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## EDITORIAL

### Journal's Journey

Recently, I had reason to ask Barry Evans about the name changes made to the AJCEH over time. He advised me that from 1973 to May 1974, it was known as the *Australian Journal of Medical Sophrology and Hypnotherapy*; between then and December 1977 its name was the *Australian Journal of Clinical Hypnosis*, and from 1997 on it was known as the *Australian Journal of Clinical and Experimental Hypnosis* (AJCEH).

As indicated by recent practice, within the two issues of AJCEH each year there is often a movement between one that is more scientifically oriented (although it still has a practice focus) and an issue within which the content is more practice focused. And thus it is with the previous issue and the current one.

This edition contains a range of practice material including case studies, case notes, scripts, and reviews. Some of the longer standing members of ASH have contributed to this edition, with Wendy-Louise Walker sharing her experience over many years in pain management, while Eugen Hlywa stretches us with his view of the benefits of hypnotic rest and Norman Shum reveals that robots can change lives.

Paul Schenk opens up the possibility of using hypnotically facilitated pseudo near-death experiences for positive change and Ramony Chan, who wrote for us recently on phantom limb pain, assists us to understand how hypnosis can assist recovery from PTSD.

Kathryn Tiffen unfolds the tale of treating a young boy who was depressed and had sleeping problems and Maria Nolan demonstrates that hypnosis enhances the use of CBT in treating anxiety, while Janet Rogers gives us another case study on hypnosis in the treatment of social phobia.

Helen Rowe gives an interesting script on disabling disability, we can read Kathryn Tiffen's script that is linked to her case study, and if you have been waiting for the final script from Allan Cyna and colleagues on birthing it is included.

*Kathryn M. Gow*

## Letter to the Editor

Dear Kathryn,

What a great issue of the *AJCEH*. It is very solid and interesting. I read it from cover to cover!

My purpose in writing this is to express my pure joy in reading Harry Stanton's