. For example, pathological levels of self-esteem are said to both predispose to, and arise from, psychological disturbance. Similarly, the enhancement of self-esteem has been described as a primary goal of psychotherapeutic intervention and as an indirect or incidental outcome of only minor clinical interest (Bednar, Gawain Wells, & VandenBos, 1991; Dryden, 1984; McKay & Fanning, 1992; Steffenhagen, 1990).

Undoubtedly, some of this uncertainty stems from the fact that the construct itself is not well understood. As with “depression,” the term “self-esteem” is used both colloquially and as a technical reference. Consequently, though most researchers and clinicians assume an intuitive understanding of the term, they may not describe the same construct when referring to it (Blascovich & Tomaka, 1991). Furthermore, the existence of self-esteem as a discrete

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component of the human personality has not been demonstrated convincingly and it remains unclear as to which of its characteristics should be regarded as normal and in what settings (Robson, 1988).

Self-esteem has a role in numerous psychological and psychopathological processes. It has been correlated with motivation, conservatism, prejudice, authoritarianism, attraction, deviant behaviour, and performance. Low self-esteem is associated with depression, anxiety, post-traumatic stress disorder, substance abuse, and adjustment to acute and chronic medical conditions (Robson, 1988; Roy, Neale, & Kendler, 1995). Unfortunately, most of the studies which have investigated the clinical significance of the construct have utilised cross-sectional designs. These do not permit determination of causation and whether changes to self-esteem are primary or secondary to the aforementioned attitudes, behaviours, and disorders.

It also remains unclear what role the enhancement of self-esteem *per se* plays in individuals' recovery from a range of mental disorders. While most forms of psychotherapy are said to benefit self-esteem, investigations of psychotherapeutic interventions that specifically target self-esteem are rare. This limitation is equally evident in the literature concerning hypnosis and self-esteem. Consequently, despite the availability of a range of hypnotic strategies aimed at enhancing self-esteem, their effectiveness in achieving this objective and thus ameliorating psychological disturbance and psychiatric disorder is no better validated than other psychotherapeutic interventions.

This paper reviews current conceptualisations of self-esteem. The constructs of self, the self-concept, and self-efficacy will be considered and differentiated from self-esteem. Studies of the role of self-esteem in the development and maintenance of mental disorders and behavioural problems, and those studies which have explored the effectiveness of interventions that target self-esteem in psychotherapy, are then reviewed. These include contributions from the clinical and experimental hypnosis literature.

THE SELF, THE EGO, SELF-CONCEPT, AND SELF-EFFICACY

Heinz Kohut, one of the most innovative proponents of a dynamic psychology of self, purposefully avoided a definition of the term in all his writings despite the fact that the construct represented a central configuration in his work.

The self is ... like all reality ... not knowable in its essence ... We can describe the various forms in which the self appears, can demonstrate the several constituents

that make up the self ... and explain their genesis and functions. We can do all that, but we will still not know the true essence of the self as differentiated from its manifestations. (Kohut, 1977, p. 310–312)

While not methodologically useful, Kohut's position emphasises the point that, like self-esteem, the self is basically a metaphorical construct used to symbolise an aspect of human psychology. Seeking to operationalise the term would undoubtedly facilitate its measurement but could also lead to reification of the concept. The creation of rigid paradigms could, in turn, influence the interpretation of empirical findings and thereby limit any further growth in an understanding of the construct.

Within the field of psychology, two theoretical schools dominate current thinking about the self. These are the psychodynamic and the cognitive-behavioural approaches. Differences between the two orientations exist not only in the methodologies they use, but also in the basic assumptions they make about the structure of personality and mediators of behaviour. Nevertheless, representations of the self as global and stable or multidimensional and dynamic are not restricted to one framework or another and a convergence in the conceptualisation of self within the two theoretical traditions is becoming increasingly evident.

The Self as Global and Stable or as Multidimensional and Dynamic

Some theorists suggest the “self” is a relatively stable and global attribute, in much the same manner as personality or intelligence. Thus, Campbell (1981) defines the term as the immediate experience of the individual's psychophysical total, including both conscious and unconscious attributes, at any given moment. In much the same vein, Meares (1992) presents a view of self as comprising the individual's moment-by-moment sense of existence.

An alternative approach conceptualises the self as multidimensional or multifaceted. In promoting this hypothesis, James (1890) emphasised the pluralistic nature of self. He suggested the “self as knower” needed to be distinguished from the “self as known,” and the “self as subjectively experienced” could differ from the “self as presented.” James further postulated that the self was composed of a number of constituent elements that served as the basis for a coherent personal identity but which retained a capacity to struggle against one another for expression (Segal & Kendall, 1990). Horney, elaborating further on this point, referred to the whole person as experienced

at any one point in time as the “actual self.” She distinguished this from the “real self,” representing the individual’s potential for further growth, and the “ideal self,” defined as the idealised image of the self that is aspired to. Intrapyschic conflict was conceived as emerging from differences in the needs and aspirations of the various aspects of self (in Robson, 1988).

Psychodynamic Perspectives of Self and its Distinction from Ego

Classical psychoanalytic theory and the related schools of ego psychology and object relations theory avoid a view of the self which embraces subjective experience in favour of one oriented towards function.

Psychodynamic thinking conceptualises the intrapsychic world as one of inter-agency conflict between the three components of Freud’s (1923) structural model of psyche, namely, the id, ego, and superego. The id functions to discharge tension arising from the instinctual drives of sexuality and aggression. It is controlled by the superego and aspects of the ego. The former combines a proscribing moral conscience and a prescribing ego-ideal. The latter is viewed as incorporating an unconscious aspect, which includes defence mechanisms, and a conscious executive entity that regulates the integration of perceptual stimuli, thought, and affect.

Within the tradition of ego psychology, the significance of the self tends to be minimised, despite the fact that Freud used the term “ego” both in reference to an impersonal intrapsychic structure and the individual’s subjective self-experience. If the self is considered at all, it tends to be differentiated from ego according to its interactional context and its functions and is viewed as representational rather than a source of action and agency in its own right. Thus, whereas ego is defined by its interplay with other intrapsychic agencies, the self is characterised as evolving from interactions with significant others. In this perspective, the self is viewed as an intrapsychic representation of the individual as experienced in interactions with others. No allowance is made for the concept of self as incorporating all subjective experience or as a source of autonomous activity in its own right (Gabbard, 1990).

Object relations theory emphasises the internalised relationships between representations of self and other. Rather than sexuality and aggression being primary drives, object relations theorists attribute prominence to the individual’s drive to establish relationships. The internalisation of object relations involves the splitting of the ego into unconscious suborganisations.

The self-suborganisations incorporate aspects of the ego in which the individual experiences ideas and feelings as his/her own. The object-suborganisations are those aspects of the ego that the individual identifies with an external agency. Conflict is not merely a struggle between impulse and defence, but also a clash between opposing pairs of internal self- and object-suborganisations (Ogden, 1983).

Recent attempts to integrate object relations theory with ego psychology have considered further the relationship of the ego and the self. Models of the self-as-agency have been described, in which the self is seen as actually playing a role in initiating relatedness and unity with the environment (Sutherland, 1983). Alternatives to the notion that self and ego are distinct have also been explored and include the proposition that the self is embedded in the ego and is the end product of many self-representations.

Whereas object relations theory emphasises the internalised relationships between representations of self and other, self-psychology stresses how external relationships help maintain self-esteem and self-cohesion. For self-psychologists, the construct of self is central to an understanding of human behaviour. Meares (1992) defined the self as one's immediate sense of being, which is experienced in the context of an organised structure of memories of states of personal existence, also known as self-representations. The latter is a concept that is also central to cognitive models of self-organisation, and refers to assumptions and beliefs about the self that evolve as an outcome of interactions with significant others in the environment during the developmental phase. Narcissism (or put simply, self-love) is presented as normative and with its own developmental pathway. Narcissistic needs are viewed as persisting throughout life, in parallel with object love or the drive to form relationships with others. Thus, self-esteem is presented as a component of the normal personality and not the sign of developmental immaturity implied by Freud in his formulation of the psyche (1914).

Cognitive-Behavioural Perspectives on Self

Theorists in the behavioural tradition initially rejected the self as a valid area of investigation. This was because of its subjective nature, the lack of an operational definition, and consequent difficulties associated with its measurement. The increasing acceptance of hypothetical constructs as predictors of behaviour and the reframing of self as a cognitive construct have combined to render theorising about self as a legitimate area of interest to cognitive-behaviourists (Harter, 1990).

Within a cognitive-behavioural framework, the self comprises a complex system of multifaceted structures made up of affective, cognitive, and behavioural structural components known as self-schemas (Markus & Nurius, 1986). Schemas are pre-existing generic memory representations that facilitate retrieval and organise new information into categories, sets of beliefs about different aspects of the self, which give meaning to events (Meares, 1992). Collectively, they form the basis of the self-concept (Blaskovich & Tomaka, 1991; Bednar et al., 1991).

Individuals hold an array of representations about the self, which are constructed from the information contained in the unfolding experiences of life. Self-concept is also influenced by judgments made of the individual by others and identifications with family and friends (Beck, Rush, Shaw, & Emery, 1979). For reasons of temperament or experience, a small number of self-representations receive a high degree of cognitive, affective, and somatic elaboration. These give rise to the self-schemas that come to dominate both conscious and unconscious awareness, forming the “core” self (Markus, 1990).

This view of the self was extended by Cloninger, Svrakic, and Przybeck (1993) who described an empirically based seven-factor model of personality in which the self-concept was presumed to be a mediating factor through which temperament and character interact. Self-concept varies according to the extent to which a person identifies the self as an autonomous individual, an integral part of humanity, and an integral part of the universe as a whole.

Within this framework, self-esteem is viewed as a cognitive construct that emerges from the self-concept and constituting a set of evaluative beliefs about the self (Guidano & Leotti, 1983). Cloninger et al.’s seven-factor model provides a theoretical basis for the role of self-esteem as a determinant and consequence of a range of behavioural abnormalities and mental disorders.

A related concept in cognitive-behavioural theory is self-efficacy, defined as confidence in one’s ability to deal with change by implementing adaptive and problem solving behaviours (Rutter, 1985). Though related to self-esteem, the terms are not synonymous and may not even be correlated in certain situations (Gage & Polatajko, 1994).

The concept of self-efficacy arose from the observation of discrepancies between attained skills and performance outcomes. Though skill and motivation are basic requirements for performance, differences in performance between individuals with equivalent skills must be attributed to other processes. Traditional cognitive models have ascribed the skill-performance

discrepancy to a variation in action–outcome expectancy. This represents a belief that a given response will lead to a particular goal. Bandura (1977) suggests, however, that action–outcome expectancy does not account for all of the variance between skills and performance, and that a separate cognitive process, which he termed self-efficacy, must be considered as an additional explanatory factor.

The term “perceived self-efficacy” (PSE) refers to the subjective judgment of one’s capacity to utilise one’s skills in order to organise and implement a course of action, with the aim of attaining a designated performance (Bandura, 1982). The development of PSE is a dynamic process, influenced by experiences of success and failure in the tasks individuals carry out throughout life. PSE is affected by four variables:

1. Personal performance accomplishments are the most influential, and the success or failure of one’s efforts will enhance and decrease PSE respectively.
2. The vicarious experience of observing others perform specific tasks allows for learning to precede actual performance, enhancing the expectation that a specific task can be carried out competently.
3. Persuasion is a less effective strategy, and involves the use of language to communicate rational thoughts, which challenge false assumptions about one’s competence.
4. Physiological arousal may communicate fear and, in so doing, may decrease one’s expectation of success in a given task. Strategies that induce relaxation and decrease arousal may enhance self-efficacy.

Information derived from these four sources is interpreted and integrated through a process of cognitive appraisal which itself is influenced by the life experiences of the self, and by others and the environment. The appraisal process involves an analysis of the requirements of the task, the degree to which success or failure can be internally or externally attributed, and finally, the personal and situational resources and constraints that may have influenced the task. The greater the degree to which the individual can attribute success to stable internal factors and failure to external or transient internal factors, the greater the sense of self-efficacy (Gage & Polatajko, 1994).

Bandura and Adams (1977) demonstrated that PSE is an important determinant of performance and improvements in PSE are good predictors of improved subsequent performance. Additionally, they demonstrated that improved PSE is enhanced when subjects use active learning, rather than

vicarious learning, suggesting that performance-based procedures are more powerful learning strategies than symbolically based experiences (Gage & Polatajko, 1994). These findings have since been replicated in a number of controlled experiments (Gage & Polatajko, 1994).

Rutter (1985) contends that self-esteem may arise from self-efficacy. Such a relationship undoubtedly exists, and self-esteem does appear to be affected by experiences of success and failure in dealing with the physical and interpersonal world. Moreover, the attribution of one's successes to internal qualities and of one's failures to external factors appears to be an important process in maintaining self-esteem. However, self-efficacy is only correlated with self-esteem when task competency is valued by, and highly relevant to, the individual. For example, one may be uncompetitive as an athlete, and have poor perceived self-efficacy in this area. This may not impact upon self-esteem if other competencies exist that attract social approval or confer social status, or help the individual master challenges (Brooks, 1992).

SELF-ESTEEM

As with definitions of "self," there are differences in the conceptualisation of self-esteem. Whereas structural psychoanalytic models of personality view self-esteem as a product of tension between different components of the psyche, cognitive models emphasise the influence of self-representations or self-schemata, and behavioural models devote attention to the impact of observable behaviours on the individual's sense of self-worth. In contrast, interpersonal and systemic models shift attention away from intrapsychic processes and highlight exclusively the importance of relationships between individuals and within society in the development of self-regard.

The Structure of Self-Esteem

Global self-esteem is defined as overall feelings of self-worth, derived from evaluations of specific aspects of the self-concept. The assumption that self-esteem is a composite rather than a single entity has relevance to both the clinical and the research setting. Individuals who experience diminished esteem in specific aspects of the self may compensate for this by reducing the salience and personal relevance of those aspects of self and/or emphasising areas of higher self-esteem. A similar approach to treatment may also assist clinicians dealing with lowered self-esteem in individuals (Blascovich & Tomaka, 1991).

Numerous dimensions of self-esteem have been described. Rosenberg (1965) referred to personal self-worth and appearance and, like Coopersmith (1967), alluded to the importance of perceived social competence and power. The role of interpretive processes in arriving at a self-view was highlighted by Beck's cognitive theory of depression (Beck et al., 1979). This was further refined by work on learned helplessness (Abramson, Seligman, & Teasdale, 1978), which proposed that self-esteem might be influenced by attributional style, in particular the internal attribution of negative events. Romney (1994) extended this hypothesis to incorporate stable and global attributions.

An important aspect of self-esteem that is often neglected in formulations of the construct is the affective response evoked by the self-evaluative cognitions that comprise it. Robson alluded to this in describing self-esteem as "the sense of contentment and self-acceptance that stems from a person's appraisal of his own worth, significance, attractiveness, competence, and ability to satisfy his aspirations" (1988, p. 13). Similarly, Meares (1992) referred to the almost indefinable feeling at the core of self-esteem, activated by the mirroring responses of others to expressions and actions that are unique, personal, and infused with meaning to the individual concerned. Such an emotional response must be differentiated from the associated cognitions, for though ideas of mastery and associated plans of action do arise from it, it embodies a variety of feelings that emerge as a result of perceived judgments of self-worth (Grunebaum & Solomon, 1987).

The Determinants of Self-Esteem

The various theoretical frameworks hold the common assumption that self-esteem is influenced by psychosocial and environmental factors. In contrast to the abundance of studies on psychosocial determinants, little attention has been paid to the genetic or familial determinants of self-esteem. The importance of these factors is suggested by twin and adoption studies of various other personality characteristics that show some degree of genetic control for most traits (McGuffin & Thapar, 1992).

The Influence of Genetic Factors on Self-Esteem

In the only published study of its kind, Roy et al. (1995) attempted to quantify the relative importance of genetic and environmental influences on self-esteem by comparing over 600 monozygotic and dizygotic female Caucasian twin pairs. These were assessed for levels of self-esteem on two occasions,

about 16 months apart. The authors suggested self-esteem was a relatively stable trait. Genetic factors accounted for about 52% of the variance and environmental factors for the remainder. One-third of the genetic variance of self-esteem could be accounted for by three factors: one common to neuroticism, depression, and self-esteem; another to self-esteem and depression; and a third specific only to self-esteem.

The implication of this finding is that the genetic influence on self-esteem is likely to be complex and is probably mediated by other inherited factors that, in turn, modify self-esteem. Thus, the heritability of self-esteem may be linked to that of certain mental disorders, such as depression, with which it has been correlated and which is itself subject to some degree of genetic control (Silberg, Heath, & Kessler, 1990). Another factor that could mediate the heritability of self-esteem is temperament. Indeed, the four dimensions of temperament identified by Cloninger et al. (1993) have all been shown to be independently heritable.

Psychosocial Influences on Self-Esteem

Despite the undoubted importance of genetic factors and temperament, environmental factors accounted for nearly a half of the total variance in self-esteem identified in the Roy et al. (1995) study. The effect of these factors tended to be stable over the period of the study, and typically, the ones that appeared to influence self-esteem most were not common to both members of a twin pair. In addition, no evidence was found to suggest that short-term fluctuation in the environment impacted significantly upon self-esteem.

These findings are consistent with theories that self-esteem can be influenced by aspects of the childhood environment not shared by members of the twin pair, such as differences in parental attitudes to each child. Moreover, enduring conditions of adult life, such as chronic unemployment or marital discord, and the lasting effects of discrete events in adulthood, such as marital separation or physical or psychological trauma, could also have an important bearing upon self-esteem.

The Influence of Parent–Child Relationships on Self-Esteem

Within the psychodynamic tradition, the importance of interpersonal relationships in acquiring a sense of self-worth was brought to prominence by the object relations school. Mahler, Pine, and Bergman (1975) postulated a process of individuation within the parent–child dyad in infancy which is

marked by the consolidation of individuality and the beginnings of object constancy. This occurs in the pre-oedipal phase in the third year of life, and involves the integration of split views of the mother into a whole. This is then internalised as an emotionally soothing inner presence and, in this manner, the regulation of self-esteem becomes reliant upon internalised sources.

Bowlby (1988), whose formulation of attachment theory was influenced in part by the object relations school, also emphasised the importance of the infant–mother relationship. He suggested the quality of attachment experiences in early childhood impacted upon future development through the formation of internal working models of the self and of the mother that were then generalised to other relationships. Consequently, secure attachment to a principal figure in early childhood may be the basis for incorporating self-reliance as an enduring personality trait and developing a stable sense of self-worth. Interestingly, attachment style may continue to influence self-regard even into adulthood. Roberts, Gotlib, and Kassel (1996) reported that an insecure attachment style in adulthood can be associated with dysfunctional attitudes, which in turn predispose to lower levels of self-esteem.

Brooks (1992) suggested the development of self-esteem also involves the dynamic interaction of a child's inborn temperament and environmental forces that respond to or act independently of the child. Thus, the difficult child is characterised as demanding, frequently over-reacts to situations, reveals little pleasure in activities, and fails to attend or respond positively to others. He or she is more likely to evoke a negative reaction from others. In contrast, the easy child, who is typically calm, warms up to and engages with strangers readily and takes pleasure in activities, is more likely to evoke positive responses (Thomas & Chess, 1984).

A number of factors moderate the impact of a child's temperament upon self-esteem. The extent to which the responses of others are internalised, forming the basis of self-evaluation, is influenced by the unique qualities of the child. Consequently, positive and negative responses from caregivers do not necessarily lead to predictable effects upon self-esteem. Moreover, the nature of the match between child and other, typically the parent in early childhood and peers and teachers in middle childhood and beyond, is of vital importance (Brooks, 1992).

Coopersmith (1967) clarified the qualitative elements within the child–parent relationship that predispose to high self-esteem in childhood. These include the unconditional acceptance of children by their parents; clearly defined and enforced limits to their behaviour; respect and latitude for

individual action; and high self-esteem in the parents. Oliver and Paull (1995) studied 186 undergraduate university students still in frequent contact with their families, to determine associations between parental rearing style, family climate, self-esteem, self-efficacy, and depression. "Affectionless control" — the perception of family and parents as providing little affection but excessive control — accounted for 13% of the variance in self-esteem, self-efficacy, and depression.

Gender issues also require consideration. In general, it appears the self-esteem of men is more vulnerable to the perceived appraisals of parents than is that of women (Bartle, Anderson, & Sabatelli, 1989; Kawash, Kerr, & Clewes, 1985). Conte, Plutchik, Picard, Buck, and Karasu (1996) reported on a retrospective questionnaire-based survey of 155 psychiatric patients and found that measures of self-esteem were more highly correlated with parenting variables for men than for women. Specifically, items measuring parental acceptance/autonomy were positively correlated and items measuring parental inconsistency were negatively correlated with self-esteem. Among women, only paternal rejection was associated with low self-esteem.

The Influence of Peer Relationships in Childhood and Adolescence on Self-Esteem

A number of authors have shifted the focus of research interest to peer relationships in childhood and adolescence. Grunebaum and Solomon (1987) emphasised that, while the child–parent relationship provides a foundation of security, which facilitates exploration of the social environment, it is within the child's peer relationships that the growth of self-mastery, social skills, and self-definition occur. 'It is through ... the actual interaction and play among equals [of a positive nature] that the child becomes less afraid of others, can bear to ... see himself in their reflected appraisals ... [and] ... develops a better sense of self and self-esteem' (p. 506).

Isberg, Hauser, and Jacobson, (1989) suggested decreasing reliance upon parental feedback for self-esteem regulation is dependent upon ego development and individuation. Gecas and Schwalbe (1986) and Hoelter (1984) suggested the influence of peer relationships may be greater in adolescent females, further evidence of a more rapid development of ego in females than in males.

The Influence of Interpersonal Variables and Other Situational Factors Throughout the Life Span on Self-Esteem

The extent to which self-esteem in adults continues to be influenced by social forces and life events is controversial. Some authors emphasise the role of interpersonal relationships in infancy, childhood, or adolescence, and view self-esteem as reflecting a stable and enduring set of attitudes (McCrae & Costa, 1988). In contrast, others propose that situational factors, life events, and social feedback can modify aspects of self-esteem throughout the life span (Rutter, 1987).

From this perspective, self-esteem has been described as inseparable from its relational context and as “never finally settled ... [but only ever] re-negotiated at each developmental crisis” (Cotton, 1983, p. 139). Cooley (1902), referring to the importance of the reactions of others in shaping self-esteem, introduced the concept of the “looking-glass self.” Extending this idea further, self-esteem has been conceptualised as a product of the reflected appraisals of others, including signals of attention, love, submission, respect, approval, praise, and affection (Brooks, 1992; Mead, 1934). Rutter (1987) expressed the view that secure, harmonious love relationships, together with successful task accomplishments, continue to influence the self-concept throughout the life cycle.

Markus and Nurius (1986) proposed a model of self-esteem that assumes the construct to combine both stable and dynamic elements. In this model, a core self reflecting enduring self-concepts is distinguished from a working self, which is more tentatively held and includes concepts of the self that are more situationally responsive.

Cognitive–Behavioural Models

Behavioural formulations focus exclusively on the observable. Thus, Bednar et al. (1991) proposed that self-esteem is the natural consequence of a person’s tendency to confront what one fears and has previously avoided. Brooks (1992) defined self-esteem as involving not just an appreciation of one’s worth and importance, but also a capacity to act responsibly and with respect towards others. Self-esteem includes attitudes of regard towards others, as well as towards the self.

From the perspective of cognitive models of personality and behaviour, self-esteem is an enduring system of beliefs about oneself, one’s social environment, one’s ability to deal with life’s challenges and control what will happen. As

with the construct of self, self-esteem may be viewed as stable and global or dynamic and multidimensional. It is activated by experience, shaped by behaviour, and then influenced by the outcomes of that behaviour, giving rise to a dynamic reciprocal process that is continuously in force (Brooks, 1994).

Within a cognitive framework, self-esteem is embedded in the individual's self-representations and the evaluative component of the self-concept. This is in contrast to the content component, which is made up of the physical characteristics, attitudes, social roles, and cultural affiliations unique to the person. Self-referent evaluations are concerned with issues of self-acceptance, self-worth, self-regard, self-efficacy, and degree of correlation between the actual and ideal self (Katz, Rodin, & Davis, 1995).

The cognitions forming the basis of self-esteem may derive, not just from the experience of interpersonal relationships, but also from internal and external comparisons. Thus, in adolescents, self-esteem appears dependent upon comparisons with peers and is based upon popularity, power over others, and task competence (Coopersmith, 1967). Internal comparisons may also be relevant, between the ideal self that incorporates one's aspirations and the actual self founded upon one's achievements (*Lancet*, 1988).

This process of comparing that which is aspired to with that which is perceived within oneself was elaborated by Brissett (1972). He describes two social-psychological processes which can influence self-esteem. The first, a process of self-evaluation, involves making a conscious judgment about the social significance of one's attributes. One's achievements are considered according to a set of standards or values that include an image of the ideal self and internalised social judgments regarding one's identity and one's performance in achieving that identity. In contrast, the second process, self-worth, embodies a sense of having executive control over one's behaviour. This involves making one's behaviour consistent with one's self-concept and the assumptions one makes about oneself. Thus, whereas the process of self-evaluation is perceived as being externally controlled, that of self-worth has an intrinsic quality. Brissett argued the two processes do not always complement each other, and that their failure to do so may lead to personal unhappiness.

A Social or Systemic Perspective

Within the systemic perspective, self-esteem is seen as being influenced by a network of interpersonal relationships that extends beyond individuals and is dependent upon group membership. In some cultures, a sense of self-worth is

based largely upon membership of family, social group, tribe, nation, and even religion, with initiation rites characterising acceptance into the group. At another level, self-esteem may even depend upon whether the individual can see himself in a comprehensible relationship to the rest of the universe and, in this manner, spiritual beliefs may indeed actuate a sense of self-worth (*Lancet*, 1988).

A number of studies have actually investigated the social correlates of low self-esteem. Kaplan (1975) tested high school students on three occasions over a 12-month period and demonstrated that self-derogation scores did not remain stable for a large proportion of the sample. Perceived devaluation of self by peers predicted a worsening in negative self-attitudes. Bachman and O'Malley (1977), in following up a sample of 1,600 male high school students to early adulthood, found that once self-esteem as baseline, family background, and prior ability were controlled for, job status made an additional contribution to self-esteem.

In an important cross-sectional investigation of 395 women, Brown, Bifulco, Veiel, and Andrews (1990) found that negative interactions with family members and the lack of a close confiding relationship were associated with negative self-evaluation, while higher-status employment was correlated with a positive evaluation of self. When the same sample of women was re-evaluated after a period of seven years, the most powerful predictors of change in self-esteem were favourable changes in the quality of close relationships and increased work status, both for the woman and her partner. It was unclear from the design of the study whether the changes in self-esteem and mental state preceded or were followed by the psychosocial changes.

The Stability of Self-Esteem Through the Life Cycle

Self-esteem has been conceptualised by some as a stable entity, in much the same way as personality or intelligence. The empirical evidence on this point, however, is conflicting and points to the existence of continuities and discontinuities in the course of development.

Dusek and Flaherty (1981) observed that self-esteem develops during childhood and remains relatively stable throughout adolescence. This has been confirmed by a number of longitudinal studies, which demonstrated few changes in self-esteem from late childhood through the teenage years and into early adulthood (Bachman & O'Malley, 1977; Barnes & Farrier, 1985).

The failure to demonstrate changes in self-esteem with age, however, may be in part due to limitations in the measures used (Robson, 1988). Indeed, other investigators have shown that, in the short term at least, self-esteem can be manipulated experimentally (Anderson & Williams, 1985) and that age can be shown to account for some variance in self-esteem over the course of the developmental cycle (Nehrke, Hulicka, & Morganti, 1980).

Variations in self-esteem with age were investigated by Block and Robins (1993), who studied 92 adolescents, over a nine-year period from early adolescence to early adulthood. The longitudinal consistency of self-esteem was greater for females than for males. This implied self-esteem was well established by early adolescence in females, but not males, whose self-representations remained relatively malleable. For the combined sample, no age-related changes in the mean level of self-esteem were recorded. Males, however, tended to increase and females decrease in self-esteem over time, though there was appreciable consistency in rank-order. This accords with cross-sectional data suggesting there are more girls than boys with low self-esteem, and that this difference grows larger by late adolescence (Simmons & Rosenberg, 1975). Block and Robins (1993) point to gender differences in socialisation, which restrict the range of experiences for girls but broaden it for boys, as one possible explanation of this difference.

Of interest, when changes in self-esteem occurred between early adolescence and early adulthood, specific personality characteristics predicted increases in self-esteem. These differ according to gender. Thus, significant in females were interpersonal qualities involving an orientation towards others, such as protectiveness, humour, warmth and generosity. In males, self-esteem increased in those subjects who were able to control personal anxiety levels, implying an orientation towards the self.

In old age, the stability of self-esteem is less well understood, as few studies have been carried out on elderly subjects. An investigation based upon telephone interviews with 300 retired workers in the U.S. found that self-esteem did not decline in the transition to retirement. Pre-retirement self-esteem and pre-retirement commitment to the role of worker or spouse continued to exert a positive effect upon self-esteem after retirement (Reitzes,

Mutran, & Fernandez, 1996). On the other hand, loss of self-esteem can occur, in association with retirement from competitive activities and an awareness of society's largely unsympathetic attitude to old people, and this may lead to depression (Butler & Lewis, 1973).

THE CLINICAL SIGNIFICANCE OF SELF-ESTEEM

Each individual's self-esteem may be conceived as a causal variable that determines or influences other psychosocial phenomena, or as an outcome variable influenced by life events and interpersonal feedback.

As an outcome variable, reductions in self-esteem may follow the experience of such stressful life events as unemployment, or medical or psychiatric illness. As a causal factor, positive self-esteem may be considered a necessary condition for achievement. It is a driving force behind all human activity and an organising principle upon which personal theories of reality are constructed (Robson, 1988). Self-esteem also has a role in information processing, motivation, and such interpersonal activities as the choice of a life partner (Katz et al., 1995). The way children think and feel about themselves affects the quality of their relationships with peers, the prevalence of drug and alcohol abuse and teenage pregnancy, together with motivation and performance in school and in sports. Self-esteem also influences the willingness of adolescents to persevere at various tasks and their capacity to be resilient and bounce back from adversity (Brooks, 1992).

Correlations of High Self-Esteem

Persons with high self-esteem are less socially isolated, and demonstrate fewer tendencies to be exploitative or hostile-dependent with others. Coopersmith (1967) postulated persons with high self-esteem are more accepting, better able to lead active lives, and demonstrate a sense of being self-determining. They are better able to tolerate internal or external distress without isolating themselves from inner experiences, are less anxious, less sensitive to criticism, more willing to express a controversial opinion, and pay greater attention to personal values than to group mores. They tend to have better physical health, enjoy better relationships, value independence, welcome competition, and anticipate more success (Rosenberg, 1965).

Positive and stable self-esteem influences one's ability to cope with stressful life circumstances. Individuals with higher self-esteem are said to be more successful at problem solving, show greater resilience in response to stress and

are more likely to seek out and use social supports. Stressful experiences may also bolster self-esteem if successfully navigated by increasing self-confidence, self-efficacy and promoting personality growth and self-worth (Rutter, 1985).

Correlations of Low Self-Esteem

Low self-esteem is correlated with a number of personality characteristics including dependency, the need for approval, helplessness, apathy, feelings of powerlessness, isolation, withdrawal, submissiveness, and compliance. Masked hostility, passivity, and a tendency to downgrade or denigrate others or project one's failings onto others are also significantly correlated with low self-esteem. Poor self-regard predisposes the individual to reduced ability to choose jobs suited to one's needs and abilities, a diminished association between task performance and satisfaction, a tendency to accept unfavourable assessments as accurate, less likelihood of scholastic success, and vulnerability to interpersonal problems in adolescence. In the elderly, low self-esteem is associated with poorer health, more daily pain, greater disability, and increased somatisation, together with anxiety and depression (Ingham, Kreitman, Miller, Sashidharan, & Surtees, 1986; Robson, 1988).

The Relationship Between Low Self-Esteem and Depression

Low self-esteem is correlated with depression in child psychiatric patients, adult psychiatric patients, and college student samples (Overholser, Adams, Lehnert, & Brinkman, 1995). What remains unclear is whether changes to self-esteem are primary or secondary to the onset of affective disturbances. Thus, low self-esteem has been conceptualised as a consequence of depressive behaviour, in particular, inactivity and a lack of reinforcement (Lewinsohn, 1975); as an outcome of the depression-prone personality (Pardoën, Bauwens, Tracy, Martin, & Mendlewicz, 1993); and as central to the pathogenesis of depression (Beck et al., 1979).

Beck and his colleagues (Beck et al., 1979) postulated that, among individuals predisposed to depression, negative attitudes and value judgments towards the self exist in a latent state, and are then activated by minor experiences of deprivation and guilt. Abramson et al. (1978) further argued that depressed individuals were characterised by a tendency to make attributions for negative life events that were internal, global, and stable. In other words, negative events are perceived as resulting from factors that are the

individual's responsibility, persist throughout time, and generalise to other situations. Romney (1994), in a study of 45 psychiatric patients with both psychotic and affective disorders, found that all three attributional styles affected depression solely through the mediation of self-esteem.

As with clinical research pertaining to self-esteem in other domains, investigations of the relationship between depression and low self-esteem tend to be cross-sectional in design. Issues of causality, therefore, are difficult to assess and one must rely on prospective studies in order to clarify the role of self-esteem in the development and maintenance of depressive disorders.

In adolescent psychiatric in-patients, improvement in depression coincides with increases in global self-esteem, and there is a strong association between the severity of depression and low self-esteem (King, Naylor, Segal, Evans, & Shain, 1993).¹ In another prospective study, Gardner and Oei (1981) studied 16 depressed subjects assigned to behavioural and cognitive treatments. No relationship between depression and self-esteem was evident at baseline. However, post-treatment, there was significant negative correlation between the two, suggesting recovery from depression had a positive impact on self-esteem. These findings appear to lend weight to Lewinsohn's (1975) hypothesis that feelings of low self-esteem and depression need not necessarily co-exist. Brown et al. (1990) further distinguished between negative and positive evaluations of self and observed these can co-exist in depressed individuals and have different implications for treatment.

Other factors may moderate the impact of self-evaluative beliefs and depression. When 1,656 adolescents were investigated at 16 and 22 years, the prevalence of depression was highest among those persons from divorced families who, at age 16 years, also reported low self-esteem. An intimate relationship was found to protect young adults from depression even in the presence of the risk factor of low self-esteem in adolescence, irrespective of family background or gender (Palosaari & Aro, 1995).

Low self-esteem may indirectly increase the risk of suicidal behaviour by increasing hopelessness and pessimism about the future. Hopelessness is a cognitive factor closely related to suicidal behaviour and suicidal ideation, and tends to be stable over time (Beck, Steer, Kovacs, & Garrison, 1985). In a study

¹ It is important to highlight that self-esteem deficits, including self-reproach, poor self-image, negative self-concept, and low self-worth are especially prominent in depressed adolescents and tend to be more common than the biological symptoms of depression often reported by adults (Inamdar, Siomopoulos, Osborn, & Bianchi, 1979).

designed to examine self-esteem deficits and suicidality in adolescents, 542 adolescent psychiatric inpatients and high school students were investigated. Differences appeared to be determined by gender and hospitalisation status, so that males reported mean higher self-esteem than females, while high-school students scored higher on self-esteem than hospital patients. Correlations between variables, however, remained similar across gender and hospitalisation status. Thus, low self-esteem was related to higher levels of depression, hopelessness, suicidal ideation, and an increased likelihood of having previously attempted suicide. When predicting the presence of suicidal ideation, depression and hopelessness accounted for 20% of the variance, while self-esteem added a further 9%. Among all adolescents with low self-esteem, 48% had attempted suicide at least once, compared to 21% of subjects with high self-esteem, a significant difference (Overholser et al., 1995).

Self-Esteem and Restricting and Purging Eating Disorders

Low self-esteem is well recognised among individuals with eating disorders (Lindeman, 1994). Silverstone (1992) proposed chronic self-esteem may be a necessary prerequisite to the development of an eating disorder and, further, might represent the final common pathway through which the multiple aetiological factors involved in the causation of eating disorders act.

Evidence in support of an association between the purging and restricting eating disorders and low self-esteem derives from correlational studies in subjects already afflicted (Weinreich, Doherty, & Harris, 1985). In the first prospective study to investigate the role of self-esteem in the aetiology of eating disorders prior to their onset, self-esteem was measured in 594 schoolgirls aged 11–12 years. Almost 400 of these girls were successfully followed up at the age of 15–16 years. Girls with low self-esteem at age 11–12 years were eight times more likely to have developed eating disorders and other psychosocial problems at follow-up. The authors argued these results needed replication, but recommended the enhancement of self-esteem be considered in the prevention of eating disorders (Button, Sonuga-Barke, Davis, & Thompson, 1996).

Self-Esteem and Obesity

The relationship between self-esteem and obesity has not received a great deal of empirical evaluation, so that the exact nature of the relationship between the two is not entirely clear. Specifically, it is yet to be determined whether

self-esteem is consistently related to obesity. In addition, it remains uncertain whether physical or global self-esteem is affected by obesity, whether the relationship differs according to demographic variables such as age, gender, or race/ethnicity, and whether self-esteem moderates changes to weight during weight loss treatment programs.

French, Story, and Perry (1995) reviewed 35 studies investigating the relationship between self-esteem and obesity in children and adolescents. Thirteen cross-sectional studies clearly showed lower self-esteem in obese children and adolescents. Five of the six studies that included a measure of body self-esteem showed this was diminished compared to normal weight controls. Six out of eight treatment studies showed that weight loss treatment programs appear to improve self-esteem. It remains unclear whether increases in self-esteem are related to enhanced weight loss.

Self-Esteem and Cancer

In this setting, self-esteem has been investigated as an outcome variable, a mediator of other psychosocial outcomes, and as a personal resource that facilitates coping. Unidimensional global measures of self-esteem generally reveal no significant differences between cancer patients and controls. However, when self-esteem is investigated as a multifaceted construct, one of the most consistent findings is of a diminution of body self-esteem, especially in patients with disfiguring cancer treatments. There is limited evidence of heightened self-worth, but other domains of self-esteem are poorly investigated because of the lack of suitable multidimensional inventories. Positive self-esteem does not predict survival or treatment compliance, but appears to mediate the effects of social supports upon the wellbeing of melanoma survivors, as well as the psychological adjustment of a group of women three months after removal of a breast lump (Katz et al., 1995).

PSYCHOTHERAPY AND SELF-ESTEEM

Although global self-esteem is a relatively stable characteristic, especially in adults (Blascovich & Tomaka, 1991), it has already been noted that aspects of self-esteem can be modified by environmental factors, even in adult life, and that global measures might not be sufficiently sensitive to detect changes in constituent domains of self-esteem.

McGuire and McGuire (1996) demonstrated that self-esteem could be enhanced by using directed thinking tasks. These were aimed at manipulating the prominence of emotionally salient self-characteristics in order to maximise desirable ones and minimise unattractive ones. In a separate experiment, lowering of self-esteem resulted in depression, anxiety, hostility, and withdrawal (Wilson & Krane, 1980). Such findings suggest increasing self-esteem in a therapeutic setting is possible and might actually ameliorate clinically significant disturbances, such as affective disorders. Indeed, Fennel and Zimmer (1987, in Robson, 1988) demonstrated a short-term improvement in depressed mood in persons who spent 30 minutes focusing upon positive aspects of the self-concept. Whether such changes in mood or self-esteem can be made to last was not made clear from the study.

In a meta-analysis of 400 psychotherapy outcome studies, Smith and Glass (1977) reported the greatest overall benefit of all forms of therapy was to reduce fear and anxiety and increase self-esteem. Interestingly, despite this finding and the work of several authors on the non-specific effects of psychotherapy (e.g., Frank, 1974), the enhancement of self-esteem is not generally regarded a specific focus of psychotherapy and its impact upon self-esteem is rarely monitored.

Studies of interventions specifically designed to enhance self-esteem are rare. In the only such empirical study identified, Schreiber and Schreiber (1995) described a study in which 22 undergraduate university students were exposed to 20 sessions over 10 weeks of muscle relaxation coupled with positive self-esteem suggestions. When compared to a control group of 30 students, the experimental group had higher academic scores, but no differences in measures of self-esteem or anxiety were found.

Of the different forms of psychotherapy, cognitive-behaviour therapy (CBT) appears best suited to achieve the direct enhancement of self-esteem. Viewing self-esteem as a cognitive structure comprising the evaluative component of the self-concept suggests the possibility of change through such processes as cognitive restructuring.

The two theoretical developments that most influenced the development of CBT were the rational-emotive therapy (RET) of Ellis (in Dryden, 1984) and the cognitive model of depression described by Beck (Beck et al., 1979). Both share the view that psychological disorders, such as depression, arise as a consequence of irrational or maladaptive ways of thinking.

The primary psychological disturbance identified in Ellis's model consists of a tendency to make absolutistic evaluations of perceived events, which are then couched in terms of dogmatic "musts," "shoulds," "ought to's," "have to's," and so on. Various types of irrational thinking are then derived from such statements, including global evaluations of the self, which are argued to be irrational by definition. Three key phases in RET can be identified. Initially, clients are helped to identify the links between their irrational beliefs and dysfunctional emotions and behavioural responses to these. Then, the therapist helps the individual gain insight by challenging these distorted beliefs and encouraging alternative rational beliefs. Finally, a working-through phase permits acquisition of emotional insight whereby the client is able to internalise these rational ideas, act on them, and integrate them into their emotional repertoire (Dryden, 1984).

Beck's model of depression, which has become the template for cognitive models of a range of psychological disorders, also refers to a set of distortions of reasoning known as the cognitive triad. This consists of negative views of the self, current experience, and the future. Beck noted that depressed patients characteristically view themselves as wanting in the very attributes they value the most. Shortcomings are magnified, strengths ignored, and a distorted view of self maintained by habitual errors of reasoning. These include: overgeneralisation from single events; selective abstraction by which positive information can be ignored; arbitrary inference involving the drawing of negative conclusions which are unsupported by the evidence as a whole; magnification and minimisation in evaluating the implications and importance of events; personalisation in which one takes responsibility for negative events over which one has no control; and absolutistic dichotomous thinking or thinking in polar opposites.

Beck's model of personality further assumes that irrational thoughts stem from underlying schemata or cognitive templates, previously described in this paper, through which all experience is interpreted and which can become modified by successful therapeutic intervention (Twaddle & Scott, 1991). The cognitive-behaviour therapy that emerged from Beck's formulation of depression combines a number of techniques that can be applied to the enhancement of self-esteem. These include cognitive restructuring, rehearsal (Gauthier, Pellerin, & Renaud, 1983), and activity scheduling (Gardner & Oei, 1981).

In treatment, cognitive therapists regard negative self-evaluations as hypotheses that require empirical testing. Pervasive self-criticisms are brought to awareness by encouraging the client to monitor automatic negative thoughts, say in a diary. The individual is then taught to make connections between thought and mood and to assess objectively the evidence for and against assumptions about the self, the environment, and the future. In this manner, the person learns to identify cognitive distortions and, consequently, to interpret experiences more realistically. Rational thinking hopefully leads to affective change and amelioration of the presenting complaint.

Difficulties associated with the restructuring of dysfunctional patterns of thinking about the self may result from problems involved in altering attributional styles which underlie poor self-esteem (Sober-Ain & Kidd, 1984). Although learned helplessness theory suggests attributing negative events to unstable, external, specific factors has greater impact on positive self-esteem than internal, stable, and global attributions, this has not been shown to have clinical significance. Seligman (1981) and Fuchs and Rehm (1977) both recommended cognitive strategies that include a focus upon self-concepts, self-evaluation, self-efficacy, and attributional thinking. Rehm's therapy of self-management has been evaluated, compared with Beck's CBT, and found to be effective in the treatment of depression. However, there is no evidence to suggest that it is successful in affecting change in attributional thinking or self-evaluation or that improvements in mood in depressed patients occur as a result of such changes (Twaddle & Scott, 1991).

HYPNOSIS IN ENHANCING SELF-ESTEEM, EGO-STRENGTHENING, AND PERFORMANCE ENHANCEMENT

Hypnotic techniques offer the clinician an abundance of options for enhancing self-esteem and self-efficacy. Their impact upon the core beliefs that characterise self-esteem may be direct, as in the case of ego-strengthening, or indirect, as in the case of a variety of interventions which enhance self-worth through the relief of distressing affects, behaviours, and cognitions and the resolution of intrapsychic conflict.

Ego-Strengthening

Hartland (1971) published one of the earliest descriptions of the application of hypnosis to the enhancement of self-esteem, calling his technique ego-

strengthening. Its use is based upon the principle that negative responses to physical or psychological impairment might arise both as a consequence of the impairment itself and as a result of secondary alterations to aspects of the self-concept. Thus, just as a physically compromised patient may be stabilised before proceeding to surgery, so too a psychologically impaired individual may benefit from positive suggestions of self-worth and personal effectiveness. As Hartland postulated, some clients may be unwilling to let go of their symptoms until they feel strong enough to do without them.

Because of the significant impact upon clinical practice made by Hartland's (1971) publication, the concept of ego strength is of considerable importance in the field. Ego strength differs from self-esteem, though self-esteem is probably a product of high ego strength. Put simply, ego strength refers to the capacity of the ego to carry out its functions of dealing with external reality and integrating the conflicting demands of reality with those of the id and superego. Conceptualisation of ego strength is difficult, both because of its high level of abstraction and its multi-faceted nature. Approaches to the evaluation of ego strength appear to revolve around assessment of the relative intactness of ego functions and the ease with which impaired ego functions can be restored to efficiency (Calnan, 1977).

Ego-strengthening comprises a set of standard suggestions aimed at augmenting the client's ego, ego defences, and general sense of self-worth, with the expectation that such an outcome will facilitate symptom resolution. The technique described by Hartland involves the use of suggestions that the future will be brighter; confidence, health, and energy will be restored; and that the client will acquire whatever goals they desire. The pairing of such suggestions with feelings of calmness and relaxation in the hypnotic state is intended to facilitate the subject's uncritical acceptance of what are essentially post-hypnotic suggestions.

Numerous authors recommend that ego-strengthening suggestions be included in almost every induction, to reinforce self-reliance and a positive self-image (Waxman, 1989). Indeed they are often described, in original or amended form, as augmentative to a range of therapeutic paradigms. Nevertheless, Gibson and Heap (1991) have criticised them for their non-specificity and the absence of any imagery-evoking instructions. For instance, suggestions such as "you will think more clearly" and "you will feel happier" involve complex processes, and it seems unlikely that subjects will respond to them in the same way as the suggestion of arm levitation or a pleasant image. Moreover, little is revealed about how such states are to be achieved.

The experience of hypnosis can be pleasant and uplifting, especially when the client has the sense of being in some kind of an altered state. It is most likely this, together with the person's confidence, trust, and hopeful expectation concerning therapy, that is being exploited in Hartland's ego-strengthening technique, rather than their suggestibility per se. If these ingredients are absent, then the ego-strengthening routine will fall decidedly flat, even with a suggestible subject.

Accordingly, Gibson and Heap (1991) recommend that ego-strengthening suggestions should be tailored to the individual needs of the client. The therapist should also be more precise about the behavioural, cognitive, and physiological responses presumed to mediate the desired feelings of strength, optimism, self-confidence, and calmness. This may include the use of imagery and metaphor, specific post-hypnotic suggestions, and the anchoring of cues to desired emotional and cognitive states.

A variation of ego-strengthening, which achieves the greater precision recommended by Gibson and Heap, is termed ego-assertiveness retraining (Waxman, 1989). It is derived from the assertiveness training techniques of Wolpe and Lazarus (1966) and constitutes an approach to enhancing self-efficacy for specific tasks. In the hypnotic state, the subject's enhanced capacity for dissociation and visual imagery is used to recreate, in imagination, the feared situation. The subject is then asked to imagine increasingly threatening interactions, and positive suggestions of self-assertion are paired with feelings of calmness, composure, control, and confidence. Cognitive rehearsal and role-play are utilised to demonstrate coping and to enhance self-confidence and beliefs of self-efficacy. This process may be repeated through a hierarchy of fears or of increasingly complex performances, with the client being required to reinforce therapeutic gains by repeating exposure in vivo between sessions.

Other Hypnotic Techniques Used to Enhance Self-Esteem

From a cognitive-behavioural perspective, many of the hypnotic interventions used to strengthen self-esteem may be viewed as involving the client learning, through a process of persuasion, how to challenge their irrational assumptions underlying the self-concept. Thus, while the client is in a trance state, self-hypnotic and self-management skills for coping with anxiety, anger, or other emotions can be taught, and cognitive therapy concepts and methods for altering imprinted ideas reinforced. Post-hypnotic suggestions are used to

reinforce and facilitate positive internal dialogue and self-talk (Hammond, 1990).

The heightened suggestibility that characterises the hypnotic state is used to reinforce specific beliefs clients hold about their ability to achieve specific outcomes, thereby enhancing self-efficacy and, indirectly, self-esteem. This can be achieved through the use of metaphors, direct and indirect suggestions, such as ego-strengthening suggestions, trance ratification procedures to convince the person of the power of the mind and inner potentials, and personalised self-hypnosis tapes to provide regular reinforcement of suggestions.

Finally, their heightened capacity for visualisation, characteristic of hypnosis, can help clients experience positive interactions and successful performances in imagination. In this way, they may be exposed to enactive experiences, which have a powerful influence upon learning and self-efficacy beliefs (Bandura, 1977). Techniques that achieve these outcomes may involve age progression and mental rehearsal, as well as hypnotic conditioning techniques.

From the psychodynamic viewpoint, positive self-esteem is a state of being on good terms with one's superego. Consequently, psychotherapeutic interventions aimed at enhancing self-esteem achieve this outcome by reducing the degree of intrapsychic conflict between aspects of the tripartite psyche. This is the essence of the presumed work of psychodynamic psychotherapy — to extend the sphere and control of the ego by freeing it from the conflicts of earlier life. Hypnosis can be used in this way by facilitating the rapid unconscious exploration and working through of the roots of self-image problems.

Hypnosis is also especially relevant in mobilising non-verbal processes in order to achieve therapeutic outcomes. In this respect, symbolic imagery techniques may be relevant and hypnosis can be used to obtain unconscious commitments from the client. Watkins and Watkins' (1979) ego-state therapy utilises symbolism and metaphor in order to access specific ego states. In this manner, ego-strengthening is achieved and mature and constructive ego-states are allowed to achieve executive control over immature ones more of the time (McNeal & Frederick, 1993).

Empirical Studies of the Effectiveness of Hypnosis in Enhancing Self-Esteem and Alleviating Associated Clinical Disorders

Although ego-strengthening is often mentioned in the clinical hypnosis literature, very little is known about the effectiveness of strategies to enhance self-esteem. In my review of the literature for this paper, only four studies could be identified which studied the impact of hypnotic interventions on self-esteem, using instruments that are acceptable measures of self-esteem.

In the first of these studies, Flannery and Baer (1975) attempted to determine whether, among students in a natural classroom setting, academic self-esteem could be altered by the use of hypnosis, suggestion, or a behaviour modification procedure. Eight subjects were assigned to each of four experimental groups, including a hypnosis group and an attention-control group. Subjects were exposed to each intervention for one hour weekly over four weeks. The authors did not describe the content of the therapeutic intervention. No significant differences or trends were observed, though subjects reported numerous subjective benefits.

Johnson and his colleagues (Johnson, Johnson, Olsen, & Newman, 1987) explored the impact of group hypnotic and self-hypnotic training on the academic performance of learning disabled children and their self-esteem. Three hypnotic training sessions and instructions for six weeks of daily self-hypnotic practice, containing suggestions for imagery related to improvement, were given to 15 children aged 7 to 13 years, their reading teacher, and parents. Their responses were compared to a similar but untreated control group of 18 children. No overall differences were observed between the groups for either academic performance or self-esteem. A multiple regression analysis revealed that, for the experimental group, the children's hypnotic susceptibility score and self-hypnotic practice by the children and parents were the most important predictors of improvement in self-esteem.

In their study, Koe and Oldridge (1987) investigated the interaction between hypnotisability and Hartland's ego-strengthening techniques on improved self-esteem. Fifty-two volunteer university students were divided into four groups, and told that they were about to participate in an experiment to evaluate the impact of hypnosis on reading performance and self-concept. Subjects in each experimental cell underwent systematic relaxation, hypnotic induction and deepening, and visualisation of a tranquil scene, selected by subjects. Post-hypnotic suggestions, adapted for reading, were then administered.

In the Achievement group, direct performance exhorting suggestions were provided. In the Self-Esteem group, the suggestions provided implied increased self-efficacy and in the Other-Esteem group, subjects' perception of the opinions of significant others was targeted. A fourth group received a combination of self-and other-esteem suggestions. Findings indicated that, in susceptible subjects, defined as scoring above the mean on the Harvard Group Scale of Hypnotic Susceptibility, significant improvements in self-concept were evident after four sessions of hypnotic treatment. Aspects of the self-concept most responsive to treatment were self-satisfaction and personal self-concept, as opposed to changes in identity, behaviour, or social relationships. Significant effects were not found for type of suggestion, though susceptible subjects did worst with direct suggestions.

Finally, Taylor (1995) examined the effects of a behavioural stress-management program on HIV-positive men who were asymptomatic, but had T-cell counts below 400. Ten subjects were randomly assigned to treatment and no-treatment groups. Treatment consisted of 20 bi-weekly sessions of progressive muscle relaxation and electromyograph biofeedback-assisted relaxation training, meditation, and hypnosis. The hypnotic element of the treatment intervention consisted of progressive relaxation, deepening using a visual metaphor, positive esteem suggestions, and post-hypnotic suggestions of remaining disease-free.

At baseline, all subjects showed abnormal scores on measures of anxiety and mood. Self-esteem scores were average or below average. At study exit, the treatment group showed significant improvement on all the dependent measures, including anxiety, mood, self-esteem, and T-cell count. This was maintained at one month follow-up. A limitation of this study was the small sample size. Further, the design did not allow one to determine whether the improvement in self-esteem was independent of the improvement in anxiety, depression, and possibly physical wellbeing.

CONCLUSION

The evidence reviewed does suggest that high self-esteem is associated with adaptive functioning and personal contentment. It further points convincingly to an association between low self-esteem and a number of clinical disorders and dysfunctional attitudes and behaviours. The relative lack of prospective studies, however, is problematic as it remains unclear how this relationship evolves, and whether the importance of self-esteem is as a predisposing,

precipitating, or maintaining factor. In addition, questions as to the stability of self-esteem and of changes induced by a variety of psychosocial factors remain largely unanswered.

Researching the impact of hypnosis upon self-esteem is made difficult by the absence of an operationalised definition of self-esteem and a lack of widely accepted scales for the rating of self-esteem. The available data from studies with hypnosis suggest an intuitive effectiveness of hypnotic techniques in enhancing self-esteem and ameliorating psychological distress. While empirical research is imperative in establishing the effectiveness of any therapeutic technique, practitioners of clinical hypnosis seemingly attest to the value of hypnosis in enhancing self-esteem and promoting more positive performance.

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KNOWLEDGE, ATTITUDES, AND BELIEFS ABOUT CLINICAL HYPNOSIS

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This study investigated knowledge, attitudes, beliefs, and motivation regarding clinical hypnosis. A comparison was made between those who had previous experience with hypnosis and people who had no previous experience with hypnosis. Results indicated that previous experience with hypnosis was associated with significantly more accurate knowledge, more positive attitudes and beliefs about hypnosis, and greater intention to use clinical hypnosis. There were no significant differences between younger and older non-experienced or hypnosis-experienced participants in relation to accuracy of knowledge, positive beliefs about hypnosis, beliefs about the mental stability of hypnotisable people, or fear about hypnosis. Those who obtained their information about hypnosis from personal experiences had significantly more accurate knowledge about hypnosis than those who obtained their information from stage hypnosis/television presentations. They also had significantly more positive beliefs and less fear about hypnosis than those who obtained their information from stage hypnosis/television presentations

Past research into knowledge, attitudes, and beliefs about hypnosis has focused on how these factors have related to the sources of their information about hypnosis, their level of hypnotic responsiveness, and how compatible commonly held public views of hypnosis have been with scientific knowledge. Johnson and Hauck (1999) noted that misconceptions on the part of the general public have been thought by many researchers to be due to stage

hypnotists, sensationalistic media stories, or superstitions passed from one person to another (Marcuse, 1964; Wallace, 1979). This past research relating to sources of information about hypnosis has mainly focused on stage hypnosis demonstrations and their effects on perceptions of hypnosis (Echterling & Whalen, 1995; Large & James, 1991). However, results in this area have been mixed. Some studies have reported that stage hypnosis has a very negative effect on audience members' knowledge, attitudes, and beliefs about hypnosis (Large & James, 1991); others have reported that it has both positive and negative effects on audience members' attitudes, beliefs, and knowledge about hypnosis (Echterling & Whalen, 1995); and yet others have reported that stage hypnosis has no effect on audience members' attitudes, beliefs, and knowledge about hypnosis (Hawkins & Bartsch, 2000).

The findings of Hawkins and Bartsch (2000) highlighted a considerable difference between obtaining information about hypnosis from an educational lecture, which significantly increased the respondents' levels of accurate knowledge about the subject, and obtaining information about hypnosis from a stage performance, which resulted in no such increases in knowledge. The Hawkins and Bartsch study was particularly noteworthy because of (a) the comparability of different treatment groups consisting of the lecture-exposed, past experience of hypnosis, and control groups, in terms of age, sex, and previous clinical or stage hypnotic experience; (b) the comparability of experienced and inexperienced groups on age and gender; and (c) the use of a standardised, highly reliable measure, the Attitudes Towards Hypnosis Scale (Spanos, Brett, Menary, & Cross, 1987). However, their results need to be cautiously interpreted as their sample only represented a small subgroup of society (77 undergraduate university students). This may have posed a threat to the external validity of the study.

Interestingly, results from a study by Johnson and Hauck (1999) indicated that although respondents obtained their information from a variety of different sources (clinicians, television shows, movies, stage hypnosis presentations, friends, fiction, and teachers), their beliefs about hypnosis were remarkably consistent. From these findings, Johnson and Hauck concluded that there might be a general consistency in the way hypnosis has been portrayed across the various sources or that a generic cultural belief about hypnosis might supersede the influence of any one source of information. Results from this study also suggested that younger people were less likely to fear the possible effects of hypnosis than older people, thus they were consequently more motivated to consider using hypnosis in the future. This

was a methodologically sound study utilising a large representative sample of 272 Americans.

Hawkins and Bartsch's (2000) study also found that knowledge, attitudes, and beliefs about hypnosis are critical factors in determining responsiveness to hypnotic suggestions. Their findings may be explained through a theory of social behaviour: Ajzen and Fishbein's (1980) theory of reasoned action. This theory states that a causal sequence of behaviour stems (a) from an individual's beliefs and attitudes, (b) from what the individual considers to be the "social norm," which influences (c) the intention behind the individual's behaviour, and finally (d) determines whether or not the actual behaviour is performed (see Figure 1). This theory is also influenced and modified by the knowledge the person has about the specific action. Thus, Hawkins and Bartsch (2000) found that an individual will respond to hypnotic suggestions at their optimal level of hypnotic responsiveness if they have accurate knowledge and positive attitudes about hypnosis, few fearful beliefs about the possible effects of hypnosis, and few negative beliefs about the mental stability of hypnotisable people.

Results from Hawkins and Bartsch's (2000) study also showed that those who had been hypnotised in the past were more likely to have an accurate concept of hypnosis and hypnotisability, and, as a result, were less likely to fear the possible effects of hypnosis than those with no previous experience. However, no significant differences were found between these two groups in

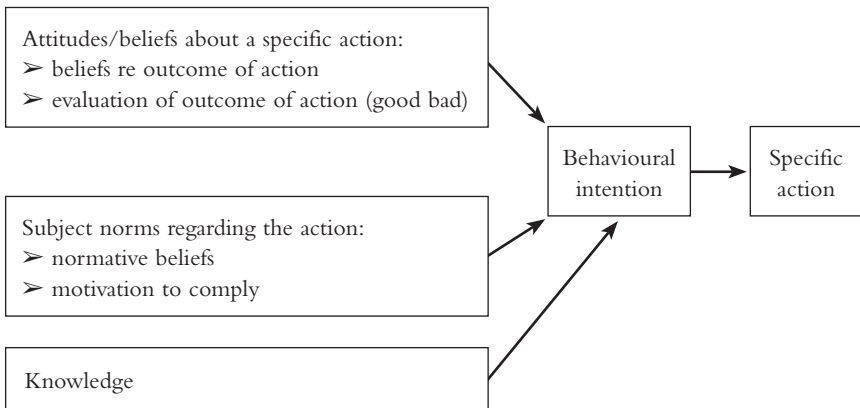


Figure 1: Theory of Reasoned Action (Adapted From Ajzen & Fishbein, 1980)

relation to positive attitudes toward hypnosis or beliefs about the mental stability of hypnotisable people (Hawkins & Bartsch, 2000).

In order to add to the body of knowledge in this area, the current study was undertaken specifically to address the following. First, to investigate how knowledge, attitudes, and beliefs about hypnosis influence motivation to use clinical hypnosis in the future. This important link had not been previously investigated and reported in the literature. Second, to further investigate the recommendation of Hawkins and Bartsch (2000) that potential clients receive adequate information prior to the use of hypnosis (a position which has been held in good quality training programs). Third, to test for significant differences between those who had previous experience with hypnosis and those who had not, in relation to attitudes, beliefs, and knowledge about hypnosis. In order to investigate differences that occurred as a function of experience with clinical hypnosis, two groups were recruited: those who had previously experienced hypnosis and those who had not. Thus, to further investigate these areas of ambiguity and lack of knowledge, the following hypotheses were proposed.

- H1: Hypnosis-experienced participants would have (a) significantly more accurate knowledge about hypnosis; (b) more positive beliefs about hypnosis, hold fewer stereotypical/negative beliefs about the mental stability of hypnotisable people, have less fear of hypnosis; and (c) be more likely to consider using hypnosis in the future for clinical purposes than those who had not had previous experience with hypnosis.
- H2: Younger participants in the non-experienced group would (a) have significantly more accurate knowledge about hypnosis; (b) have positive beliefs about hypnosis, hold fewer stereotypical/negative beliefs about the mental stability of hypnotisable people, and have less fear; and (c) be more likely to consider using hypnosis in the future for clinical purposes than those who are older.
- H3: No significant differences would be found between younger and older hypnosis-experienced participants in relation to (a) knowledge about hypnosis; (b) attitudes and beliefs; and (c) motivation and consideration of future use of hypnosis.
- H4: Those who obtain their information about hypnosis from personal experience would have (a) significantly more accurate knowledge about hypnosis; (b) positive beliefs about hypnosis, fewer stereotypical/negative beliefs about the mental stability of hypnotisable people, and less fear of

hypnosis; and (c) more motivation to consider using clinical hypnosis than those who gained their information from other sources.

METHOD

Participants

Hypnosis-experienced participants (84) were recruited from the waiting rooms of psychological practices of members of the Australian Society of Hypnosis (ASH). The ASH members who advertised their services under the “hypnotherapists” section of the Gold Coast, Brisbane, and Sunshine Coast Yellow Pages were recruited for the study. Non-experienced participants (102) were recruited from the waiting rooms of medical centres. Other data of the sample, including the mean age of males and females in each group, is also shown in Table 1.

A median split was performed to categorise those aged 38 years and

Table 1: Means and Standard Deviations of Age by Experience and Gender

Experience and gender	Mean age (<i>SD</i>)	<i>N</i>
Hypnosis-experienced		(84)
Males	40.12 (2.72)	26
Females	44.00 (1.95)	49
Did not specify gender		9
Non-experienced		(102)
Males	37.92 (2.19)	39
Females	39.51 (2.04)	57
Did not specify gender		6

younger as the “younger group” ($M = 28.11$, $SD = .60$) and those aged 39 years and older as the “older group” ($M = 52.40$, $SD = .92$).

Measures

Participants completed a 4-part questionnaire: part 1 related to demographics and sources of information regarding hypnosis; part 2 measured attitudes/beliefs about hypnosis; part 3 measured the accuracy of their knowledge about hypnosis; and part 4 measured their intention to use hypnosis in the future for clinical purposes.

The Attitudes Towards Hypnosis Scale (ATHS; Spanos et al., 1987) is

14-item scale that measures three factors: (a) how positive participants' beliefs were about hypnosis; (b) their beliefs regarding the mental stability of hypnotisable people; and (c) how fearful they were of the possible effects of hypnosis. Each item was rated on a 5-point scale ranging from "Strongly Agree" to "Strongly Disagree." High scores indicated: (a) an openness to the idea of hypnosis and being hypnotised, (b) the view that hypnosis is not a fear-provoking procedure, and (c) the notion that those who can be hypnotised are not weak minded, nor are they mentally unstable.

Spanos et al. (1987) report good internal consistency of the ATHS. Using Chronbach's (1951) alpha, they found that reliability was highest for the total scale ($\alpha = .81$), and reasonably high for each of the subscales (Positive beliefs, $\alpha = .72$, Mental stability, $\alpha = .62$, and Fearlessness, $\alpha = .70$). In the present study the Cronbach alpha coefficients for the total ATHS ($\alpha = .92$) and for each subscale (Positive beliefs, $\alpha = .90$, Mental stability, $\alpha = .77$, and Fearlessness, $\alpha = .87$) were all high.

Knowledge about hypnosis was measured by 12 true/false hypnosis questions, which were adapted from Hawkins and Bartsch (2000) and an undated pamphlet by R.L. Perry Hypnosis Centre. Correct answers were given a score of 1, while incorrect answers (wrong answer or unsure) were given a score of 0, giving a possible range of 0–12. High scores on this scale indicated greater accuracy in relation to knowledge about hypnosis. The Knowledge scale had good internal consistency, with a Cronbach alpha coefficient of .75. This scale also had good face validity and content validity, for it reflected common misconceptions about hypnosis found in the literature and in clinical practice.

Intention to use clinical hypnosis to treat a number of psychological and medical conditions was measured by a 9-item scale. Each item was rated on a 5-point scale ranging from "Highly Likely" to "Highly Unlikely." High scores indicated a greater intention to use clinical hypnosis. This scale was developed from research relating to the common uses of clinical hypnosis, for no comparable measure existed in the current literature. The Intention scale had good internal consistency, with a Cronbach alpha coefficient of .92. This scale had good face validity and content validity, because the conditions specified reflected common uses of clinical hypnosis found in the literature. A number of experts also confirmed that the conditions specified in the Intention scale reflected common uses of clinical hypnosis.

Design

A between-subjects factorial design was used to investigate the extent to which hypnosis-experienced participants and non-experienced participants differed in relation to their attitudes, beliefs, and knowledge about hypnosis, and their intention to use hypnosis in the future for clinical purposes. There were three independent variables in this study. The first was hypnosis experience (hypnosis-experienced group vs. non-experienced group). The second was age category (younger group vs. older group). The third was source of information about hypnosis (four information-source groups: personal experience, stage/television presentations, from others, and books/literature). The three dependent variables were the scores on the ATHS (Positive beliefs, Mental stability, and Fearlessness), Knowledge scale, and Intention scale.

Procedure

Once approval was obtained to recruit participants from the various psychology practices/medical centres, signs were posted in the waiting rooms to solicit interest. Questionnaire packages were left beneath these signs. Individuals who were interested in participating each took a questionnaire package, completed questionnaires, and returned them in the envelope that was provided in the package, sealed, and put it into the box that was provided.

The data from the completed questionnaires was then entered into SPSS 10.0 for analysis.

RESULTS

Descriptive Statistics

Descriptive statistics were computed for each of the groups across all of the dependent variables and are displayed in Table 2. The mean scores for the two experience groups appeared to differ, with the hypnosis-experienced group scoring higher than the non-experienced group on the ATHS, the Knowledge, and the Intention scales.

The mean scores for the younger and older hypnosis-experienced groups also appeared to differ in relation to the Positive beliefs subscale of the ATHS and the Intention scale, with the younger hypnosis-experienced group scoring higher than the older hypnosis-experienced group. The mean scores for these two groups also appeared to differ in relation to the other two ATHS subscales, with the older hypnosis-experienced group scoring higher than the younger

Table 2: Descriptive Statistics for Dependent Variables by Experience, Experience x Age Category, and Information Source

Groups	ATHS means (SD)			Knowledge scale means (SD)	Intention scale means (SD)
	Positive beliefs	Mental stability	Fearlessness		
Experience					
Hyp.-experienced	19.41 (.42)	17.02 (.30)	20.40 (.44)	7.95 (.25)	36.07 (.64)
Non-experienced	15.26 (.49)	15.42 (.28)	15.12 (.42)	5.50 (.27)	29.84 (.82)
Experience x age category					
Younger hyp.-exp.	20.10 (3.99)	16.65 (2.85)	19.90 (4.25)	7.84 (2.82)	34.87 (6.84)
Older hyp.-exp.	18.74 (3.64)	17.15 (2.69)	20.49 (3.96)	7.98 (1.91)	36.66 (5.18)
Younger non.-exp.	16.33 (4.52)	15.64 (2.41)	15.71 (3.86)	5.31 (2.85)	29.72 (7.54)
Older non-exp.	13.88 (5.16)	15.22 (3.31)	14.20 (4.73)	5.56 (2.49)	29.76 (9.37)
Information source					
Personal experience	19.42 (.82)	16.38 (.51)	19.58 (.69)	7.33 (.41)	36.04 (1.07)
Stage/television	14.38 (.88)	15.79 (.52)	14.14 (.91)	4.97 (.49)	30.21 (1.59)

hypnosis-experienced group.

Further analyses were conducted to determine whether the hypotheses were supported and if the differences were statically significant.

Analyses

The two groups hypnosis-experienced, non-experienced were compared to confirm that they matched in relation to age, gender, education, and source of information. The only variable on which these groups were not completely matched was source of information. The hypnosis-experienced group (95.1%) were significantly more likely than the non-experienced group (4%) to have obtained their information about hypnosis from personal experience ($\chi^2 (1) = 148.42, p = .001$), whereas the non-experienced group (74.3%) were significantly more likely than the hypnosis-experienced group (34.4%) to have obtained their information from stage/television presentations ($\chi^2 (1) = 26.34, p = .001$). However, the hypnosis-experienced were no more likely to have obtained their information about hypnosis from other people or books/literature than the non-experienced group. The assumption of minimum expected cell frequency was not violated, for at least 80% of cells had expected frequencies of five or more. An alpha level of .05 was used to test for significance.

The results for hypotheses that tested the differences between the hypnosis-

Table 3: Univariate Tests for the Knowledge Scale by Experience and Age Category

Source of variation	<i>F</i> -ratio	<i>df</i>	<i>p</i>	η^2	Power
Experience	39.86	1,173	.001	.19	1.00
Age category	.25	1,173	.62	.00	.08
Experience x age category	.02	1,173	.89	.00	.05

experienced, non-experienced groups and the age category groups in relation to knowledge about hypnosis (H1a, H2a, and H3a) are presented in Table 3.

There was a significant main effect of experience ($F(1, 173) = 39.86, p = .001$), with the hypnosis-experienced group scoring significantly higher on the Knowledge scale than the non-experienced group. The results therefore supported H1a, that hypnosis-experienced participants had significantly more accurate knowledge about hypnosis than non-experienced participants. The results also supported H3a, that there was not a significant difference between younger and older hypnosis-experienced participants in relation to knowledge about hypnosis.

The results for hypotheses that tested the differences between the experience groups (hypnosis-experienced, non-experienced) and the age category groups in relation to attitudes and beliefs about hypnosis (H1b, H2b, and H3b) are presented in Table 4. At the multivariate level, there was a significant finding for the main effect of experience ($F(3, 171) = 22.69, p = .001$). At the univariate level, there was a significant main effect of experience on the Positive beliefs subscale ($F(1, 173) = 40.83, p = .001$), with the hypnosis-experienced group scoring significantly higher than the non-experienced group. There was also a significant main effect of experience on the Mental stability subscale ($F(1, 177) = 11.64, p = .001$), with the hypnosis-experienced group having higher scores than the non-experienced group. On the Fearlessness subscale there was a significant main effect of experience ($F(1, 177) = 66.53, p = .001$). Once again, the hypnosis-experienced group had higher scores than the non-experienced group. The evidence therefore supported H1b, that the hypnosis-experienced group had significantly more positive beliefs about hypnosis, held fewer stereotypical/ negative beliefs about the mental stability of hypnotisable people, and had less fear of hypnosis than the non-experienced group. The results also supported H3b, that there was not a significant difference between younger and older hypnosis-experienced participants in relation to attitudes and beliefs about hypnosis.

Table 4: Multivariate and Univariate Tests for the ATHS by Experience and Age Category

Source of variation	Multivariate <i>F</i> -ratio (Wilk's lambda)	Univariate <i>F</i> -ratio	<i>df</i>	<i>p</i>	η^2	Power
Experience	22.69		3,171	.001	.29	1.00
Positive beliefs		40.83	1,173	.001	.19	1.00
Mental stability		11.64	1,173	.001	.06	.92
Fearlessness		66.53	1,173	.001	.28	1.00
Age category	3.47		3,171	.02	.06	.77
Positive beliefs		7.91	1,173	.01	.04	.78
Mental stability		.01	1,173	.92	.00	.05
Fearlessness		.52	1,173	.47	.00	.11
Experience x age category	.96		3,171	.42	.02	.26
Positive beliefs		.66	1,173	.42	.00	.13
Mental stability		1.15	1,173	.29	.00	.19
Fearlessness		2.66	1,173	.12	.02	.39

The results for hypotheses that tested the differences between the experience groups (hypnosis-experienced, non-experienced) and the age category groups in relation to intention to use clinical hypnosis (H1c, H2c, and H3c) are presented in Table 5.

There was a significant main effect of experience ($F(1, 173) = 28.1, p = .001$), with the hypnosis-experienced group scoring significantly higher on intention than the non-experienced group. The results therefore supported H1c, that hypnosis-experienced participants were significantly more likely to consider using clinical hypnosis than non-experienced participants. The results also supported H3c, that there was not a significant difference between younger and older hypnosis-experienced participants in relation to intention to use clinical hypnosis.

Table 5: Univariate Tests for the Intention Scale by Experience and Age Category

Source of variation	<i>F</i> -ratio	<i>df</i>	<i>p</i>	η^2	Power
Experience	28.10	1,173	.001	.14	1.00
Age category	.64	1,173	.42	.00	.13
Experience x age category	.60	1,173	.44	.00	.12

To test whether those who obtained their information about hypnosis from personal experience differed from those who obtained their information about it from stage/television presentations in relation to knowledge about hypnosis (H4a), an independent-samples *t*-test was performed. A significant difference was found between these two sources of information in relation to knowledge about hypnosis ($t(51) = 3.62, p = .001$). The results therefore supported H4a, that those who obtained their information about hypnosis from personal experience had significantly more accurate knowledge about hypnosis than any other source. Results showed that those who obtained their information about hypnosis from personal experience scored significantly higher on the Knowledge scale than those who obtained their information from stage hypnosis/television presentations. The magnitude of the differences between the means ($MD = 2.37$) was large ($\eta^2 = .20$).

The results for H4a which tested the difference between the two main sources of information (personal experience, stage/television presentations) in relation to attitudes and beliefs about hypnosis (H4b) are presented in Table 6.

At the multivariate level, a statistically significant difference was found between those who obtained their information about hypnosis from personal experience and from stage hypnosis/television presentations ($F(3, 49) = 8.09, p = .001$). At the univariate level, the only differences to reach statistical significance were positive beliefs ($F(1, 51) = 17.09, p = .001$) and fearlessness ($F(1, 51) = 21.19, p = .001$), with those who obtained their information about hypnosis from personal experience scoring significantly higher than those who obtained their information from stage hypnosis/television presentations on both factors. The results therefore only partly supported H4b, that those who obtained their information about hypnosis from personal experience had more positive beliefs and less fear about hypnosis than any other source.

Table 6: Multivariate and Univariate Tests for the ATHS by Information Source

Source of variation	Multivariate <i>F</i> -ratio (Wilk's lambda)	Univariate <i>F</i> -ratio	<i>df</i>	<i>p</i>	η^2	Power
Information source	8.09		3, 49	.001	.33	.99
Positive beliefs		17.09	1, 51	.001	.25	.98
Mental stability		.62	1, 51	.44	.01	.12
Fearlessness		21.19	1, 51	.001	.29	1.00

To test whether those who obtained their information about hypnosis from personal experience differed from those who obtained their information about hypnosis from stage/television presentations in relation to intention to use clinical hypnosis (H4c), an independent-samples *t*-test was performed. The results supported H4c, that those who obtained their information about hypnosis from personal experience were more motivated to consider using clinical hypnosis than those who obtained their information from stage hypnosis/television presentations. The magnitude of the differences between the means (5.83) was large, ($\eta^2 = .15$).

DISCUSSION

The aims of this study were to investigate attitudes, beliefs, and knowledge about clinical hypnosis. Furthermore, the second aim was to investigate whether or not there was a significant relationship between views of hypnosis and intention to use hypnosis in the future for clinical purposes. The theoretical underpinnings of the study were embodied in Ajzen and Fishbein's (1980) theory of reasoned action. Two groups were compared (hypnosis-experienced, non-experienced) in order to investigate differences that occurred as a function of experience with clinical hypnosis.

The first hypothesis tested was whether there were significant differences between the two experience groups (hypnosis-experienced, non-experienced) in relation to attitudes, beliefs, knowledge, and motivation regarding hypnosis. The results supported this hypothesis as the hypnosis-experienced group had significantly more accurate knowledge about hypnosis than the non-experienced group. They also had significantly more positive beliefs about hypnosis, held fewer stereotypical/negative beliefs about the mental stability of hypnotisable people, and had less fear about hypnosis than non-experienced participants. As a result, they were significantly more likely to consider using hypnosis in the future for clinical purposes than the non-experienced group. These results have been conceptualised in Figure 2.

This result supports the notion that various researchers have claimed that the assessment of attitudes, beliefs, and knowledge about hypnosis is a critical part of the therapeutic process, in order for clinicians to modify any common fears and misconceptions that potential clients may have (Hawkins & Bartsch, 2000; Spanos et al., 1987).

The current findings suggest that experience is an influential factor that determines accuracy of knowledge about hypnosis, favourability of attitudes

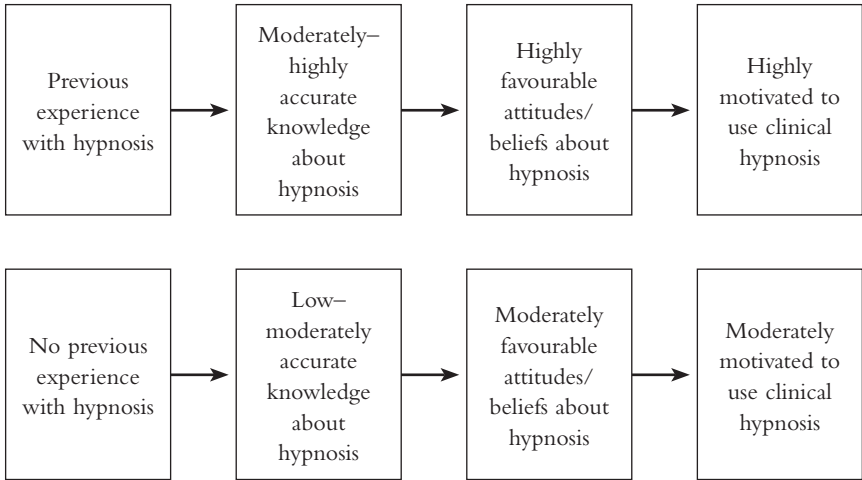


Figure 2: Model of Experience of Hypnosis and Dependent Variables

and beliefs about hypnosis, and motivation to consider using clinical hypnosis. Hawkins and Bartsch (2000) also suggested that adequate education positively affects hypnotic responsiveness. This may explain why the hypnosis-experienced group members were more motivated to consider using clinical hypnosis. This result supports past research by McConkey and Jupp (1986), which indicated that the experience of hypnosis appears to positively affect opinions about hypnosis and its effects, and that those who hold extreme misconceptions about hypnosis would probably not expose themselves to such an experience.

The results of the present study were slightly different from the results of Hawkins and Bartsch’s (2000) study. Although these researchers found a significant difference between the experience groups on knowledge and fearlessness about hypnosis, no significant differences were found between the two groups on positive beliefs about hypnosis or beliefs about the mental stability of hypnotisable people. The difference may be attributed to the larger sample size that was employed in the present study. It may also be attributed to the selection criteria that were utilised in the present study and the selection of psychology practices for the recruitment of hypnosis-experienced participants.

The second hypothesis tested whether there were significant differences between younger and older non-experienced participants in relation to attitudes, beliefs, knowledge, and motivation regarding hypnosis. The results did not support this hypothesis.

The third hypothesis tested whether there were significant differences between younger and older hypnosis-experienced participants in relation to attitudes, beliefs, knowledge, and motivation regarding hypnosis. This hypothesis was supported by the results. In relation to H3, no significant differences were expected because both age groups would have obtained at least part of their attitudes, beliefs, and knowledge about hypnosis from the same source — their previous experience with hypnosis.

The results indicated that younger and older non-experienced participants had low accurate knowledge about hypnosis, moderately favourable attitudes and beliefs about hypnosis, and were moderately motivated to use clinical hypnosis. The results also indicated that younger and older hypnosis-experienced participants had moderately accurate knowledge about hypnosis, moderately high to favourable attitudes and beliefs about hypnosis, and were moderately to highly motivated to use clinical hypnosis. As opposed to Johnson and Hauck's (1999) findings, the current findings suggest that age is not an influential factor that determines accuracy of knowledge about hypnosis, favourability of attitudes and beliefs about hypnosis, or motivation to consider using clinical hypnosis.

The fourth hypothesis tested whether the sources of information about hypnosis would significantly affect attitudes, beliefs, knowledge, and motivation in relation to clinical hypnosis. The results partly supported this hypothesis. Those who obtained their information about hypnosis from personal experiences had significantly more accurate knowledge about hypnosis than those who obtained their information from stage hypnosis/television presentations. They also had significantly more positive beliefs and less fear about hypnosis than those who obtained their information from stage hypnosis/television presentations. However, a significant difference was not found between the participants' two main sources of information about hypnosis in relation to beliefs about the mental stability of hypnotisable people. Despite this, those who obtained their information about hypnosis from personal experience were significantly more likely to consider using clinical hypnosis than those who obtained their information from stage hypnosis/television presentations. These results have been summarised in Figure 3.

These results can best be explained by the research conducted by Echterling

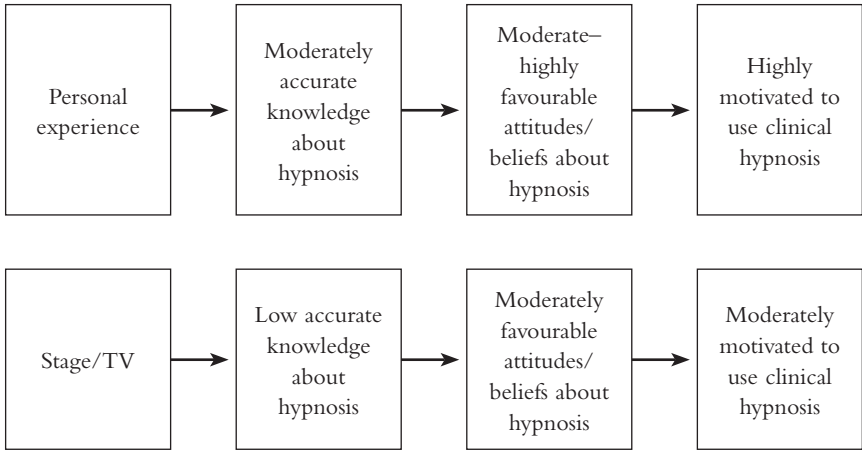


Figure 3: Model of Source of Information and Dependent Variables

and Whalen (1995) and Watkins (1999), which suggested that the contrasting effects of clinical and stage hypnosis stem from the fundamentally different purposes and methods. Watkins (1999) stated that the purpose of stage hypnosis is to entertain, whereas the purpose of clinical hypnosis is to alleviate painful symptoms and behavioural maladjustments. Because of these differences, subjects would have been given different information about hypnosis, which would have influenced the accuracy of their knowledge about hypnosis, the favourability of their attitudes and beliefs about hypnosis, and finally, their motivation to consider clinical hypnosis.

The findings of Echterling and Whalen’s (1995) study suggested that those exposed to a stage hypnosis show and those exposed to an educational lecture on hypnosis may come to treatment with very different beliefs. In relation to the findings of the present study, those who obtained their information about hypnosis from stage hypnosis/television presentations may also expect to be controlled by the hypnotist. Additionally, those who obtained their information about hypnosis from personal experience may also expect to gain greater personal power. They may even gain more personal power than those who obtained their information from an educational lecture because they are exposed to education about hypnosis from the clinician as well as from their subjective experience with clinical hypnosis.

Overview

The aim of this study was to investigate attitudes, beliefs, knowledge, and motivation in relation to clinical hypnosis. Several implications were drawn from the results of this study. First, the experience of hypnosis appears to positively affect perceptions about hypnosis, and motivation to consider using hypnosis to treat an array of psychological and medical conditions.

Second, no previous experience with hypnosis appears to have a less favourable effect on perceptions about hypnosis, and motivation to consider using hypnosis to treat an array of psychological and medical conditions. Therefore, these results implied that those who had no previous experience with hypnosis had mostly inaccurate knowledge about hypnosis, that they were uncertain about hypnosis, and about being hypnotised, and as a result were not really sure if they would consider using hypnosis for clinical purposes.

These two important findings highlight the importance of receiving accurate information about clinical hypnosis prior to the use of hypnosis, since effectiveness and future motivation to use treatment modality are likely to be affected. The results indicated that personal experience with clinical hypnosis, in combination with receiving adequate information about hypnosis, appears to be the best way to improve knowledge, attitudes, and beliefs about hypnosis, and therefore the best way to promote the use of clinical hypnosis as an efficacious treatment.

Third, the results of the hypnosis-experienced group appeared to match the results of those who obtained their information about hypnosis from personal experience across all variables. These similarities implied that obtaining information about hypnosis from an educational source rather than an entertainment source leads to (a) more accurate knowledge about clinical hypnosis, (b) more favourable attitudes and beliefs about hypnosis, and (c) more motivation to consider clinical hypnosis if recommended.

The findings also implied that age was not an influential factor in determining accuracy of knowledge about hypnosis, favourability of attitudes and beliefs about hypnosis, or motivation to consider using clinical hypnosis. An explanation for such results could only be speculated. This may have been due to the fact that people of all ages now have the same amount of access to information about hypnosis (the Internet). Another possibility could be that differences between younger and older people's knowledge, attitudes, and beliefs about hypnosis was balanced out due to the increased life experiences of older people, and the increased access to information about hypnosis that is more familiar to younger people.

In conclusion, it was evident that the words of Spanos et al. (1987) still apply today: “Clinicians who employ procedures that are labeled as hypnotic would do well to assess patients’ attitudes toward hypnosis and to modify common fears and misconceptions before initiating treatment” (Spanos et al., 1987, p. 149).

Further, psycho-education about the phenomena of hypnosis and its efficacious treatment for a range of problems may serve to positively influence clients’ (and the public’s) knowledge, attitudes, beliefs about hypnosis, and their intentions to utilise hypnosis in future treatments.

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HYPNOSIS IN THE TREATMENT OF MIGRAINE

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Hypnosis has been used extensively in the management of a range of psychobiological disorders. This case describes the use of hypnosis in the management of migraine and headaches. The patient had undergone a liver transplant following liver failure and presented for treatment for migraines that had commenced prior to the transplant. Hypnosis was used an adjunct to treatment for a complex of physical and psychological symptoms.

Lauren is a 9.5 year old girl who was referred to a general paediatrician (myself) by her liver specialist for management of migraines and headaches. She was seen in the general medical outpatients department of a paediatric hospital in April 2003.

History of Presenting Problem

Lauren has a complex past medical history. She was a previously well girl, living in South Australia with her family. She developed acute fulminant hepatic failure (liver failure) in late October 2002 and was transferred to Melbourne for management of this condition. She underwent liver transplantation approximately two weeks after she developed symptoms of liver failure. The cause of the liver failure was unable to be determined (an unidentified viral cause is likely).

Liver transplantation in children involves the recipient receiving the liver of a recently deceased patient (usually a child). The operation is lengthy (about 12 hours) and involves a stay in the intensive care unit (about one week) and then in hospital for about two months. Children are usually discharged within three months. However, one in five children will die during the procedure or

have serious complications. Lauren had a relatively smooth postoperative course except for the development of aplastic anaemia. Aplastic anaemia is a known (although rare) complication that occurs after liver transplantation, particularly in people who are transplanted for acute fulminant hepatic failure of unknown cause. Aplastic anaemia presents as reduced numbers of red cells (cells that carry oxygen around the body) and sometimes platelets (cells involved in blood clotting). Lauren had received medical treatment for aplastic anaemia without success. Her family were told that bone marrow transplantation would be offered if the aplastic anaemia did not resolve by December 2003. Due to the need to wait and see if the blood counts improved and the need for intermittent blood and platelet transfusions, Lauren was to stay in hospital in Melbourne (with her mother) for six months after the liver transplant while her father and brother stayed in South Australia.

Lauren's headaches/migraines date back to approximately two years prior to transplantation. In the past the headaches occurred approximately every two months. On occasion they were treated with paracetamol and lying down to sleep it off. More recently (i.e., in the last three months) the headaches were nearly always severe and more typically like migraines. They occurred at least once a week, although during some weeks they occurred up to five times. Lauren would first notice that she was tired, and sometimes flashing lights would occur. Lauren then experienced onset of pain, predominantly in the right frontal region (right forehead), which felt like "being hit on the head with a baseball bat." This was associated with photophobia (aversion to light), phonophobia (aversion to sound), nausea, and vomiting. Vomiting would occur on about 90% of occasions. Sleep and rest largely relieved these migraines. Taking a dose of paracetamol early would also help the pain. Changing of the hickman catheter (central venous line) dressing site on Mondays noticeably triggered the migraines. Lauren found that experience quite stressful and admitted that this probably led to her migraines.

Lauren was receiving cyclosporin (immunosuppressant medication) and magnesium supplements (routine medications following transplantation). There was a change in medication in February 2003 from tacrolimus to cyclosporin (both immunosuppressant medications) and this may have led to an increase in migraines. Occasionally cyclosporin may be associated with headaches and migraines; however, tacrolimus could not be used due to potential exacerbation of bone marrow suppression. A CT scan of her head was arranged. This showed no significant abnormality.

Family History

Lauren's mother and uncle (maternal brother) suffer from migraines.

Social History

Lauren has lived in South Australia all her life. Her family consists of her mother Kate, full-time mother (age 32 years), her father Andrew (age 34 years), primary school teacher, and her brother Mark (age 7 years). Kate is a lady who likes to take a "positive approach to life": She is very interested in alternative therapies and had tried naturopathy and healing crystals in the past. Her own mother has used these therapies. I did not meet Andrew, as he was in South Australia, but he was described as a "loving dad and a good husband." I met Lauren's brother, he was very worried about Lauren and wanted her to come home soon.

Life in South Australia was reported as very happy leading up to the transplant. Lauren was attending Grade 4 at school. She had a normal developmental history and was doing well at school. Lauren was said to be well adjusted with no significant behavioural or psychological problems. She got on well with her brother. She was described as a bit of a tomboy, liking to climb trees and play outdoors with the family dog. She was also quite a "dreamy" child, who liked to make up stories about going to faraway places.

Lauren's mother states that the transplant "saved Lauren's life just in time," but on the other hand was quite "difficult." Prior to the transplant Lauren was physically well, despite having occasional headaches. She had never been admitted to hospital before. More recently she had been living in hospital accommodation, waiting to hear whether her blood counts were improving. If that happened she could avoid a bone marrow transplant later in the year. Lauren was having weekly outpatient appointments, weekly blood tests with her bone marrow specialist, and monthly appointments with her liver specialist.

All the events that Lauren had gone through made her feel as if she had no say in getting better. The thing she hated most of all was that she might have to go through another transplant. She really wanted to go home to South Australia as soon as possible. In particular, she missed playing with her dog and with her brother Mark. Her one big wish was for her bone marrow to get better soon so she could go home and be with her whole family. In the last six months her life had been turned upside down and she described feeling "angry" and "upset" about this. She wanted to have more control about little

things like her dressing changes on Mondays. Lauren was aware she could not influence the big decisions, such as when she could go back and visit her home in South Australia: “That is up to my doctors.” On top of this she was getting “lots of headaches,” which made her feel terrible.

Mental state Examination

Appearance and behaviour: Lauren was a very pleasant, cooperative girl wearing fashionable clothes. She answered questions appropriately and spontaneously asked questions and engaged in discussion

Mood, affect: Lauren did not have a depressed affect. Her mood was congruent to the situation and was reactive.

Speech: Lauren had a normal quality of speech, and spoke in a lively and interested way.

Perception: Lauren did not appear to have any perceptual abnormalities.

Thought: Thought was age appropriate and normal in form and content. Thoughts were mainly about her illness and wishing that she could get better soon.

Cognition: Normal to advanced for her age.

Insight: Lauren had very good insight and understanding about her medical problems. She knew that she could not control some things (e.g., that she needed a liver transplant). However, she was keen to be able to control what she could (e.g., dressing changes).

Physical Examination

Lauren was strikingly pale, consistent with having anaemia. She had increased bruising of her arms and legs consistent with a low platelet count. She had a normal neurological examination and visual acuity. Her optic discs were normal. She had a liver transplant scar on her abdomen. The rest of her examination was normal, including her blood pressure. She was somewhat thin but well grown.

Assessment

Lauren is a 9.5 year old girl who has had a liver transplant for fulminant hepatic failure of unknown aetiology. This was complicated by aplastic anaemia. She presented for management of recent frequent migraines on a background of less frequent migraines for the last few years. The migraines

were identified by the patient to be triggered by being upset during dressing changes (on Mondays) with the main issue being loss of control. Lauren was able to say that she felt upset and angry that her family was separated, that she was living in Melbourne at a hospital, that all these things had happened to her, and that she could not do much to get herself better. She has no contraindications to having hypnotherapy.

Goals of Therapy and Treatment Plan

1. Allow Lauren to further express her thoughts and feelings about becoming unwell with liver failure and the subsequent medical management, uncertainty about the future, the separation of her family, and missing being home.
2. Help Lauren with her desire to have an increased amount of control over her medical management (where feasible). For example: dressing changes and migraine therapy
3. An explanation about hypnosis was given to Lauren and her mother. Lauren was offered a choice of hypnotherapy or a tablet (pizotifen) to take for her migraines. Lauren wanted to try hypnosis rather than to take more tablets.

Hypnotherapy has several advantages over medical management (pizotifen) for migraine. The potential advantages of hypnotherapy are that:

- Lauren may experience a sense of taking control and of mastery over her own body/self.
- Lauren will have an intervention which she can use at the onset of migraines to reduce or cease pain.
- Ego-strengthening could assist with despair and hopelessness.
- There is a good chance that hypnotherapy will reduce the frequency of migraine headaches. A randomised controlled trial in children compared hypnotherapy to propranolol and placebo (Olness, MacDonald, & Uden, 1987). Hypnotherapy had greater success in reducing the frequency of headaches compared with other therapies.

The treatment plan using hypnosis would have to be flexible and allow for requests by Lauren during the course of therapy, given her need to regain control over her body.

Session 1

Hypnotisability score based on Stanford Scale of Hypnotisability in Children (Morgan & Hilgard, 1975).

1. Hand lowering: Arm lowered by about 25 centimetres by end of 10 seconds: *Score 1*.
2. Arm rigidity: Arm remained rigid, no significant movement: *Score 1*.
3. Visual hallucination: *Score 1* for vivid detail about TV program.
4. Auditory hallucination: *Score 1* for words reported about TV program.
5. Dream: *Score 1* for dream about her dog playing in the garden, she is being chased by dog and laughing.
6. Age regression: *Score 1*. Has gone to shopping centre with her mum when she was 6 to buy a doll. Cannot recall what she was wearing. Was excited about getting a new doll.
7. Post-hypnotic suggestion: *Score 0*. Did not cough (as suggested) after tapping pencil on desk.

Total score = 6

We discussed ways Lauren could take control over dressings. She decided she would learn to do them herself rather than have a nurse do them.

Session 2 (one week later)

Induction: Focus on a “spot” on back of hand.

Hypnotherapy: Favourite place script with suggestions about being “boss of your body” and “I can do it.”

Alerting and Discussion: Enjoyed the session, agreed to practise at home for 5 minutes per day, at first sign of migraine onset could practise.

Session 3 (one week later)

Had two migraines in the last week, no reduction after the first session.

Induction: Focus on a “spot” on back of hand.

Hypnotherapy: Favourite place script, suggestions about being able to go to favourite place and “allow yourself to feel as relaxed and comfortable as you do now” ... “at the very first signs of a migraine, such as when you are feeling tired or get flashing lights in front of your eyes, you can go to your favourite place,” etc. On being asked about what her favourite place was, Lauren described it as being “at the top of a tree in a tree house by herself ... watching children playing on the beach and walking a dog ... a long way away.”

After this, a “magic carpet ride” script was used. Suggestions were made that she could “control the blanket” and could use her unconscious mind to “take control over her headaches and migraines” when they started by going on a “blanket ride” or by going to her “favourite place.”

I asked Lauren what the blanket ride was like while she was under trance. She told me that a “silver fish” was pulling her along.

Alerting and Discussion: I commented at the end of the session that the fish may represent not being alone, or her unconscious mind helping her. She said she was glad that she was “not alone” and that she had “help inside” her.

Session 4 (one week later)

No migraines all week. Feeling very pleased about that. Has been practising hypnosis at home.

Induction: Focus on a “spot” on back of hand.

Hypnotherapy: Favourite place script: this time is at the top of a tree with her mother and brother. Lauren can see silver butterflies everywhere and they are magic. Again a suggestion about going to her favourite place at the first sign of a migraine.

Deepening technique, then “magic blanket ride” with suggestions about being in control of the blanket and taking control when she gets migraine by going to her favourite place or taking a blanket ride. A tape was made of this session.

Alerting and Discussion: Lauren reported enjoying this session immensely and looked forward to listening to the tape at home.

Session 5 (two weeks later)

No further migraines. Lauren felt much more in control and positive, confident that she can overcome them. Her mother says Lauren seems “very happy” and is looking better. She does seem less pale and is more talkative and smiling more.

Induction and Hypnotherapy: Similar to previous session. Favourite place, magic blanket ride, continue ego-strengthening (control over own body).

Session 6 (four weeks later)

No migraine now for last 7 weeks. We talk about how Lauren has found hypnosis. She says she is very happy that she can do something to help herself and that she doesn't have migraines. Her haematologist told her that she is

stable enough to go back to South Australia soon. If her bone marrow improves she can go without a transplant. She will be able to stay in South Australia for about three months and then come back for a check-up to see if she needs a transplant.

Lauren requests that she would like to have a session today to help her bone marrow. She would like to see if it is possible to help it improve. I tell her that we can try hypnosis, that “we do not know what the limits of this are.” I mention that there are case reports of cancer patients having improvement in white cell counts with chemotherapy using hypnotherapy (Brett, 2001). We talk about what she imagines her bone marrow is like. She says she sees it like “a factory making cells.”

Induction: Stare at “spot” on back of hand.

Hypnotherapy: Favourite place, then deepening technique, ask Lauren to visualise her bone marrow and what it is like. She describes it being like a “sieve” with different coloured cells coming out “like crumbs.” The cells are coming out “slowly.” There are red crumbs, which are the red cells, white crumbs, which are white cells, and orange crumbs, which are the platelets. Platelets are coming out slower than the rest. A suggestion is then made to look for the switch in her body which controls the production of these cells, a switch which will bring them into production in exactly the right amounts needed for the body to be healthy. Lauren finds this switch; it is like a dial that can be turned from low to high. The dial is set on low, so Lauren turns the dial to high and watches what happens to all the cells. She notices they come out brighter, faster, and rounder. A tape is made.

Alerting and Discussion: Lauren will listen to tape at home.

Session 7 (two weeks later)

No headache in last 9 weeks. Has had blood test two days ago and blood count is the same. We discuss this and I say that “it will be interesting to find out what will happen over time.” I then told her, “We do not know if it will work but we can try.” Lauren is keen to have one more session of hypnosis dealing with the bone marrow.

Induction and Hypnotherapy: Similar to previous session, with further suggestions regarding control dial being turned up to give the exact right numbers of cells needed by the body.

Alerting and Discussion: Suggest using tape at home. Lauren to call me if she has any difficulties. Review again in three months when she returns to Melbourne for a check-up.

Outcome

Lauren had an excellent and sustained response to hypnotherapy in markedly reducing the frequency of migraines. Although we have not yet seen improvement in the red cell or platelet production in the two weeks after the session, Lauren has not given up on trying and felt glad that she can continue to practise at home. She really wants to know that she is doing everything she can to help herself. She stated that this made her feel happy. Overall, the ego-strengthening suggestions have worked to good effect. Lauren feels she is taking control over her body.

Discussion

Lauren is a previously well-adjusted child who has had to cope with a series of adverse and life-changing events in the last year. Any person in her situation would have felt a significant loss of control. Not only did she suddenly become unwell and need an urgent liver transplant, she subsequently developed aplastic anaemia and the prospect of a bone marrow transplant. Lauren has good insight into her situation and has a need to take control of some aspects of her therapy. I do not think she is unrealistic. In addition, I do not think she will be let down or be disappointed in using hypnotherapy for her bone marrow if it turns out that her platelet count and red cell count do not come up. I believe she will feel she has done everything she can do to help herself.

Lauren achieved the treatment goals of hypnotherapy for migraine. I am very pleased we tried hypnosis. Her success using hypnosis has had greater benefits for her than just the cessation of her migraines. She has gained a sense of mastery and also a sense of hope, which I believe she may have lost after her liver transplant.

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HYPNOSIS WITH ECZEMA

Susan Raine
Psychologist

This case describes the use of hypnosis in the treatment of a case of eczema, associated with a range of psychological and relationship concerns that both impacted on the onset of the physiological problem and exacerbated its effects. Hypnosis was utilised for a range of short- and long-term counselling issues and as an integral component of a multi-faceted treatment program.

PRESENTING PROBLEMS

Mavis was referred for treatment for a skin rash she had had for over 23 years. After consultations with four specialists during this time, the referring doctor was the first dermatologist that Mavis felt “really listened” to her. He suspected that her eczema was related to a long history of anxiety and stress, so Mavis was referred for hypnosis to ease the migratory disorder (from feet to upper body) that itched with such intensity that Mavis scratched herself until she bled. The eczema was blotchy and itchy at first consultation.

Mavis, a 73-year-old married grandmother, presented with a psychophysiological medical condition requiring a psychosocial diagnosis and intervention as part of the biopsychosocial model affecting a person’s health (Sarafino, 2002). Mavis stated she had always been a “worrier.” Her current medication was Valium 5 mg nocte.

BACKGROUND INFORMATION

Mavis had always been a good mother and wife. Her long marriage and closeness to her husband Sam had been traumatised by his recurrent battles

with cancer and heart disease. Sam had also been a previous client, so family background information was well confirmed.

With her own health also failing, the reality of losing each other was as much as she could bear, so Mavis's worried state was continuous and well founded. She had not disclosed or shared any of these fears before. Mavis had also never witnessed death, as her parents had died when she was young, so the thought of coping with a dead person terrified her.

Sam and Mavis's daughter Glenda was now in a stable marriage after a divorce and children, and Mavis and Sam now had close and active interaction with their new son-in-law and four grandchildren. This was very important to Sam and Mavis and much of their time revolved around visiting their family.

With a comfortable home and a passion for gardening, Mavis was always busy with home duties. Her life had been comfortable, with Sam earning good professional money in his day and now doing handyman work to supplement their income.

Not being well educated, Mavis was shy and reserved, a practical "salt of the earth" person. Although seemingly content and self-contained, her quietness masked a minefield of insecurity and unresolved hurt from judgments, disappointments, and abandonment by her and Sam's siblings during their weakest moments of disease, surgery, and ill health. The toll of caring for husband with no support had added to Mavis's stress and wear. Her coping was being ground into burnout (Montgomery, 1994).

Being a doer, Mavis had not considered time out for herself or any form of personal relaxation. Being a solitary person, she preferred to be doing chores, which appeared endless, either for the home or her family. Under this constant activity was a repressed sphere of worry and anger that manifested as "the rash." Mavis's main health issue had been this recurring eczema, which had plagued her for years despite many medications and treatments. The devastating, long-term effects of her symptoms were acknowledged to build rapport and understanding of her condition (Egan, 1998). Mavis was able to recognise later that the rash flared when she withheld from speaking her mind and intensified with further stress.

ASSESSMENT PROCEDURES AND OUTCOMES

In this case, a comprehensive behavioural analysis made clear the circumstances that affected the occurrence of the anxiety symptoms and the cognitions that co-occurred (Andrews, Crino, Hunt, Lampe, & Page, 2001). The specific

nature of Mavis's anxiety was further explored using clinical observation and intentional interviewing (Ivey & Ivey, 2003). Her medication (Valium) confirmed anxiety and suggested a possible sleeping problem, which was monitored. Mavis's overall distress was genuinely acknowledged, assuming a collaborative and non-oppositional stance using medical language and affirming questions. (McDaniel, Hepworth, & Doherty, 1992).

The Burns Anxiety Inventory (Burns, 1989) revealed a high score predominated by thoughts of looking foolish and inadequate in front of others. Using a psychoeducational approach, the anxiety model was then differentiated between anxiety, fear, and stress. Coping skills were then assessed using "Question Your Thoughts" reframing and cognitive restructuring (Montgomery and Morris, 2001).

A structured diary enabled recording specific situations as targets for change, noting self-modification towards self-assertion and self-efficacy. Triggers to the inner conflict Mavis experienced, that then manifested or worsened the eczema, were also explored. Using the ABC model, Mavis was then able to assess her mental programming towards a new direction and consequence. Levels of stress were self-rated and reduced using relaxation techniques.

The underlying insecurities regarding family issues were revealed through hypnosis and treated to assertion skills training and self-esteem building. Cognitive distortions, negative beliefs/fears and maladaptive avoidance behaviour were identified in order to break the coexisting anxiety patterns. Mavis's negative beliefs and expectations were further challenged.

Mavis slowly began to "speak her truth" after years of silence and repressed emotion. Hypnosis was further used to enhance self-efficacy and empowerment to explore and recognise her existing strengths and build on these to self-empowerment (Hunter, 1994).

The fear of death was explored using a psychoeducational approach, by referring to the works of Elisabeth Kubler-Ross. Death and dying were discussed openly and self-disclosure aided collaboration and rapport. Rationalising her situation using a reality check brought this fear of death under control.

By recording the reduction in itch, rash outbreak, and severity, Mavis was able to assess the physiological changes of her body in relation to the changes she made in her anxiety management and self-assertion/esteem. After four weekly sessions, Mavis's rash disappeared and at six-month follow-up had not recurred.

CASE FORMULATION

Mavis's symptoms of one or more psychological or behavioural factors (anxiety, avoidance) adversely affecting the course and severity of a general medical condition (skin rash) suggest a diagnosis of a Psychological Factor Affecting a Medical Condition

According to DSM-IV-TR criteria Mavis's diagnosis is:

Axis I	316	Psychological Symptoms Affecting Eczema
Axis II	V71.09	No diagnosis
Axis III		None
Axis IV	V62.81	Relational Problem NOS Problems with siblings and in-laws
Axis V	GAF = 70 (initial)	

TREATMENT PLAN

Short-Term Objectives

1. Build on existing rapport.
2. Genuinely acknowledge Mavis's distress assuming a collaborative and non-oppositional stance using medical language and affirming questions (McDaniel et al., 1992).
3. Bridge from each session: review case, check self-monitoring.
4. Offer positive reinforcement for progress.
5. Praise efforts to cope with stress, take time to relax.
6. Challenge Mavis's thoughts.
7. Assertion skill training to speak her mind.
8. Explain and share test results from the Burns Anxiety Inventory.
9. Use BAI as a rationale for direction, collaborative intervention, and goal setting.
10. Explore triggers to the inner conflict Mavis experiences that then manifests as, or worsens, the eczema.
11. Identify and break the patterns of cognitive distortions/negative beliefs/fears and maladaptive avoidance behaviour.
12. Challenge her negative beliefs and expectations.
13. Explore and recognise existing strengths.
14. Build on existing strengths using hypnosis and self-hypnosis (to empower Mavis).

Long-Term Objectives

1. To cope with, or preferably be rid of, the rash.
2. To be able to assertively speak her mind without fear.
3. To be able to de-stress and relax.
4. To spend time for and on herself.
5. To let go of the past.

SESSION 1

Mavis was given the opportunity to ventilate her problems, actively and empathically listened to, with unconditional respect. The devastating, long-term effects of her symptoms were acknowledged to build rapport (Egan, 1998). A psychoeducational approach was taken to aid Mavis's understanding of the stress model. Her anxious thoughts and feelings and her positioning in the fight/flight response were patterned and explained as avoidance behaviour (Montgomery 1994).

SESSION 2

Focus on Constructive Change: “What Do You Want to Work On?”

1. Symptoms especially, bad circulation, “last to clear up” was discussed as well as impact on daily life.
2. Worry and irritability affecting her marital relationship.
3. Inability to be assertive and express her emotions.
4. Fear of criticism/disapproval (unable to speak her “truth”).
5. Significant events to construct a wider map (a holistic perspective) of the problem.
6. Unwelcome experiences and events (reframe).
7. Family genogram, information and transgenerational “illness meanings,” and negative beliefs (Bor, Miller, Latz, & Salt, 1998).

SESSION 3

Mavis's goal was to cope with, or preferably be rid of, the rash. The psychological components of her physical condition could not be explained using a biomedical model. Therefore, assessment and treatment using a biopsychosocial intervention model was necessary (Brannon & Feist, 2000).

Mavis's rash was hypothesised to be anxiety/stress related. Interventions

targeting the emotional and psychological components interacting to produce the medical condition were therefore explored using the treatment planner (Jongsma & Peterson, 1999).

SESSION 4

Psychosocial stressors (a stressful situation, fear, inner conflict, lack of assertion, negative beliefs, and self-talk) were identified as predicting a recurring skin condition. These factors were also targeted as homework for intervention (Kaplan, 1985).

By monitoring her thought/behaviour patterns, it was discovered that when Mavis avoided emotional conflict the rash was exacerbated (ABC model).

Ego-enhancing hypnosis was introduced for positive change; to eliminate tension, anxiety, and fear; to restore self-confidence and to empower problem solving (Stanton, 1998).

SESSION 5

- Review of self-monitoring.
- Cognitive countering.
- Worry behaviour prevention.
- Cue-controlled relaxation.
- Time management.
- Problem solving.
- Review of skills and techniques.
- Discussion of continuing techniques covered in treatment.
- Closure.

Evaluation

An integrative counselling model, using a cognitive-behavioural approach and a self-help framework, was viewed as being most effective for this case (Marks, 1989). Problems were both looked for inside the client, with psychotherapy directed at Mavis as the intervention target, and systemically looked for beyond the apparent problem (particularly the wider and extended family). As a result of this structure, Mavis was effectively able to identify personal problems with her own fears, self-concept/esteem, self-assertion, and with family relational interactions based on avoidance.

Mavis was able to acknowledge and accept that she was in a valid place but recognised that she wanted to change. She was helped to see that she could make the changes through therapy using possibility-laced acknowledgement (O'Hanlon & Beadle, 1997). Hypnosis was used as an adjunct to treatment to taste how that change felt through age regression and projection, pain management/control, stress management, dissociation, and ego-enhancement (Fromm & Nash, 1992).

Using the coping skills model of CBT, Mavis was taught to manage her anxiety and to take responsibility for change and control over her thoughts, feelings, and behaviours. As a result, she "didn't stress over not receiving an expected letter from her daughter." On a deeper level, through cognitive therapy, based on the procedures outlined in Beck, Emery, and Greenberg (1985), beliefs, attitudes and expectations maintaining anxiety were also effectively addressed. Mavis was able to cut herself free from irrational beliefs, myths, and dysfunctional expectations that she had held on to for all of her life. Now, she "got things off her chest."

Targeting the symptoms of Mavis's anxiety, relaxation training, including self-hypnosis, meditation, music therapy, neck and shoulder rolls, massage, and progressive muscle relaxation were also taught and practised (Bernstein & Borkovec, 1973). "Take 5" time-out technique was working well on a daily basis with her husband Sam. Graded in vivo exposure in dealing with relational issues was explored to reduce Mavis's avoidance behaviour. Structured problem solving training was further added to encourage her to use this skill for everyday practical problem solving (particularly with Sam), as a framework for anxiety management skills, as an aid to planning exposure tasks, and for help in making decisions (Andrews et al., 2001). More specific steps were further structured into the homework to maintain the momentum moving towards the new direction of her choice.

Self-Evaluation

A strong therapeutic alliance was evident by the easy interactive communication process that evolved. Mavis reports that she feels "completely changed" and "had spoken her mind" due to therapy. She felt confident to self-disclose, for the first time in her life, that she had experienced childhood sexual molestation, which was appropriately dealt with, and released. Mavis also felt confident to explore her family of origin and challenge negative beliefs regarding hair colour and belonging, based on generations of alienation and superstition (Philips & Buncher, 2000).

CONCLUSION

Mavis's goals were to get rid of her eczema and gradually wean herself off medication. Therefore she needed to learn to face her fears, speak her mind, feel free of inner turmoil, cope with external stressors, and relax. Homework and treatment was directed towards breaking a long history of patterned cognition/behaviour using psychosocial interventions and CB change based on a clinically tested step-by-step plan for the drug-free management of living with anxiety by:

- Changing negative thinking habits,
- Learning to relax,
- Stopping worrying about feeling anxious,
- Managing anxious thoughts and feelings,
- Managing physical anxiety,
- Stopping worrying behaviours,
- Tackling avoidance habits, and
- Strengthening interpersonal skills.

Using a combination of treatments tailored to the client's needs proved a powerful intervention (Keane, 1995). Anxiety management training, relaxation training, meditation, hypnosis, cognitive restructuring, exposure therapy, and communication skills training were effective as a package. From a critical practitioner perspective, Mavis brought under control in five psychotherapeutic consultations a condition which had distressed her without relief for 23 years. As her biased therapist I evaluate our working alliance as extremely successful, and so much on-track that 23 years of distress seem such a waste. Mavis is now an avid supporter of hypnosis and has volunteered as a research subject to learn more about this intervention.

Postscript

Mavis first came to see me in June 2002. At 16 month follow-up she reported being "on top of the world," with no sign or recurrence of her former symptoms.

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HYPNOSIS AND CBT WITH DEPRESSION AND ANXIETY

Ester German
Psychologist

This case illustrates the use of hypnosis as an adjunct to cognitive behaviour therapy in the treatment of a mixed depressive and anxiety reaction of Mark, a 20-year-old university student. A predominant feature in his presentation was his perfectionistic standards of academic performance. He presented to the counselling service of a large university after failing an exam. Hypnosis contributed to achieving remarkable therapeutic progress in a relatively short time. On initial presentation his dysphoric feelings were extremely high. Recent test results indicated that levels of anxiety, depression, and stress returned to normal levels. Therapy is in progress. Mark's case highlights the value of hypnosis as "a tool of empowerment, specially important to diminish depression" (Yapko, 2001, p. 23).

REFERRAL

Mark is a 20-year-old first-year Engineering student who presented to a large university counselling service after receiving a referral letter notifying him of poor academic progress during the last semester. He was accompanied by his parents who said they could not understand what was going on and couldn't believe that their son failed a maths test. On that occasion, Mark hardly spoke and appeared uncomfortable and highly distressed. After referring Mark to an educational workshop to help students return to good academic standing, I invited him to return to the counselling service and to further explore his situation to see how the counselling service could be of assistance to him.

The author would like to thank Wendy Louise-Walker for her invaluable support and guidance, working as a teacher, supervisor, and mentor; Annie Andrews for encouraging me in my career development and allowing me the time to engage in this project; and Mark who allowed me to present this case study as a way "to help other students in need."

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On that second opportunity, Mark told me that he had been “feeling sad” since the last year of his high school. He said “things have gotten worse recently, last month or so, but I haven’t felt fine since year 12, more or less.”

PRESENTING PROBLEMS

Mark reported changes in his appetite, insomnia, low energy, poor concentration, and poor motivation. These feelings were accentuated over the last month while preparing for his first semester exams. He said he felt tense, anxious and inadequate, and was disappointed at his academic performance. He tried really hard, but “the more I studied, the less I achieved, I get tense, can’t sleep, can’t relax.” He expressed doubts about his career choice and said he would like to do Science instead of Engineering.

Unfortunately, before Mark could transfer from one course to the other, it was necessary for him to regain his good academic standing. Therefore he had to continue in the Engineering course until his marks were good enough for him to change his course enrolment.

When we talked about obstacles blocking his way to good academic performance, Mark explained that “I always study a lot, it has been difficult to concentrate lately, my parents scream at me, they don’t understand, it is not a matter of stopping other activities and sitting in front of my books ... they want me to study more and to stop working but that’s not the solution.” Mark described a strained relationship with his parents and recalled an old incident involving them. This was presented as an illustration of their ways of arguing. After a “big argument,” and feeling exhausted and frustrated at his “inability to talk to them,” Mark tried to self-strangulate by wrapping the cord from an iron electric around his neck. They “stopped screaming at me, I hate when they do that [screaming].”

Mark denied any current or past suicidal/self-harm plan or intention, but admitted feeling hopeless and helpless at times, as well as harbouring suicidal thoughts. He said that he often has them when he feels sad, but that he has no intention or plan to act on those feelings. “They are there, but don’t tend to upset me a lot.” “Sometimes, I feel this pain in my chest, as if my heart is so heavy that it is sinking.”

Mark requested assistance to relax and to manage his current feelings of depression and anxiety.

BACKGROUND INFORMATION

Family History and Family Life

Mark is the oldest of three children. He has two sisters, aged 16 years and 10 months. Australian born but with a Chinese background, Mark described his parents as strict, very industrious, and chronically depressed. Both parents work full-time in a telecommunication business. “My parents never smile, they are unhappy people.” Mark admitted feeling responsible for his parents’ unhappiness. He further stated he “could never meet their expectations.” According to his cultural heritage, being the oldest, he had to set a good example for his siblings. Mark felt that his parents expected much more from him than they ever did from his sisters. “They want me to excel academically, that’s all they want. It is a Chinese thing.” His fear of imperfection and the dread of not meeting self and parental expectations caused overwhelming feelings of failure. Parental approval appeared to have been conditional on Mark’s meeting high standards, and criticism and shame were related to failure to live up to those standards.

His parents appeared to have provided models of high, unbalanced standards themselves. “They always worked so hard, they are workaholics, they never smile, or have fun.” Unrelenting standards may be based on the underlying belief that one must strive to meet those standards of performance to win approval, or to avoid harsh criticism or shame (Young, 1994).

Mark described his family as a “typically Chinese” one in which conscientiousness, hard work, academic achievement, and low emotional expression were highly valued. He denied suffering from any history of sexual, physical, or emotional abuse. There was no other significant childhood trauma or history of loss reported.

Psycho-social

Mark has a group of friends from primary and high school. He mentioned experiencing some social anxieties with in-group situations or meeting new people. He indicated that he would like to become more confident socially: “Sometimes I don’t know what to say and I kept quiet.”

Mark’s interests and leisure activities include listening to and playing jazz, music in general, languages, volunteer work at the local fire brigade, reading cartoons, and socializing with his school friends. Despite parental opposition, he enjoys helping others who may be in need after natural or man-made disasters: “They [my parents] see it as a waste of time; they don’t understand,

they had asked me to quit my job so I have more time to study.” Mark’s involvement with friends from university was limited, due to his many activities, living far from university, and time restrictions. He denied any history or current problematic use of drugs or alcohol.

Academic

Mark excelled academically from an early age. He described himself as a quiet and conscientious student who was encouraged by his parents and teachers to strive towards excellence. Mark is also a gifted musician who plays the piano and the clarinet, and his talents extend to the area of languages, having mastered English, Cantonese, Mandarin, and Japanese. “I taught myself Japanese by reading Japanese cartoons.” Even though formal intelligence testing was not conducted, there was enough evidence to indicate that Mark’s cognitive functioning was within the superior/very superior range.

Significant Life Stressors

The precipitants of Mark’s crisis were failing an exam and receiving a notification of poor academic progress. However, he indicated he had been experiencing internal turmoil since he was in high school. In addition, Mark was confronted with normal developmental tasks and challenges, such as the transition from high school to university, and the process of separation/individuation from his family.

After his initial contact with our service (when he was accompanied by his parents), Mark had an individual session with me. A day later, Mark’s mother phoned me. She was concerned about her son – “he never talks to us” – and asked me if I thought she and her husband needed to worry about him. She wanted to know what he told me the day before. I explained to her the importance of protecting Mark’s confidentiality and privacy and encouraged her to talk to Mark directly. I reassured her that in the event of Mark being at any immediate risk, and after discussing the issue with him first, his parents might need to be notified. Otherwise, she agreed to discuss all her concerns directly with her son.

Suitability of Hypnosis

In order to determine how well Mark would respond to hypnotic interventions, the Stanford Hypnotic Clinical Scale (SHCS; Morgan & Hilgard, 1975) was used. This test was used to maximise the likelihood of successful hypnotic experiences for him, and for its potential to elicit clinically useful information (Council, 1999). The “moving hands together” item gave evidence of a good response to suggestions; the “age regression” item revealed important information about his childhood (he was able to recall a happy day in Year 3 vividly and with many details, including the names of the teacher and four other children sitting next to him, what he was wearing, etc.); and the post-hypnotic suggestion item indicated that he could continue to respond to suggestions after formal hypnosis was terminated. This scale was chosen because of the excellent psychometric features (reliability and validity) as well as being short, and cost and time effective. (SHCS is shorter and thus less time consuming and conforms to the Stanford scale format offering a good correlation [.72] with SHCS.) A total score of 4 (he passed 4 out of the 5 items) indicated that Mark had excellent hypnotic responsiveness (“a highly hypnotisable subject”; Moore & Powlett, 2000, p. 24).

The Depression, Anxiety and Stress Scales (DASS; Lovibond & Lovibond, 1995a, 1995b) were used to determine Mark’s levels of distress. The DASS42, which offers good reliability and validity, has been developed in Australia and is used extensively with clinical and non-clinical populations. The severity of symptoms ranges from normal, through mild, moderate, and severe, to very severe. Mark self-reported levels of depression and anxiety, and stress scales indicated that he was experiencing extremely severe degrees of distress. For example, he indicated that he could not wind down, that he experienced trembling, that he felt that he was using a lot of nervous energy. He found himself feeling tense, agitated, and close to panic, and that he had lost his interest and enthusiasm for things. He said he could not seem to experience positive feelings or pleasure or look forward to anything in the future. Indeed, Mark appeared to be in a state of crisis and inner turmoil, deeply dissatisfied with himself and with his academic achievement.

Mark presented with a combination of self-directed and socially prescribed perfectionism (Anthony & Swinson, 1998). Research studies indicate that people scoring high in self and socially oriented perfectionism tend to have a vulnerability to depression, particularly when exposed to accomplishment related stressors. Mark presented to the counselling service after failing an

important exam and not progressing satisfactorily in his academic studies. He and his parents were concerned and shocked because this was a novel situation for all of them. Mark was dependent of parental approval and in the event of his failing academically, approval was withdrawn. As a result, Mark felt extremely distressed, disappointed with himself, and perceived he had also let his parents down. He doubted his own capacity to study and excel academically, which led to a decrease of his self-esteem.

According to Frost and colleagues' multidimensional theory of perfectionism (Frost, Marten, Lahart, & Rosenblate, 1990) Mark's difficulties could possibly be related to his high personal standards and his belief that not meeting them indicated being a "failure as a person." In a questionnaire looking at perfectionism and personal expectation, Mark indicated the following: "If I fail at university, I am a failure as a person; I have extremely high goals; it is important to me that I am thoroughly competent in everything I do. I never feel I could meet my parents' expectations." Mark presented with a mixture of high parental standards ("it's a Chinese thing, parents expect excellence from their children, we have to be number one at school, only outstanding performance is good enough in my family") combined with high parental criticism ("as a child I was punished for doing things less than perfectly").

His perfectionism was linked to academic performance. For Mark, any grade below a High Distinction was unacceptable. Mark recalled a recent math test where a minor mistake took 0.05 off the 100% mark: "I felt so upset for making that mistake, it was so silly! How could I do it?" This test was worth only 10% of his overall mark. Mark's comments provided an illustration of his internalised standards and level of self-criticism when standards are not met. Mark's perfectionism interfered with his performance ("I feel tense, I work so hard, I can't sleep, I do more but achieve less"); created other associated problems such as high levels of anxiety, depression, and excessive stress; and impaired his self-esteem.

A number of studies indicate links between perfectionism and eating disorders, clinical depression, psychosomatic illness, coronary illness, and suicide. Perfectionism can be a feature of clinical depression (Hammond, 1990; Peters, 1996). According to Silverman (1995), perfectionism can be seen as a double-edged sword, "the least understood aspect of giftedness," the secret to handling being based on "harnessing its energy" or managing it in a way that does not impact negatively on performance, identity, mood, or relationships (Peters, 1996). Peters suggests managing perfectionism by appreciation of the

gift, understanding its value and purpose, setting priorities, refraining from imposing high standards on others, perseverance, avoiding self-criticism and self-derogation, working on self acceptance, believing in yourself, and by recognising the positive and not so positive aspects of it.

Mark interpreted underachievement as a sign of inability. His stress and other dysphoric feelings increased in intensity as exams approached.

Strengths and Motivation for Therapy

Mark's strengths included his multiple talents (artistic and academic), his bright mind, his sense of humour, and the capacity to learn fast. He appeared to be willing to help himself and develop more skills in the area of managing both his feelings and conflict at home. Highly motivated to change, Mark was willing and curious to learn about hypnosis. As he did not know about its use as a therapeutic technique, I provided a brief overview of hypnosis, its applications, and some of the common misunderstandings and myths surrounding it. He had no reservations about incorporating hypnosis into the treatment plan. A good rapport between the counsellor and the client augured a positive therapeutic alliance. There was no evidence of contraindications to the use of hypnosis, such as severe depressive illness with psychotic features and/or paranoid thought processes.

PERFECTIONISM, DEPRESSION, AND HYPNOSIS

Hypnosis has traditionally being considered a specific contraindication in severe depressive illness with active suicidal ideation (Walker, 2001a, 2001b; Wicks, 2000; Yapko, 2001). However, a strong body of evidence (clinical and empirical) shows that integrating hypnosis with other traditional approaches may contribute positively in achieving good clinical outcomes (Yapko, 2001). Yapko has earlier indicated that hypnosis can be "viewed as a vehicle or tool for delivering information, amplifying client responsiveness and facilitating learning on experiential (multidimensional) levels" (Yapko, 1992).

In my opinion, Mark's presentation was more consistent with an adjustment reaction with mixed depression and anxiety features than a major depressive disorder where hypnosis may not be the treatment of choice.

Perfectionism was considered to play a powerful negative influence in this situation, as well as a risk and maintenance factor. Hypnosis was used to address a particular feature of the phenomenology of Mark's presentation. Strategic hypnotic interventions were part of a larger goal-oriented therapy

emphasising skills building, and integrating different intervention strategies (Yapko, 2001). The strategies included cognitive-behavioural, psycho-educational and interpersonal.

Hypnosis was chosen to target perfectionism because it provided a way to shift attention and to diminish the self-monitoring functions of consciousness. It was important to help Mark clear his mind of self-doubt, negativity, and critical self-awareness. Hypnosis was also used because it promotes the suspension of the vigilant monitoring associated with waking consciousness: “keeping in mind the three main factors of the hypnotic experience — increased capacity for dissociation, increased capacity for loss of self in experience, and increased suggestibility — I use these a bit like musical instruments” (Lipsett, 1997; Walker, 2000).

Silverman (1995) highlighted a link between perfectionism and giftedness. This author believes that perfectionism may be an inevitable part of being talented and gifted, and can be construed in a positive light, as a strength rather than a negative and dysfunctional trait. An interesting clinical question considered was: Is Mark’s perfectionism an example of a healthy striving for excellence, or is it a self-defeating and obsessive preoccupation with perfection (Peters, 1996)?

In line with Peters (1996) and Silverman (1995), it appeared that Mark had the ability to channel his striving after perfection to promote his growth, as a self-actualizing need, and that he could thus reduce the potential for creating a negative impact on his mood, relationships, and studies. He was encouraged to manage his perfectionism in a way that was productive to him, rather than destructive.

GOALS OF THERAPEUTIC MANAGEMENT

Mark requested assistance to relax and to improve his academic performance so he could then change courses. We agreed to focus therapeutic work on enhancing his inner strength and on psychological tools to manage his distress and frustration. We discussed the importance of increasing his flexibility (and accepting less than perfect standards), self-acceptance, and reliance on his own resources. In addition, Mark would benefit from learning relaxation techniques, becoming more comfortable with taking risks, making mistakes, and asserting his individuality (separation issues from family of origin).

There was no evidence that Mark suffered any vegetative symptoms related to the depressive illness requiring medication (his lack of appetite and sleeping difficulties proved to be short-lived and reactive to his distress). Nevertheless, I recommended Mark to see his general practitioner for a general check-up to rule out any possible biological aetiology in his presentation. To my knowledge, Mark had no other co morbid conditions.

We contracted for 8–10 weekly sessions, addressing the following target areas and goals:

- To increase flexibility. The use of indirect, non-directed conversational hypnotic techniques was preferred because there was evidence that Mark had a tendency to rebel against direct suggestions. It was important to facilitate the process of him appreciating his uniqueness and to discover other facets of himself. To achieve that it was considered useful to incorporate elements that he enjoyed and valued and that were readily accessible to him, such as music.
- To initiate cognitive restructuring. Standard cognitive-behaviour therapy techniques were used to facilitate a process of challenging self-defeating cognitions. Hypnotic and post-hypnotic suggestions were used as ego strengtheners.
- To teach relaxation techniques including physical (progressive muscle relaxation, deep breathing techniques, etc.) and mental strategies (self-hypnosis, mindfulness, meditation, and others as appropriate).
- To provide supportive counselling to hold and support Mark emotionally through a normal developmental transition and associated tasks.

SPECIFIC INTERVENTIONS INCORPORATING HYPNOTIC TECHNIQUES

The first hypnotic induction was conducted following the SHCS protocol. Mark enjoyed the experience and said he felt “strangely relaxed,” meaning “it is unusual for me not to feel tense.” The second induction used instructed eye closure with a deep breathing exercise, with counting as a deepener. Once Mark felt he was in trance he indicated that to me using ideomotor signalling. In a conversational style, and using a script adapted from Hammond (1990) and Peters (1996), therapy was conducted. The suggestions reframed perfectionism as a gift, a positive energy that needed to be embraced and contained, pointing to the importance of taking risks, changing perspective on mistake making, and developing patience with gradual improvement.

Suggestions and post-hypnotic suggestions were used as ego-strengtheners. Out of trance state, Mark reported enjoying the “relaxation exercise” (his favorite way of calling hypnosis). He said he felt very “floppy” and saw himself floating. We explored the issue of taking risks and making mistakes. He had the following insight: “This is a cycle. If I disappoint my parents I disappoint myself; if let them down, I feel guilty and miserable. Then, I tell myself to try harder next time. I always give my best shot. I try so hard, I burn out. When that happens, I begin to feel anxious and depressed again.”

We conceptualised mistakes as “learning opportunities” and agreed to use his sense of humour to decrease the solemnity associated with his mistakes. Mark was keen to do some homework that week. Homework consisted of telling his friends about those “silly, little mistakes” he often made and hid from them. I suggested to him that he could perhaps take things a step further: to attempt deliberately to have more of those silly little mistakes and to become used to them. Those little mistakes would also give him more opportunities to laugh and to accept being less than perfect as a normal and desirable goal. A tape with the recording of the session was given for Mark to help him practise twice daily for a week.

At the next session Mark said he had been doing his “relaxation” exercises. He reported a general improvement in his sleeping pattern and was very pleased at noticing an improvement in his ability to concentrate on his studies. He said doing the relaxation exercise daily “makes me feel more relaxed the next day, less tense during classes and exams. I don’t feel as upset as I was when I first came here.” We talked about excessive parental pressure and how counterproductive it could be. Mark found it difficult to cope with his parents telling him to study more, and their yelling frustrated him: “I can’t talk to them when they scream at me. They say that’s the way they talk.” He believed that his parents did not treat his younger sister in the same manner. Mark recalled an incident from the night before: “I finished studying, and was trying to relax listening to music. My father came to my room and screamed: ‘Why aren’t you studying? You’ve got an exam tomorrow!’” Mark said he had learned to ignore his parents at times, but that he had a tendency to bottle up his resentment and frustration: “I feel upset and angry when they scream at me. I don’t generally tell them how I feel.” We further explored the incident in high school when Mark self-harmed in front of his parents. “I felt pushed into the extreme of having to decide whether to kill myself or not,” he said. “The only way out was to wrap a cable around my neck during the argument. After that, they backed off only for a short while.”

Mark would like his parents to realize he was growing up and “allow me to do what I want.” Then he gave me examples of how parental criticism had in fact made him more rebellious, wanting to do things even more intensely. He told me about other restrictions imposed to him such as: “They don’t allow me to watch TV after 7.30. I am not a child anymore!” This discussion gave us the opportunity to explore strategies to release pent-up emotions and to avoid emotional implosions and/or explosions. Mark said he liked to listen to jazz and to play it when he was stressed. He was encouraged to practise more self-soothing strategies and to continue with the use of hypnotic techniques between sessions.

A new exercise combining progressive muscle relaxation, breathing, and counting was introduced to Mark. He enjoyed it and said he was able to breathe out all excess energy and tension. However, he found it difficult to visualise numbers after reaching number 9: “then my mind went blank and empty, I wasn’t upset or anything.”

After this exercise, he told me about that his suicidal thoughts were no longer bothering him. “They are fleeting thoughts, I don’t worry about them any more.” He compared them with the time he started counselling and concluded that they were now less frequent, less intense, and “not emotionally charged any more.”

On the next session, hypnosis combining imaginative involvement and music was introduced. Using guidelines provided by Walker (1998, pers. comm.) music was used as a deepener and as the content of the session. Two musical pieces (by J. S. Bach) were selected to deepen trance and to act as a vehicle for suggestions (“in the brightness of the music all self-doubts, anxiety and misery will dissolve away ... and the more they are dissolved away, the more clear and bright your own mind becomes ...”). As the music continued, Mark was invited to elicit a relaxation response and a serene state of mind. He was encouraged to use his capacity to become absorbed and lost in the music, along with positive feelings of serenity, increased calm, and optimism to see the beauty, uniqueness, and brightness of his mind. Post-hypnotic suggestions encouraged Mark to use music for anxiety and stress reduction, as a relief of excessive mental and physical tension. These incorporated suggestions to enhance academic performance, promoting “effortless concentration, capacity to focus on his studies, memory skills and problem solving” (Hammond, 1990; Walker, pers. comm.)

After practising hypnotic relaxation using music, Mark reported feeling completely relaxed and absorbed, finding the music “strange but nice, new and

pleasant. The music blocked everything else! I was so relaxed; I didn't feel my body and did not pay attention to anything else but the music." It is interesting to note that Mark was becoming visibly more comfortable and relaxed; he looked more animated and was more interactive during sessions. Initially he was rather quiet and reserved, with few spontaneous comments. Hypnotic suggestions were reinforced back in the waking state. Music with associated feeling seemed to have been a most enjoyable experience for Mark.

The strategic interventions that will be presented to Mark in the next future will be:

1. Self-hypnosis as another way to reinforce self-efficacy and skills acquisition.
2. Mindfulness meditation as a way to reduce his vulnerability to self-destructive emotions and to increase his resilience (German, 2003).
3. Reading therapy to increase his knowledge and to prevent relapse. Books recommended included Yapko's *Breaking the Patterns of Depression* (1997); Young and Klosko's *Reinventing Your Life* (1994), with special attention to the chapter 15, "It's Never Quite Good Enough: The Unrelenting Standards Lifetrap"; and Aisbeth's *Taming the Black Dog* (2000).

OUTCOME

At the time of writing this case study, therapy with Mark was in progress. During our last session, the DASS was re-administered. Results indicated that levels of depression, anxiety, and stress were within the normal range. In a relatively short time (about three months) Mark was able to decrease his dysphoric feelings markedly, moving his levels of distress from extremely high to normal.

Mark reported improvements in his ability to concentrate and to study, and his marks in ongoing assignments during the second semester were a good reflection of that. He experienced a small setback when he panicked in a test recently: "I couldn't understand anything, then I felt so angry with myself for not being able to respond to questions ... but this test contributes only 8% of the total mark and I did well all semester ... I choose to let go of it now ... not much can be done now." I congratulated him for his ability to practise his newly learned skills. It was apparent to me that Mark had more flexibility and more psychological tools to handle such situations.

He also indicated he was able to use music and progressive muscle relaxation to facilitate sleep. His sleeping patterns progressively returned to normal. Mark was looking forward to travelling to Japan during the summer holidays. He had organised this trip for the end of the semester and was going to meet a friend there. Mark told me that his parents were concerned about the length of his trip (three weeks), but he felt proud of saving the money to travel alone. He saw this trip as a good opportunity to keep on improving his proficiency in Japanese.

At the time of writing this case study, students were preparing for the end of the semester exams, a time that can be stressful for most students. I continue to see Mark on a weekly basis. If necessary, we could extend our therapeutic contract to continue working on other important issues. With Mark feeling less agitated and generally more relaxed, some insecurities and performance and social anxieties could be targeted to be the focus of future interventions.

DISCUSSION

Thanks to Mark's excellent responsiveness to suggestions, compliance and receptivity to suggestions in the waking state was maximised. Moreover, he was able to incorporate them into his self-concept similarly to the way he did as a child, internalising parental evaluative comments into his self-concept through ego-strengthening, and in this case the use of post-hypnotic suggestions. "Gifted hypnotic subjects are more suggestible than the general population in the waking state, without hypnosis, but this is accentuated in hypnosis" (Walker, 2000).

The work done during and in between sessions was successful in creating more flexibility and risk taking (in relation to perfectionism and self-acceptance) as well as providing useful life skills.

Suggestion by the hypnotist is not active only in hypnosis. The suggestions or comments of the hypnotist can set very strong expectancies about what will be experienced in hypnosis and these will be part-determinants of what occurs for the subject after induction of hypnosis. Suggestions made in hypnosis can be effective in the waking state after hypnosis has ended, and these are called post-hypnotic suggestions. They can be very important in linking what has been learned, incorporated, or experienced in hypnosis back to the subject's world of external reality. (Walker, 2000)

As Peters (1996) has indicated, perfectionism might be an inevitable aspect of having a bright mind. Mark proved to be highly motivated and receptive in therapy, where a collaborative approach to determine short- and long-term goals was employed. He was committed to practising between sessions and did all his homework. Because he was highly and personally involved in the process, his self-esteem and self-confidence grew as he became more skilled and successfully mastered some of his difficult feelings.

Emphasis was placed on tailoring the treatment approach to Mark's specific needs, focusing on skills building and personal empowerment, and teaching him proactive and preventive skills to help him in the bright future that lies ahead.

Psychotherapy with Mark was and continues to be an active process of exchanging ideas, setting up homework tasks, developing problem-solving skills, and most importantly, using the therapeutic relationship as the foundation and the vehicle to produce change (Yapko, 2001). Hypnosis was used as a way to access and to amplify Mark's multiple personal resources.

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HYPNOSIS AND SMOKING

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Psychologist

This study reports the use of hypnosis with a young woman who was seeking to resolve her smoking addiction. Early in treatment it became clear that she had unresolved grief, loss, and anger concerning her sexual abuse as a young child by her father who had died many years previously. This experience had hindered her emotional development, current emotions and lifestyle, and contributed to her low self-esteem, negative feelings of self-worth, and subsequent smoking addiction. Hypnosis was incorporated into an extensive period of counselling, and was effectively used to enable this client to cease her smoking addiction, to conclude her unresolved grief and anger, and to use her newly found peace as a means of ego-strengthening, confidence building, and promoting positive future expectations.

PRESENTING PROBLEM

Jasmine was an 18-year-old female student who self-referred to the counselling and welfare service at a secondary school. She was currently completing Year 12 and wanted to better manage her concentration difficulties, her general anxiety, and what she described as “my smoking addiction.” Jasmine was also concerned that she would be asked to leave school because she had recently been verbally abusive to her teachers during class, and angry that she had been continually stopped from smoking on the school premises. She had been suspended from school on a number of occasions because of this behaviour. Jasmine wanted to complete her final year at school successfully, and later study at a tertiary institution. Her teachers had told her she was a highly able student, and was capable of achieving good results at school. However, Jasmine believed

that she had recently become increasingly stressed, anxious, frustrated, depressed and angry, and that she was smoking more frequently “to calm myself down.” Jasmine felt that she had little control over her behaviour, and that her situation was worsening.

INITIAL INTERVIEW

Jasmine lived with her mother and 10-year-old sister. Her parents separated six years earlier and her father had died five years ago when she was 13 years old. Jasmine was reported to have progressed normally through primary and secondary school. There was no evidence of any emotional or learning difficulties, or of previous behavioural problems at school.

Jasmine presented as an intelligent and articulate young woman who was very keen to talk about her problems. She appeared to be anxious, restless and agitated, and she tapped her fingers, wrung her hands, and leaned forward in an intense manner while talking. She would constantly look towards the door, often speaking in a hushed voice, as if she feared an interruption.

Jasmine stated that she had referred herself for assistance because she wanted to stop her “smoking addiction.” She gave a number of reasons for wanting to do this. One of the main reasons was her increasing dependence on the nicotine in cigarettes, and she disliked the feeling of not being in control. Another reason was the trouble this had produced at school, resulting in a number of suspensions. Because of her increasing need for cigarettes during class time, she was becoming stressed and angry, and she had verbally abused her teachers when frustrated. Jasmine believed that, generally, she had a positive relationship with all her teachers and she regretted her behaviour, which had disappointed her, on these occasions. She was confident in her ability to complete Year 12, and had achieved good results when she had made a reasonable effort. Although unclear at this stage about her career choices, she wanted to attend a tertiary institution and “do something worthwhile in my life.”

Jasmine was also aware of the time-consuming and expensive consequences of her habitual smoking. She also reported that she was increasingly unable to participate in important social, occupational, school, or recreational activities, because these activities occurred in smoking-restricted areas. She had given up netball, and was unable to secure part-time employment because of the number of hours she would have to spend in a smoke-free environment. Jasmine had also found that she was spending less time with her close friends who did not smoke, and more time with people who reinforced and

encouraged her habit. Her preferred circle of friends was diminishing. She had also become increasingly verbally abusive to even her closest friends.

Jasmine felt that it was particularly difficult to stop the habit of smoking as she was becoming increasingly physically dependent upon nicotine. The symptoms of withdrawal were distressing when she tried to stop or reduce her intake of cigarettes. Jasmine was able to express her problems clearly. "Whenever I try to cut down, I get so angry and frustrated with everything. I worry about everything that's gone wrong in my life. I can't sleep at night. I can't concentrate on all the work at school when I'm feeling like this. I know that I can get good grades, and that I can do even better. I was really pleased when I got an A for my work in English. But sometimes I just get uptight, and I think that I can't do this any more, and that it doesn't matter anyway. Sometimes I don't feel angry at all. I just feel really miserable and depressed ... sort of useless ... I feel tired, and I don't feel like doing anything. Then I think, 'What's the point of all this?' I know I give up. That's when I light up a cigarette to calm me down."

To relieve these symptoms, Jasmine would smoke when she first woke in the morning. Because smoking was prohibited at school, she would also smoke more before attending school, and in the streets around the school during recess and lunchtime.

When Jasmine was asked to explain her statement, "I worry about everything that has gone wrong in my life," she became anxious, secretive, and began to whisper. She reported that she began smoking six years ago, when she was 12 years old. Her mother and father both smoked, and she grew up familiar with "the smell of smoke in the house." Jasmine's parents used to argue a great deal throughout her childhood. Her father "used to drink a lot, and he would come home late at night, angry and drunk." He frequently hit Jasmine and her mother, who Jasmine said "always put up with this, and never did anything about it."

Later, when her little sister was born, Jasmine stated that things got worse. She then became very distressed, and reported that her father had sexually abused her on a number of occasions when she was about 11 years old. These events occurred when her mother was out of the house. Jasmine reported that she did not remember the details of what her father had done to her because she wanted to forget about it all, and thinking about it had always made her feel worse. She had only told her closest female friends about the sexual abuse and never discussed it with her mother. However, she felt that her mother might have known, or guessed, but "like the hitting, she never did anything

about it. I often wondered why she did nothing to help me.” One reason Jasmine thought her mother might have known was because her parents separated soon after these events. She did not see her father again, and he died approximately one year later from alcohol-related problems. Jasmine stated that she hated her father and was angry about what he had done to her. She was not sad, she did not cry when she heard that he had died, and she still resented her mother for neither helping nor protecting her. Her present relationship with her mother was “not good.” Sometimes she hardly spoke to her mother, and would argue with her over small things. Jasmine felt that she might be able to talk to her mother about the sexual abuse by her father one day “when I have pulled the rest of my life together. Then maybe I will be able to understand both me and her.”

Jasmine stated that her most important goals were to stop smoking, keep out of trouble at school, and pass Year 12, and that this was why she had sought assistance. She thought that maybe she began to smoke when she was so young because she felt so bad about what had happened to her and wanted hurt herself. She also viewed smoking as a challenge against authority. Later, it became even more difficult to stop smoking. Her friends had begun to smoke and they then encouraged each other. Jasmine said that smoking had made her feel more sophisticated and grown up. She felt at times that it helped her to concentrate and to relax, and gave her confidence. Smoking also gave her something to do with her hands when she felt nervous. She smoked when she first woke in the morning, during and after meals, and while talking on the telephone. She had recently started to smoke in bed.

Jasmine’s awareness of the dangers and social consequences of smoking was discussed. She knew of several relatives, and relatives of friends, who had become ill or had died as a result of a smoking-related disease. Jasmine stated that several of her friends disapproved of her smoking and had said that she smelled of cigarettes. She had given up sport, and going to the gymnasium, because physical activities made her feel “puffed out.” Her family doctor had frequently encouraged her to stop smoking during consultations because she had recently developed a cough and had an increasing susceptibility to colds.

To assess Jasmine’s motivation to change her behaviour and stop smoking, some of the basic dangers of nicotine use were discussed with her. Some of the known medical facts associated with smoking cessation were discussed. It was also pointed out that most individuals have many failures before they stop smoking for good, and that many people who have stopped smoking still report having the desire for a cigarette.

Jasmine stated that she was aware of many problems associated with smoking. In the past she had felt that these were reasons why she should “stop smoking one day in the future,” as it would be a long time until her health was affected. More recently, she had come to the realisation that cigarettes were already affecting her health. This realisation, her addiction, and the effects it was having on her emotions and behaviour at school, were the main reason why she was motivated to stop.

TREATMENT GOALS

Treatment goals were structured around Jasmine’s aim of smoking cessation; coping with anxiety, anger and frustration; and with issues relating to the pain and anger of past sexual abuse. It was considered necessary to deal with all these factors in order to assist Jasmine to give up smoking.

It was therefore considered important to assist her in the following ways:

1. To experience relaxation, and to enable her to learn how to achieve this for herself through self-hypnosis.
2. To manage the anxiety associated with the need to smoke.
3. To work through her anger and the need to smoke, and the hypothesis that this was based in childhood sexual abuse.
4. To deal more calmly and rationally with anxiety and with anger-provoking and frustrating situations.
5. To develop a positive sense of self-esteem, of mastery, and of control over her life choices, including trust of self, valuing of inner resources, and a positive identity.
6. To continue to be future-focused despite past negative experiences.

ROLE FOR HYPNOSIS IN THIS CASE

There were eight main reasons for introducing hypnosis to Jasmine:

1. She was highly motivated to try hypnosis, and she believed that she would find it helpful. In the past she had found that listening to relaxing music had helped her to “settle down” and calm her thoughts.
2. Research has shown that hypnosis is a useful method in the treatment of anxiety and stress (Barnard, 2002). Regular practice of hypnotic techniques has been found to increase the amount of focused relaxed time, and enhance the ability to relax and manage anxiety. Improvements in sleeping patterns and levels of physical energy have also been noted (Yapko, 1997).

By learning deep relaxation, Jasmine would be able to get immediate relief for her anxiety, and therefore cope better by applying these techniques when confronted with anger-provoking and frustrating situations.

3. Hypnotherapy is considered to be the best therapeutic help for smoking cessation, and has an excellent success rate (Allen, 1997). Hypnotic treatment programs conducted over a number of sessions have also been found to dramatically increase success rates compared with a single-session approach (Hammond, 1990).
4. Jasmine had experienced very little positive feedback throughout her childhood. As a result she has suffered from low self-esteem and lack of confidence. The use of hypnosis and the hypnotic technique of ego-strengthening could be used to bypass the critical conscious mind to implant positive suggestions about self-worth. Treating feelings of low self-efficacy and powerlessness with suggestions for ego-strengthening has also been found to be vitally important in relapse prevention efforts with smoking (Hammond, 1990).
5. It was considered that many of Jasmine's current anxiety, anger, and smoking problems were the result of early childhood traumatic experiences and associated negative emotional affect. Hypnosis has been useful in dealing with unresolved grief and emotions connected with past incidents (Wadsworth, 1995).
6. Jasmine frequently spoke with distress and anger of memories of her traumatic past and family arguments. It was important that she was able to eventually "move on" and not become preoccupied with the emotions that these memories elicited, during therapy and in her day-to-day life. It was therefore of paramount importance that Jasmine be encouraged to develop a future-oriented focus on positive outcomes and goals. Hypnotic procedures have been used successfully to highlight a person's strengths and to minimise maladaptive behaviour by focusing on a positive future moving towards specific goals (Yapko, 1995).
7. Hypnosis provides a useful technique for enhancing Jasmine's sense of control, and therefore control of the anxiety that has impaired her ability to function and learn more effectively. The self-management skills taught during hypnosis for handling anxiety and agitation would help enhance Jasmine's sense of control, and therefore be useful for her during difficult times. The use of these skills would also have potential for reducing the further development of negativity and stress.

8. Self-hypnosis would provide a useful technique for assisting Jasmine to utilise, practise, and reinforce the skills learnt, and the suggestions made during the therapy sessions.

SUITABILITY FOR HYPNOSIS

Jasmine presented as an intelligent young woman. When hypnosis was explained to her, she was interested in applying this technique as a self-help measure. She enjoyed listening to instrumental music, particularly the flute, and she often became lost in her thoughts and imaginings, and the emotions that this instrument evoked.

She demonstrated a very good capacity for the positive visual, auditory, kinaesthetic, olfactory, and gustatory imagery and she spoke not only with enthusiasm about her experiences with these different types of images, but she appeared to be relaxed and comfortable with this procedure.

THE USE OF HYPNOSIS IN TREATMENT

Eight therapy sessions were conducted over a six-week period, with the first four of them conducted over two weeks. These sessions had the following treatment goals:

1. The assessment of Jasmine's response to hypnotic techniques.
2. The use of hypnosis to reduce Jasmine's anxiety, worry, stress, anger, and frustration.
3. The use of hypnosis to work through Jasmine's emotions — her anxiety, anger, and grief associated with childhood sexual abuse.
4. The use of hypnosis to encourage smoking cessation.
5. The use of hypnosis to support ego-strengthening methods to help Jasmine develop a positive identity by increasing her self-esteem and feelings of self-worth.
6. The use of hypnosis to encourage positive expectations for the future.
7. The use of hypnosis to promote Jasmine's sense of control over her life, and her life choices.

Session 1

Relaxation and Anxiety Reduction The first session focused on reducing Jasmine's feelings of anxiety and stress. The overall aim of this session was to teach progressive muscle relaxation and general relaxation techniques to assist

her with managing the stress and tension in her body. Jasmine was asked to think about a special and relaxing place that she could visit in her imagination where she could experience relaxation, peace, and comfort. She stated that she had enjoyed visiting the botanical gardens as a child, and that this had always been a pleasurable and relaxing place for her, with many happy memories.

Induction was conducted using eye closure followed by progressive muscle relaxation. Eye closure was achieved by asking Jasmine to close her eyes in her own time, along with the relevant suggestions. At this point it was thought that there might be occasions during therapy when it would be useful to utilise an ideomotor response technique. Jasmine was asked to communicate using finger movements by raising the index finger on her right and her left hands to signal yes or no. She indicated that she had understood the instructions that had been given to her by using the index finger of her right hand to signify a “yes” response.

Progressive muscle relaxation was achieved by using a fractional induction procedure in order to deepen the trance. Deeper relaxation was suggested with each exhaled breath. This procedure enabled Jasmine to progressively and selectively focus on tension, and on relaxation in those parts of her body that were experiencing it.

To enhance the deepening stage, Jasmine was asked to focus on going deeper into a relaxed state by utilising a counting down procedure from 10 to 1. The release of tension was encouraged by this procedure, together with suggestions of peace and comfort ... letting anger, stress, and anxiety flow from her body, and experiencing the calmness of the relaxation of mind and body together. To allow Jasmine to enjoy a pleasurable experience, she was asked to imagine herself in her beautiful botanical garden. Suggestions of pleasant visual, auditory, olfactory, and kinaesthetic garden imagery were made amidst feelings of safety, peace, calmness, comfort, and relaxation of her mind and body.

A selection of flute music was introduced to further enhance the deepening stage. As Jasmine had enjoyed her past experiences of listening to the flute, this music was chosen to bring a further sense of relaxation and happiness to her world. The music selected was *Romantic Music for Flute and Harp*, by Janos Balint and Nora Mericz, and it was played while suggestions were made to encourage Jasmine to visualise herself in her beautiful botanical garden scene, where she could further experience such things as the fragrance and colour of the flowers, the sounds of nature and of birds singing, the drone of insects, the splash and gurgle of cascading water, water droplets sparkling and glistening,

the soft filtering of diffused light, and a soft drifting breeze, along with feelings of peace, comfort, safety, and a gentle drifting down into peace and harmony of her body, mind, and spirit. At this point, Jasmine was given as much time as she needed to enjoy this experience.

Jasmine demonstrated her depth of trance by responding positively to the ideomotor responses suggested earlier. She was able to raise the index finger on her left or right hand in response to questions relating to the quality and depth of her experiences. Also, as trance continued, it was noted that Jasmine's breathing had gradually become more regular, rhythmic, and louder, indicating her increasing depth of trance.

De-hypnotising was achieved by counting backwards from 20 to 1. It was clear that Jasmine had been able to disassociate easily, and become deeply involved in the hypnotic experience. It was therefore important to give her sufficient time during this period to bring her awareness back to the present.

At the end of this session Jasmine stated that she enjoyed her experiences and that she felt relaxed and comfortable. Closing her eyes made it easier to relax and think more clearly. She reported that the progressive muscle relaxation procedure had enabled her to become more aware of the tension in all the muscles of her body. The words "softening ... loosening ... and lengthening ... as all the tension drains away" had particular meaning for her, and made her feel very heavy, more comfortable, and relaxed. The idea of "breathing out anxiety and stress" also appealed to Jasmine, who stated that it was good to be in control of her thoughts, and that she enjoyed the feeling of making the thoughts so pleasant. She felt that she had not been so relaxed for a long time.

Jasmine was given an audiotape recording of this session for her use at home, called "Jasmine's Relaxing Garden." She was told that she could enjoy this feeling of being relaxed whenever she liked, and that reducing her anxiety and becoming more relaxed were the first steps towards helping herself in the achievement of her goal to stop smoking.

Session 2

Releasing Negative-Emotions Jasmine reported that she had listened to "Jasmine's Relaxing Garden" on a number of occasions during the day and at night. She had practised progressive muscle relaxation and had found it useful in helping her focus on her body tension. Visualising her special garden place and listening to the flute music had helped her feel peaceful, relaxed, and in

control of her thoughts. She had found it easier to sleep at night because she did not feel as tense. Although she had not counted the number of cigarettes she had smoked since the last session, she reported that perhaps she was smoking less, "but not significantly so." The main difference she had noticed was that she had felt more relaxed when lighting up a cigarette, and she that did not experience feelings of anxiety and urgency.

A discussion followed about the imagery of a relaxing place having a beneficial effect upon her level of anxiety, anger, and feelings of confidence and control. Jasmine reported that the sound and feeling of water also made her feel very relaxed. She liked the idea of floating aimlessly in a small boat or yacht on a calm river, sea, or lake.

Induction was again achieved by eye closure and progressive muscle relaxation. As a deepener, a script which included suggestions for increased strength, power, freedom of choice with regard to stress and anger reduction, and positive future direction was utilised.

It was suggested that Jasmine imagine herself in a sailing boat, floating on a lake and enjoying the scent of a mountain pine forest, the clearness of the sky, the splash and gurgle of the water, the sounds of nature all around, together with feelings of warmth, relaxation, peace, and comfort, and with all anxiety, stress, and anger draining away with every breath. This procedure was followed by therapeutic suggestions that included drawing Jasmine's attention to her habit of reacting in a manner that has been stressful for her, as well as her negativity, anxiety, and general lack of confidence. Further therapeutic suggestions were made with regard to her ability to take positive control of her life by referring to her increasing power and strength in choosing to steer her boat in the right direction for her. It was acknowledged that it could also be pleasant to choose to drift peacefully, and to feel calmness and confidence in the freedom of choice.

At this time it was considered appropriate to introduce suggestions that would assist Jasmine in releasing many of the negative emotions that had been impeding her progress and adjustment in life. This therapeutic intervention was specifically aimed at addressing the negative thinking and negative self-beliefs that were leading to Jasmine's anxiety, stress, and angry outbursts. Suggestions were made for the letting go and release of negative emotions such as anger, frustration, sadness, grief, and guilt. It was also suggested to jasmine that negative emotions can never change anything, but are simply a waste of energy, are hurtful, and prevent progress and the development of other beneficial emotions such as positive thoughts and feelings that will help

her achieve her goals. Further suggestions centred on the idea that Jasmine could have the confidence to choose to have positive thoughts and emotions such as love, compassion, understanding, forgiveness, and acceptance of herself and others.

At this point, a further therapeutic strategy was introduced, including safe place visualisation. Jasmine was introduced to the idea that behind each of three doors were stored all of her life memories, experiences, and emotions, both positive and negative. Suggestions were made that behind Door 3 were locked memories or secrets hidden from Jasmine by her own self-conscious mind. These memories were hurt, sadness, anger, and frustration, causing much misery for her. It was suggested that these memories and secrets would lose their power when the door was opened and they were exposed to the light of Jasmine's conscious awareness. In this way the memories would lose their power to hurt and cause problems ever again. It was explained to Jasmine that once she had dealt with all of the memories important to her in the room, the power of those memories to harm her would be negated. When she was satisfied that she had done all that was necessary to deal with the memories, the door would close easily. However, if there were still some issues to be dealt with, then the door would not close. Jasmine was asked to spend some time in the room looking around at the memories and secrets that were now exposed, and to allow some time for this to happen. When she was finally asked the question, "Can you close Door 3 now?" Jasmine indicated a "yes" response by slowly nodding her head and lifting her right index finger.

The following activity was introduced at the end of this session in order to allow Jasmine the opportunity to experience something pleasant and positive. While in trance, she was asked to allow herself the opportunity to experience those things which are pleasant and positive, such as a pleasant thought or memory, a happy event, a warm and all-embracing feeling, a pleasant taste or fragrance, or a brilliant colour that will suddenly evoke a feeling.

Following trance, Jasmine discussed the feelings and emotions experienced during this session. She enjoyed the suggestions of relaxation, warmth, comfort, happiness, and self-confidence, and she felt that these feelings were of assistance to her because they made her feel much better. The idea of releasing her negative emotions was also very useful, as it helped her to focus on them and see their effects on her behaviour more clearly. During trance Jasmine was able to address some of the trauma of her past sexual abuse. She did not want to discuss the memories behind Door 3, but she felt that they were no longer as painful, and that she was now more able to put them behind her and move

forward. She felt that her anger and anxiety at her mother's inability to protect her as a vulnerable child had been processed, and that these feelings had lessened. Her pleasant thought was of a brilliantly coloured orange and purple butterfly fluttering and gently resting on the leaves of a tree. Jasmine stated that she felt very relaxed and more peaceful as a result of her experiences in this session. An audiotape of this session, called "Releasing Negative Emotions," was given to her to listen to at home in order to further assist her.

Session 3

Smoking Control Again Jasmine reported beneficial results from listening to the audiotapes of scripts from the previous two sessions, and she found the relaxation and positive mental rehearsal most useful. These benefits included positive feelings of increased relaxation and control, pleasant happy thoughts, and reduced anxiety, stress, and anger. She had practised feelings of relaxation, calmness, and control whenever she began to feel anxious or angry, and was able to utilise positive imagery and visualisation. Jasmine stated that she now felt that she understood herself and others more. She also felt much stronger as a person, and stated that she was even more willing and able to face the challenge of successfully stopping her smoking habit.

During this session a relaxing script was again repeated, using safe place visualisation. The relaxation therapy was then extended using a deepening technique, again emphasising the absence of anxiety and stress, and the presence of feelings of comfort, safety, tranquillity, calmness, and peace.

Initial suggestions were made to give Jasmine self-confidence with her decision to give up smoking and to enjoy the journey towards that goal. This was followed by a detailed and factual description of the damage that Jasmine inflicts on her body each time she lights up a cigarette ... The ingestion into her body in excess of 4,000 different chemical compounds, many of these being deadly poisons, and none of them in any way beneficial ... decreased concentration and judgment ... increased heartbeat and blood pressure, heart disease, pulmonary emphysema, cancer in the vital organs of the body, excessive skin wrinkling, and an early death. In contrast, Jasmine was encouraged to imagine what her life would be like without smoking ... more alive ... no longer offending others with stinking tobacco-laden breath, hair, clothes, and stained teeth ... and to experience herself as a confident non-smoker ... fitter, healthier, more attractive ... proud her achievements and feeling good about herself for having the power and commitment to make the

decision to give up this foul and destructive habit. A number of post-hypnotic suggestions were given with regard to encouraging Jasmine to make the decision when she will stop smoking. These included suggestions of choice followed by commitment, such as “You may decide to quit smoking right now ... or perhaps you may decide that later on today is a good time for you ... perhaps you may quit after lunch ... after dinner ... or just before you go to bed.”

Jasmine was again given an audiotape recording of this session to listen to at home and suggested that this should be called “Stop Smoking Now.”

Session 4

Smoking Control — Enhancement Jasmine was delighted to report that she had not smoked a cigarette since the last session. She had listened to all the audiotapes made during the previous three sessions, and had found each of them very helpful in a different way. The “Stop Smoking Now” audiotape had further strengthened her resolve to cease this habit immediately. She particularly liked the part where the suggestion was made that firstly, the decision to stop smoking, and secondly, the choice of when to stop smoking, were hers. This made her feel more in control of her decision. She stated that when she had suggested that the audiotape of Session 3 be called “Stop Smoking Now,” it was at that point that she had decided to follow her own advice, and stop smoking immediately.

Jasmine stated that the first cigarette of the day had been the most difficult one to give up, as she had always smoked more in the morning than in the afternoon. Initial withdrawal symptoms included an increased craving for sweets and chocolates, and she had felt a little dreamier and more easily distracted during the day. However, she felt that these symptoms were lessening as each day passed. She was now more regular in her sleeping patterns, and was able to relax and fall asleep more easily at night.

Induction was again achieved with a relaxing script and safe place visualisation. Enhancement of Jasmine’s smoking control was considered to be crucial at this stage. In hypnosis it was suggested to her that smoking is a poison for her body that she needs her body to live, and that she owes her body respect and protection. The emphasis here was on Jasmine protecting her body from poison, rather than fighting smoking itself. This was followed by further suggestions to modify Jasmine’s smoking behaviour by restating her personal reasons for wanting to stop smoking.

Further suggestions followed with the aim of increasing and consolidating Jasmine's motivation, including suggestions for positive self-talk and internal dialogue in order to increase her determination and resolve to stop smoking and enjoy every day as much as possible. She was given an audiotape of the scripts that were conducted during this session and suggested that this audiotape be called "Free From Smoking."

Session 5

Ego-Strengthening Jasmine reported she had discontinued smoking completely, and that she no longer experienced the need for a cigarette. She felt that listening to the tapes had given her much encouragement and confidence to continue with her efforts. The focus of this session was on hypnotic suggestions aimed at the enhancement of Jasmine's self-esteem.

Induction and relaxation again included safe place visualisation followed by a number of ego-enhancing suggestions. Jasmine was encouraged to allow herself to go back to a time when she was confident in her ability to take control and to experience the pleasant and reassuring feelings of powerful and pleasant memories. It was then suggested that she could feel really proud of her decision to remain free, healthier, and alive, and that she is a woman who used to smoke but who now no longer needs to.

This session was concluded with additional suggestions aimed at the further enhancement of Jasmine's self-esteem and sense of control. Suggestions were made that she is a unique and special person who is allowing herself to become increasingly aware of the assets, qualities, and beauty within her. Further suggestions centred on the idea of Jasmine being able to trust in her own judgment, values, and opinions. As a result of this new awareness, she would be more able to trust and respect herself, and therefore become more independent, self-sufficient, strong, kind, loving, and happy ... she would then be more able to accept and forgive herself and others. Further positive affirmations of acceptance and respect of self were repeated.

After the debriefing stage Jasmine stated that she had enjoyed the pleasant, happy, and reassuring feelings that she had experienced during this session. She no longer felt sorry for herself, and had a new awareness of her positive strengths and faith in her ability to display them. At this point Jasmine stated that she had a more positive opinion and experience of herself. She decided to call the audiotape of the therapy scripts for this session "Taking Control of the New Me."

Sessions 6–8

Keeping the Change Jasmine reported that since the last session she has been relaxed, calm, and comfortable, and without any urge to smoke.

The focus over the next three sessions was to revise, discuss, further reinforce, and integrate what Jasmine had learnt. It was considered vital to consolidate the positive change that had occurred over the previous five sessions, and to continue to promote feelings of success and mastery, so that Jasmine could continue to allow herself to experience those things that are pleasant and positive for her. This was achieved by introducing further suggestions to encourage a sense of victory, increased willpower, and self-control over her previous smoking habit. Jasmine was encouraged to experience the feeling of picking up a packet of cigarettes, then putting the packet down again, and to experience the strong feeling of victory that would come over her when she put the packet down. This was followed by a number of suggestions that encouraged her to imagine the pleasant and healthy feelings experienced in a day without smoking, in which she is in control, not the cigarette. Jasmine's success and increased self-confidence enabled her to visualise this process successfully.

Further suggestions focused on Jasmine's new awareness, feeling fully alive, strong, healthy, and starting a new life. This was followed by reinforcement of Jasmine's promise and commitment to herself in making the decision to stop smoking. The suggestion was made that Jasmine had come to a "lifestyle junction" where she had made the choice not to continue down the "same old road" where she was "enslaved by a packet of cigarettes," but instead had chosen "a new road of opportunity" where she was able to continue living her life in a new, positive, strong, and healthy way. Suggestions were made that because Jasmine wanted to make changes in her life, then these changes would require her to choose new paths. Focusing on Jasmine's option of choice, and facilitating her belief in choice, was considered to be an important step towards understanding her past behaviour and becoming more future-focused.

Audiotapes of all the scripts introduced during these three sessions were given to Jasmine. At the end of Session 8, a further audiotape containing a general relaxation self-hypnosis training script was also given for future management in her life of any general day-to-day anxiety.

Additional Interventions

At the end of the eighth session Jasmine was given the following “Tips for New Ex-Smokers.” Each recommendation was discussed with Jasmine, and adapted to her previous history and present needs.

1. Clean and store away all ashtrays.
2. Exercise if there is any withdrawal tension. Check with your doctor regarding private exercise if you have any health problems.
3. If there is an urge to smoke — sit down and relax, take a deep breath, hold it for 5–10 seconds, and release it slowly.
4. Increase fluid intake — juice, water, diet drinks, etc. (no caffeine).
5. Decrease decaffeinated coffee and alcohol.
6. If needed, get a supply of sugarless gum, or use carrot/celery sticks if you feel you need something in your mouth.
7. Talk with another non-smoker, or someone who has recently stopped smoking, in order to provide motivation and positive reinforcement.
8. Send daily progress postcards for 10 days, and six-month and one-year follow-up cards.
9. Keep thinking, “I am now an ex-smoker.”
10. Call if you have any problems. Do not smoke that first cigarette and you will be fine.

SUMMARY AND COMMENTS

Counselling and hypnotherapy with Jasmine were conducted over eight sessions during a period of six weeks. The number of hypnotherapy sessions was offered over a six-week period because the average number of days between the initial abstinence and relapse for smokers has been reported to be approximately 17 days (Marlatt, 1985; cited in Hammond, 1990).

Hypnosis was successfully used to enable Jasmine to cease her smoking addiction. While the cessation of her smoking behaviour seemed to be the focus, hypnosis also proved to be a valuable technique in the treatment of Jasmine’s underlying anxiety, anger, and pain of sexual abuse. The relaxation skills learned early in the treatment period helped to facilitate her progress through the various stages of treatment. These results suggest that Jasmine was very responsive to the suggestions made while in a hypnotic state. Hypnosis uncovered issues and provided new and beneficial insights into Jasmine’s past and present behaviour, her sexual abuse, and her relationship with her mother.

The therapeutic techniques learnt during hypnosis enabled her to develop positive new directions, and an enhanced self-concept, based on her strengths and successes. Jasmine felt empowered by her new sense of self-worth and control over her life. She understood that further improvements in her life, and quality of life, rested on her ability to take responsibility for her future and to diminish the negative impact and influence of her past experiences. Jasmine now welcomed and looked forward to the future with a newly found quiet and positive optimism.

At six months follow-up, these treatment gains had continued.

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HYPNOSIS IN THE MANAGEMENT OF ACUTE AND PERSISTENT PAIN: SUPPORT FROM THE RECENT LITERATURE

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Despite conclusive evidence for the efficacy of clinical hypnosis in the management of both acute and persistent (chronic) pain, hypnosis is under-utilised in these applications. The present literature review was undertaken with the aim of providing practitioners with the necessary evidence to support their clinical practice in this important area. The contribution of the elements of the hypnotic induction — suggestion, relaxation, imagery and distraction — are examined and contrasted with similar elements in a cognitive-behavioural intervention. The literature on the neurophysiology of hypnotic pain modulation is summarised. Four of the major areas where hypnosis is of particular efficacy — surgery, childbirth, burns, and cancer — are specifically discussed.

There is strong evidence for the role of hypnosis in managing pain. Numerous studies, including a number of meta-analyses (Kirsch, Montgomery, & Sapirstein, 1995, Montgomery, DuHamel, & Redd, 2000; Redd, Montgomery, & DuHamel, 2001) have pointed to the significant efficacy of hypnosis in managing many pain conditions. This includes an enhanced effect compared to CBT (Kirsch et al., 1995) and relaxation (Gay, Philippot, & Luminet, 2002) alone, with both increased symptom relief and speed of effect. Syrjala and Abrams, who do not always differentiate “hypnosis” and “imagery” in their chapter, “Hypnosis and Imagery in the Treatment of Pain,” in Gatchel and Turk (1996) state: “Thus imagery strategies have repeatedly demonstrated the greatest effect size of all cognitive-behavioural strategies tested for efficacy in pain control” (p. 234).

While hypnosis usually involves the use of imagery, the two terms are not interchangeable. Hypnosis has been described as a state of altered awareness (Spiegel, 1994) during which the individual is more susceptible to suggestion. (Syrjala & Abrams, 1996). There is debate within the literature regarding the terms “state” and “altered awareness” (see Holroyd, 1996). What is accepted is that attentional focusing, relaxation, distraction, visualisation, and suggestion are all common components of a hypnotic induction. (Syrjala & Abrams, 1996). A considerable body of research has investigated the contribution of each of these components.

Suggestion is generally considered to be an integral part of hypnosis (Syrjala & Abrams, 1996, 1999), whether explicit or implied. Numerous studies of the application of hypnosis in pain management, for example, the meta-analysis of Montgomery et al. (2000), support a strong analgesic effect from hypnotic suggestion. Hilgard & Hilgard (1994) have examined the differential effect of hypnotic suggestion for analgesia between experimental subjects of high and low levels of hypnotisability, demonstrating significant pain reduction in the former group, with the response of the latter group being no better than response to placebo. (Although the placebo effect in itself is recognised as beneficial: Turner, Deyo, Loeser, VonKorff, & Fordyce, 1994). Other studies (Holroyd 1996), however, point to the difference between laboratory studies and the clinical application of hypnotic techniques, and demonstrate that with high motivation and training even low hypnotisable patients can obtain significant benefit. For this reason hypnotisability is rarely assessed in clinical interventions.

Hypnosis is often used to induce relaxation, which in itself is of demonstrated efficacy in reducing chronic pain (NIH Assessment Panel, 1996). The NIH authors also note the capacity of hypnosis “for evoking intense relaxation” (p. 8). Gay et al. (2002) compared the effectiveness of Jacobson relaxation and Eriksonian hypnosis in reducing subjective pain and amount of analgesic medication in patients suffering from osteoarthritis pain: Both treatments were effective compared with controls, but the benefit appeared more rapidly in the patients treated with hypnosis.

Hypnosis is often also used to help the patient to direct attention away from the pain, particularly in acute pain. However, it is recognised that with persistent pain distraction is not always sufficient, and other hypnotic techniques including sensory transformation strategies and direct suggestion are added (Hilgard & Hilgard, 1994; Syrjala & Abrams, 1996). Distraction does, however, retain an important role in the management of chronic pain,

providing patients with an opportunity to turn their focus away from their pain for a time. Syrjala and Abrams (1999) point out that distraction is not the same as denial or avoidance. Rather, they see distraction through the use of imagery as an active coping strategy, the positive effect of which enhances the likelihood that patients will continue to utilise this coping mechanism.

Unlike most imagery techniques, hypnosis may or may not involve visual imagery (Syrjala & Abrams, 1996). While these authors frequently use the term “relaxation with imagery” in the place of “hypnosis” in their clinical practice (a convention followed by many other clinicians), they state: “It is the intentional use of suggestion that is the primary distinction between imagery and hypnosis” (Syrjala & Abrams, 1999, p. 310). Most hypnotic techniques do however employ imagery, which as already stated has been repeatedly shown to be the most effective of all cognitive-behavioural strategies. (Fernandez & Turk, 1989; Syrjala & Abrams, 1999).

The role of hypnosis in anxiety reduction, and the differentiation of affective distress or suffering, compared to sensory pain perception, has also been investigated. Although hypnosis is effective in reducing anxiety, which may in turn raise the pain threshold, Hilgard and Hilgard (1994) in summarising the literature conclude that anxiety and analgesia are separable components of the total pain experience and can be independently altered by hypnosis.

The neurophysiology of the hypnotic response and hypnotic pain modulation has been extensively investigated using a number of instruments including EEG event-related potentials (ERPs) and positron emission tomography (PET). Many of these investigations, including those of De Pascalis, Magurano, and Bellusci (1999), De Pascalis, Magurano, Bellusci, and Chen, (2001) and Nash (2002), demonstrate a differential effect between high and low hypnotisable patients.

Hypnosis is hypothesised to block pain from entering consciousness by activating the frontal-limbic attention system to inhibit pain impulse transmission from thalamic to cortical structures. (NIH Assessment Panel, 1996).

Holroyd (1996) extends the model of central nervous system (CNS) downward inhibition to inform clinical practice with persistent pain sufferers. She sees hypnoanalgesia as inducing decreased nerve reaction, with a concurrent affective experience of comfort and a sensory reduction in pain, which can then be learnt and generalised in the non-hypnotic state.

As with other cognitive-behavioural techniques, the acquisition of effective pain management skills through self-hypnosis in particular increases the

patient's sense of self-control and self-efficacy, leading to generally better outcomes. (Harper, 1999; Hilgard & Hilgard, 1994; Lynch, 1999).

Hypnosis is of demonstrated efficacy in both acute and chronic pain conditions, with research focusing on a number of conditions, including the four major areas detailed below

The utility of hypnosis in *surgical interventions* in reducing pain, as well as aiding recovery and enhancing safety, is well-documented (Fredericks, 2001). A recent meta-analysis of the effectiveness of adjunctive hypnosis with surgical patients (Montgomery et al., 2002) supported a significant benefit from hypnosis for a variety of interventions, with 89% of patients demonstrating better outcomes than the control group across each of six clinical outcome measures, including pain intensity, use of pain medication, physiological indicators, negative affect, recovery rates, and treatment time. The recommendation of this review was that clinicians consider providing patients with a brief hypnosis intervention as a routine part of surgical treatment.

This finding and recommendation is further extended by the work of Lang and Rosen (2002) demonstrating that the use of adjunct self-hypnosis reduced the cost of radiologic procedures by reducing recovery times and the costs of complications, even with the costs of the hypnosis and additional room time factored in.

Similarly, a number of studies provide support for the use of hypnosis in *childbirth* in relation to a variety of outcomes, including ability to cope with pain, reduced use of pain medications, shorter labour, higher rate of uncomplicated deliveries, and improved psychological indicators, including reduced rates of depression, anxiety, and increased childbirth satisfaction. Irving and Pope (2002) provide an overview of these studies and identify some methodological flaws in the studies conducted to date. However, hypnosis would appear to have much to offer in this area.

Burns patients are a particular group for whom hypnosis can be of particular assistance in managing the excruciating pain and associated anxiety experienced by these patients, particularly for dressing changes and wound debridement. Numerous studies (Frenay, Faymonville, Evlieger, Albert, & Vanderkelen, 2001; Ohrbach, Patterson, Carrougher, & Gibran, 1998; Patterson, Goldberg, & Ehde, 1996; Patterson, Adcock, & Bomadier, 1997; Wright & Drummond, 2000) conclude that hypnosis appears to have a unique role with these patients, with Patterson et al. (1996) stating "the burn unit may be one of the most useful arenas for the application of this technique." Patterson et al. (1997) further conclude that patients with burn injuries may have a heightened

receptivity to hypnosis compared with the general population, and they explore possible reasons for this. Ohrbach et al. (1998) describe a single case of a patient with severe burns who after an adverse response to opioid medication experienced excellent pain control and absence of need for anxiolytic medication through the use of hypnosis.

Williams, in his chapter on acute pain management in Gatchel and Turk (1996), describes clinical protocols for the use of hypnosis with burns patients.

Hypnosis has been frequently used to assist *cancer* patients with various aspects of their condition and treatment, including general pain management, management of painful procedures, and reduction in nausea and anticipatory nausea. Numerous studies (Genuis, 1995; Sellick & Zaza, 1998; Spiegel & Moore, 1997; Steggles, Maxwell, Lightfoot, Damore-Petingola, & Mayer, 1997; Syrjala, Donaldson, Davis, Kippes, & Carr, 1995) provide evidence for the efficacy of these interventions, although generally no significant difference has been found between hypnosis and cognitive-behaviour therapy (which includes imagery) or group support alone. In “Cancer Pain,” Syrjala and Abrams (1999) do however conclude that “the strongest clinical trial data validate the efficacy of support combined with imagery or hypnosis” (p. 310). Hypnosis may be of particular value in paediatric oncology. Christina Liossi (2003) provides an excellent overview of the evidence for and clinical practice of hypnosis in this application.

Syrjala & Abrams (1996) provide a comprehensive overview of the clinical practice of hypnosis in pain management, including detailed assessment protocols, hypnotic inductions, imagery, hypnotic suggestions, consideration of specific patient characteristics, and solutions for commonly occurring problems.

A number of studies have questioned why hypnosis is not more widely used in pain management programs, given its proven efficacy, and have recommended its greater application in this area (Montgomery et al., 2000; Holroyd, 1996).

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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.

MARITAL HYPNOTHERAPY

Bob Rich

Psychologist

Judy and Chris, who have been living together for ten years, married three years ago prior to having children. They now have two sons, aged two years and three months. Judy was a teacher before the first child. Chris runs his own business in a tough and demanding field, employing 20 people.

Judy came to me first, complaining that she was seriously considering leaving Chris. She was repelled by his touch and avoided intimacy with him. She therefore doubted that she still loved him. At the same time, she felt that there was a great deal to lose if the marriage was split, in terms of financial security, child raising, and personal considerations such as loneliness and isolation. On balance, she wanted to give one more serious try to making the relationship work.

They had gone to counselling before, and Chris had attended an anger management course. Each time, there was transient improvement, but according to Judy he soon went back to his old ways. This was the main reason she was sceptical that there could be any permanent improvement.

During this initial assessment session, Judy was sure that their problems were all Chris's fault. She explained that she came from a very harmonious background where all family members supported each other. Arguments were rare and politeness was the norm. In contrast, Chris's family of origin were very loud and argumentative. Their humorous interchanges seemed like verbal abuse to her. Chris's mother was not respected by anyone in the family; all spoke roughly and disparagingly to her.

Chris's father ran a successful business, and as his sons grew up he involved them as partners — all except for Chris, whom he had always dismissed and belittled. According to Judy, this was why business success was so important to Chris: he needed to prove to his father that he could be as good.

Chris had rejected his family values. Judy said that the greatest insult to him was, "You're like your father."

Her diagnosis of the situation was that, despite his efforts, Chris had been unable to divest himself of his family's traditions and was now treating her in the way his father treated his mother. Increasingly, he'd speak roughly and abusively to her, and they would argue over the slightest issues. Then, while she was still upset, angry, and devastated, he'd demand a cuddle.

Over the years, while rejecting his style, she found herself copying it. During arguments she gave as good as she got, screaming at him and using foul language. She hated this in herself. She said that both of them were keen to protect the children from this pattern, and wanted them to grow up to be considerate, decent people.

Conventional Counselling

After this initial session, I saw the couple together five times. Using narrative therapy (White & Epston, 1990), I externalised the problem as "Family Style." This was what they had to battle together. I taught them progressive muscular relaxation leading to "cue-controlled relaxation" (Bernstein & Borkovec, 1973). That is, after repeated practice, they could expect to achieve instant mental and physical relaxation upon breathing out while silently saying, "Let go!"

It turned out that Judy practised the relaxation routine every day, but Chris did not.

I also taught them the “Assertive Formula”: “When you [do something I don’t like], I feel [angry/repelled/whatever], so please [do this].” They practised it in front of me, and did so at home, at least when they remembered.

Part of their homework was to make a list of “What I do to annoy the other.” They then checked this for accuracy.

They both agreed to a contract, listing the changes they wanted to make in order to please the other, and both agreed to accept the other person as a helper in achieving the changes. This converted reminders such as “You’re shouting again” from a nag to friendly assistance. They resumed fun activities together, such as going to a restaurant as a “courting couple,” something they hadn’t done for years.

One powerful intervention was to instruct them in child-raising strategies. The unspoken, but I think understood, implication was that the same strategies should be applied to each other, not only to the children. This included concepts such as giving unconditional love to the child; disapproving of an activity or behaviour, but not the person; spending both planned and spontaneous “quality time” with the children; giving rewards (such as a smile, a cuddle, or words of praise) for good behaviour while, where possible, ignoring undesirable behaviour; never saying anything that will lower the child’s self-image; rewarding the cessation of undesired behaviour.

After mastering a variety of cognitive-behavioural tools like this, Judy and Chris reported a considerable decrease in the frequency of conflicts. During the two weeks before the final session, there had been several potential trigger situations, and yet they had avoided an argument every time. Feeling happy, we agreed to terminate counselling.

I gave them “relapse prevention”: told them that when (not if) one or both of them slipped back into the old pattern, they needed to be kind and forgiving to each other, and to themselves. If they could break a ten-year pattern, they could break a one-off backslip, as long as it didn’t act as the start of a new destructive cycle.

I also told them that it was no failure to need a refresher session some time in the future.

Couples Therapy via Hypnosis

One month later, Judy telephoned me in considerable distress. They'd had a series of major arguments, and she had made Chris move out. He was sleeping in a small self-contained flat on their property, had frequent contact with the children, but the two of them avoided each other.

We made an appointment. She came alone.

Judy told me that Chris had reverted to his previous pattern. He kept shouting and swearing at her, made belittling comments, put her down all the time. She could no longer stand the tone of his voice, even when he was angry at something or someone other than her. A few days before she'd told him to move out, a neighbour had allowed a coal burn to get out of hand and it took the fire brigade to stop the fire from endangering the whole area. Chris had shouted and sworn about the issue when he came home from work, and in automatic response to his tone of voice and body language, Judy started shouting and swearing at him.

To my surprise and delight, Judy told me that, despite all this, she still wanted to keep trying to save the marriage.

We discussed the real problem. They had both forgotten the "relapse prevention": to be kind to themselves and each other when a backslip occurred. When one of them temporarily returned to old ways of functioning, the other reverted to the old way of reacting. Judy agreed that both of them were now skilled and practised at using the various tools they learned during our sessions, but ... but with all the recent conflict, neither of them bothered to use them.

What they needed was an automatic, non-volitional reminder to react in a desired manner to a provocative situation. I suggested using hypnosis to achieve this.

Judy agreed.

Judy

We discussed hypnosis and explored her habitual use of imagery. She liked a summer beach, walking on the sand, and also being in the mountains. The automatic reaction she chose was to become calm whenever anyone in her presence became angry. She had practised yoga and meditation in the past, so I told her she would probably find it easy to go into a hypnotic trance.

Indeed, she slipped into a trance almost before I began an induction, perhaps in response to this suggestion. After the preliminaries (referring to

being in control, being able to distance and ignore any sounds, being able to move around in the chair in order to stay comfortable), I got her to concentrate on her breathing, then lifted her arm and said “Hold it” as she breathed in. The arm stayed hovering, and I used its slow descent to deepen an already good trance.

On subsequent sessions, I used a variety of other inductions. The last one, in the third hypnotic session, was for Judy to close her eyes, loosely clasp her hands, and hold her middle fingers apart. When they touched, she immediately went into a deep trance.

Deepening in every session was a walk along a summer beach, with vivid word pictures invoking all the senses. I repeatedly told her that the experience of being on the beach was always available to her as a resource for calmness and strength, even when fully alert and involved in complex, demanding activities.

Also repeated in different words were ego-strengthening suggestions such as “You are okay. You are intelligent, and attractive, and have done many good things in your life.” I placed a suggestion that these thoughts would pop into her mind whenever anyone made belittling comments to her.

We returned to the beach and associated the magic power of the sea with strength, calmness, and serenity. I gave her chosen post-hypnotic suggestion that she will be at the beach and be strong and calm whenever she is in the presence of anger from another person.

Judy had three sessions involving hypnosis, at the end of which she was able to self-hypnotise by hallucinating my voice saying the induction, and then at the end bringing her out. During the last session, I made the suggestion that she would be able to hear my voice whenever she chose to do so, but that the actual wording was hers to vary at need.

Chris

I requested an individual session with Chris. He turned up early, and was very highly motivated to do anything to resuscitate his marriage.

He also had three weekly sessions, coming at times different from his wife’s.

Chris’s story of what went wrong was very different from Judy’s. The precipitating event, according to him, was when he was about to take his little son to the circus. They were to pick up a friend along the way. Judy had to go to the shop, and asked him to wait and mind the baby while she was gone, for

about ten minutes. When she returned three-quarters of an hour later he shouted that she was “a selfish bitch” and the argument was on.

According to Chris, things didn't work because Judy still considered that their problems were all completely his fault. For example, on the way to a restaurant, she told him in the car that what she really wanted was for him to crawl on his knees, apologising to her. Naturally, this spoiled their night out.

Chris was also keen to try hypnosis as a way of controlling his automatic reactions to her provocations (from within his frame of reference). His request was touching: when she did something to annoy him, he wanted to remember that “I want her to be happy.”

When we explored his usual way of thinking, he proved to have very poor imagery, and his habitual mental state was to be busy, analytical, and practical. Not surprisingly, he found it hard to achieve a trance. In the first session, he simply sat in the chair, relaxed but alert. Nevertheless, I went through the procedure, made ego-strengthening suggestions, and placed his chosen suggestion several times in different contexts.

In the second session, he told me that there had been no opportunities to see whether the post-hypnotic suggestion had worked or not. Again, he simply sat through my spiel, clearly alert. I brought him out of the trance he wasn't in, and talked about it. He mentioned that he had a headache. So, still in the alert state, I got him to imagine the fuel gauge on his bulldozer and converted it into a pain gauge. He managed to move the needle down to a 3, then we continued talking. A few minutes later, he told me in surprise that the headache was gone.

Immediately, we tried a second induction. I avoided imagery, and simply suggested he concentrate on his breathing: “breathing in peace ... breathing out tension ...”

He visibly slumped in the chair, and I went on to ego-strengthening, and repeated his chosen suggestion (“When she annoys me, I will remember that I want her to be happy”) in a number of different wordings. However, while debriefing afterwards, he said he still hadn't been in a trance. I am sure that in fact he had achieved a light trance, but didn't recognise it as such. Part of the evidence for this is that signs of tension and stress had left his face and posture by the end of the session.

Before the third session, I obtained a “staying awake” script from a colleague, and tried it out on Chris. This is a 1,500 words long confusional technique with statements like: “This time I don't want you to try and go into a trance. I want you to try and stay awake and alert. What I want you to notice as you

try to stay wide awake is that you can be alert and yet easily drift into a very deep, peaceful state of relaxation ... You can try to stay awake as your upper eyelids continue feeling heavier, and close easily and gently all by themselves ... I want you to keep your eyes open as long as you can, but it's perfectly okay to close them if they want to close. But try to keep them open as long as they don't want to close by themselves. And you can remain comfortable having your eyelids remain either open or shut as long as you need them that way ... Trying to stay awake enables you to keep experiencing a more calm and soothing feeling of peace all over your body, from the top of your head to the bottom of your feet ..."

I kept going over parts of the script, incorporating revisions from the previous two sessions, and eventually, after nearly half an hour, he closed his eyes, his body slumped and face grew slack. During debriefing afterwards, he told me that suddenly he had felt different at that point.

Progress During Hypnotherapy

After the first pair of sessions, there was only one instance when Chris spoke roughly to Judy. She looked on this as a sign that things weren't improving, but I pointed out that one instance was excellent progress.

When Chris came for his second individual session, he told me he was back in the house. Partly, this was because Judy had caught gastro from the children who had both suffered with it, and he looked after all three of them. He had also contacted Judy's father, who visited, and had a long talk with her.

In the third and final pair of sessions, they both told me that they once more shared the marital bed, and enjoyed it. They were having fun together, and when tensions arose they handled them using the various cognitive tools they'd learned during the first series of sessions. Their chosen post-hypnotic suggestions worked for both of them.

Chris told me that there was one instance when Judy telephoned him at work and started to swear at him. He calmly told her to cool down, and hung up. She rang again half an hour later and apologised. He said, "This was a first." The remarkable thing from my point of view was that he hadn't responded in kind. When I asked him why, he just said, "I want her to be happy," but I think he didn't even realise that this was the post-hypnotic suggestion at work.

Judy is back at yoga regularly, and at last contact (a month after termination) was self-hypnotising herself daily. Chris has so far had no problems with controlling any initial angry reactions to Judy's behaviour when she annoys him.

My assessment is that hypnosis had a very useful, but strictly circumscribed, role to play: to ensure that relapse prevention occurred. The actual work of cutting long-established destructive cycles was achieved by the cognitive-behavioural therapy that had preceded the hypnotic sessions.

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THE USE OF HYPNOTHERAPY IN MORNING SICKNESS AND ANXIETY

Paul Gallacher
Medical Practitioner

The following case study is based on a client I treated whilst I was based in the Northern Territory as a general practitioner. Actual names of individuals and places have been changed.

Jane was a 30-year-old art teacher who was living with her husband Bob in Kitchler, a remote town in the Northern Territory. She had arrived recently to start a six-month relief post and within two weeks of arrival found out she was four weeks pregnant.

I was a locum general practitioner and it was in that context that Jane first consulted me. This was her first pregnancy and she was experiencing quite severe morning sickness which required hospital admission due to her state of dehydration. During the admission she appeared very anxious, yet was unwilling to elaborate on any possible factors other than “the sickness.”

Over several weeks her morning sickness and symptoms of anxiety continued. Treatable medical causes for her nausea were excluded.

In this case I decided to introduce hypnotherapy as an adjunct to treatment. Both the process and result were of significant therapeutic value to Jane and a memorable learning experience for myself.

DESCRIPTION OF PRESENTING PROBLEM

By around eight weeks gestation, Jane looked exhausted and appeared very stressed.

- She was vomiting several times a day, frequently unable to tolerate fluids, which had already required two hospital admissions. The hot north “Top End” weather was aggravating this.
- Jane stated she felt her work colleagues were being unsympathetic towards her. She had initially felt “set up to fail” on arrival as she was, according to her, perceived as being interfering every time she passed a professional opinion. More recently she had had to phone in sick and she felt this was met with an element of sarcasm and passive aggression, which upset her. She also noted feeling very anxious and tense over the previous weeks. Her sleep pattern had been disruptive, she was finding it difficult to concentrate at times and she was tending to avoid social situations, which was out of character.
- She reluctantly admitted she had found the move to Kitchler more difficult than she expected. She attributed this to the summer heat, isolation and what she called “small town syndrome”; she felt the place was full of “big fish in little ponds” and frequently seemed to find herself having disagreements with the locals over trivial things. She recalled that up till that point she had travelled widely and had always seemed able to fit in easily when arriving at new communities.
- Bob, in contrast, loved the town and Jane felt he was at times minimising her concerns. Bob had taken six months leave from his job as a public servant and she felt that this, in a sense, typified an irritating aspect of their relationship in that she was usually the main breadwinner and ended up taking less time off to relax than Bob. She noted with a sense of ambivalence that she always felt herself to be the strong one, both in the classroom and in the relationship.
- Although they were both keen to have a child and were delighted with the news, Jane did state that the timing was very bad in that she felt she did not have any supports around her.

PAST MEDICAL HISTORY

Obstetric: No previous pregnancies or abortions.

Medical: Recent gastroenteritis, no significant past illness.

Substance use: Ex-cigarette smoker of five years.

Drug use: Nil other than contraceptive pill, possibly poor absorption from recent diarrhoea resulted in pregnancy.

Psychiatric: Nil.

DEVELOPMENTAL HISTORY

Jane was born in England. Her mother had come from a wealthy background and had married a man from a much poorer family. Jane recalled a happy almost idyllic early childhood. She had a brother with whom she got on. When she was about 12 years old she won a scholarship to a private day school, which she found rigorous and challenging. "I was a straight A student," she said. Jane enjoyed the prestige, acknowledging that obtaining other people's praise had been a great motivator throughout her life. However, she soon became resentful of her family's low income, as this excluded her from participating in expensive school weekend activities such as horse riding and sailing. Around that time she developed a long-standing combative relationship with her mother.

As a teenager Jane had many male admirers and she remembered having been rather flirtatious. "I knew I was attractive and enjoyed the attention."

Jane went to university and obtained a first degree in Graphic Art. Around that time she met a lawyer with whom she had a five-year relationship. They split up: "We were too similar and he was too nice to me." Shortly after that she moved to Australia, initially for a working holiday, but she met Bob and they settled down. Both her parents lived in the U.K. and she once remarked that she was "a bit distant with them." She described the relationship with Bob as "really good," though there had been some arguments since moving to Kitchler.

PSYCHOLOGICAL, PERSONALITY, AND MENTAL STATE EXAMINATION

Jane stated she had always been prone to worrying, though never to the extent of recent weeks. At first she described her personality in rather boastful and robust terms, stating she was an extrovert and loved meeting new people. However, she later admitted to dealing with stress by avoiding the precipitant

until the last possible moment. She tended to binge eat when upset but had never induced vomiting, nor had she ever suffered from anorexia nervosa.

She presented as a rather tired looking woman, well groomed, looking her stated age, appearing anxious with mildly increased psychomotor tempo. Jane's speech was logical and sequential, with normal prosody. She described her mood as "Okay ... Well, really stressed out"; her affect was appropriate and reactive. There was no evidence of a formal thought disorder or psychotic process. She denied any self-harm ideation and appeared to have partial insight into her anxiety state.

DIAGNOSIS AND TREATMENT OPTIONS

- DSM IV Axis I: Acute Adjustment Disorder with Anxiety
- Axis II: Possible Avoidant personality traits
- Axis III: Hyperemesis Gravidarum
- Axis IV: Recent relocation to remote community
- Axis V: GAF 70 (reasonably good functioning)

Jane's case presented a number of challenges, especially considering the very limited community resources in a remote town. I liaised closely with the visiting obstetrician. Treatable causes of nausea were excluded and antenatal planning organised.

Psychological treatment options were less clear. I was aware that Jane was moving back to Brisbane in six months and felt it could be inappropriate to attempt an analytical approach, as this could overburden an already tense situation.

Jane herself was rather ambivalent regarding any form of counselling, seeing it as proof everyone would think, "It's all my fault."

Initially I found myself becoming irritated with Jane. She seemed to demand that all her concerns be listened to in every detail over lengthy consultations, yet she appeared flippant and dismissive whenever a treatment approach was suggested. With some restraint, I resolved not to react to these feelings, but instead to monitor this emerging aspect of countertransference.

Other factors that needed to be addressed were boundaries and professional privacy, both of which are often potentially problematic in a small isolated community. Bob had recently got a job in the hospital where Jane consulted and he was very popular. Many of the nurses were good friends with the teachers.

Jane was adamant, quite reasonably, that she did not wish to take any medication other than vitamins during her pregnancy.

At first, running concurrently with the weekly medical consultations, I attempted to address aspects of Jane's concerns using a cognitive approach. Whether due to her anxiety state or my lack of skill, there was no obvious improvement. "What's the point of just talking?"

I then suggested hypnotherapy, and although Jane expressed scepticism to such an extent that I almost retracted the idea, she was surprisingly keen to experience a hypnotherapy session.

HYPNOTHERAPY SESSIONS

Assessment and Preparation

Despite her scepticism, Jane did appear to have a number of favourable factors. She read widely and appeared to have a rich imagination, and as an art teacher she would have a refined sense of imagery. Having already consulted me for several weeks there was already some degree of rapport. She was also proud of her ability at goal setting. There was no evidence of a psychotic disorder or any other contraindication.

Jane was given a simple ideomotor-motor visual suggestion of a balloon gently lifting her right arm, which she fully experienced. This gave her a sense of achievement and also helped assessment of her hypnotisability.

I also asked her to imagine eating a lemon, using all senses, and again she experienced quite a vivid response with both facial grimacing and some salivation.

Jane asked me a list of questions about hypnosis and some misconceptions were addressed. A basic explanation of the hypnotic phenomenon was presented with the concept of a powerful deeper unconscious mind introduced.

Session 1

Although rather anxious on presentation, Jane was reassured and a permissive induction was given in the form of a modified eye fixation. This was followed by a counting down deepening technique.

An indirect ego-strengthening series of suggestions was given, followed by a permissive visualisation to a "place of serenity" where "you can receive what you most need right now." She appeared extremely relaxed and was advised to return to normal consciousness when she was ready. Post-hypnotic suggestions were also given to the effect that she would easily be able to return to that

relaxed state, and also that her nausea would greatly diminish. She opened her eyes after about a further five minutes and looked refreshed.

Feedback from Jane confirmed these observations. She felt she had “really gone somewhere” and was keen to have further sessions. She did comment that she found the counting down deepener irritating as the count was too slow: “I was at 2 but you were still at 7”. Further deepeners were of stairway images with no counting.

Further Sessions

The second session three days later was similar to the first, though ideomotor signals were set up to obtain feedback regarding pace and verification that key suggestions had been accepted.

The symptoms of morning sickness were addressed both in specific suggestions, specific visualisations (a nausea dial that she could control), and in a post-hypnotic suggestion that if nausea did occur it would be rapidly abolished by a hand signal. Feedback was encouraging and her nausea had dramatically reduced within a week of therapy.

Once the nausea reduced to only a minor infrequent symptom, sessions occurred approximately weekly. One session was taped and Jane was encouraged to practise self-hypnosis every day. Over the following fortnight she noticed a marked decline in feelings of anxiety and was able to concentrate more.

As the nausea receded, Jane was keen to experience some hypnosis in preparation for labour, and from around 16 weeks gestation onwards sessions were inclusive of this. Although initially I believed this was starting preparation for labour rather early, in many ways these sessions had the additional effect of supplying her with the reassurance and support she missed from her friends in Brisbane.

Sessions included guided imagery of contractions as ocean waves, which Jane could enjoy surfing on, arm rigidity as a powerful demonstrator of hypnotically enhanced strength, and visualising the body in labour as a large coffee plunger, which could be controlled with ease. She was able to experience glove anaesthesia. Dissociative phenomena were also elicited on several occasions when she had a real sense of being out of her body. This skill was especially useful when she experienced low back pain later in pregnancy.

Although I believed a significant part of Jane’s tendency to experience at times quite intense anxiety stemmed from her childhood, her personality

structure, and certain life beliefs she held about herself and others, my instinct was to concentrate mainly on ego-strengthening and gentle “safe place” permissive sessions rather than risk a more analytical approach.

Sessions continued weekly and her self-hypnosis skills, which she practised daily, were developing quickly.

I began to notice Jane started “owning” the sessions more. She had had some books on hypnotherapy sent up from Brisbane and wanted another tape made with additional affirmations and suggestions she had constructed. Some of her suggestions appeared extremely insightful when compared with her first presentation: “I am strong and accept help from others”; “I anticipate harmony and respect at work.” Apparently she was getting on much better with her colleagues at school as well as with Bob. She had experienced age progression hypnosis regarding a harmonious labour and had used the same principles in self-hypnosis to visualise a harmonious workplace where she “saw” herself addressing potential discourtesies at work in a controlled manner without becoming anxious or aggressive.

Jane also reported visiting “the garden of serenity” every day and entered into dialogue there with a female figure she had visualised to represent “the wise woman in me somewhere.” One evening in this setting she recounted she had a spontaneous dialogue with this figure and that she had intuitively appreciated for the first time that her own approaching motherhood had stimulated a lot of buried resentment about her mother. Jane said she felt like two people. One was the child resenting her mother for somehow being responsible for her being the poor kid in the class. However, she could also appreciate the situation from the adult prospective and felt “a huge wave of compassion for both my younger self and my mum.”

At 26 weeks gestation Jane and Bob moved back to Brisbane as originally planned. Both were very much looking forward to the birth of their first child. Jane stated she had found her six months in Kitchler rewarding and that she had learned a lot about herself.

Later on I received a call from Jane. She told me she had implemented the labour hypnotherapy techniques with good effect, had had an uncomplicated labour, and had given birth to a healthy boy. She mentioned that she was in more frequent contact with her parents and that they were coming out to Australia for the first time in the near future to visit her and the family.

CONCLUSION

As a GP recently trained in hypnotherapy, I learned a great deal from this case:

- Hypnotherapy does not have to be complex to be effective.
- Hypnotherapy can empower clients by encouraging them to take an active collaborative role in their own therapy and to learn new skills that can later be adopted for different situations.
- The case was an apt reminder to me of the importance of being aware of and monitoring one's own feelings towards clients, especially initial negative ones, and to use that awareness insightfully.
- Clients frequently have misconceptions about hypnotherapy. However, for some it does offer fresh hope. It is often seen as a "doing" rather than "just sitting around talking" form of therapy.
- Hypnotherapy proved a very useful adjunct to management when drug use is hazardous, such as with the possibility teratogenesis.
- Rather than the hypnotherapist aiming to uncover suppressed conflicts directly, it is often more appropriate to help the client develop states of deep relaxation. This can serve as a conduit to subconscious conflicts, which can be brought to consciousness in a safe way congruent to the client's current psychological state and resources.
- It is important that the hypnotherapist inspires in the client a sense of positive expectation. For the fledgling hypnotherapist it is easy to react adversely to a client or even a colleague's sceptical remark or opinion. In this case I experienced a growing sense of confidence from the feedback I received from Jane. I found that one of the most powerful means of enhancing a client's sense of expectation is by nurturing one's own feelings of enthusiasm, confidence, and expectation.

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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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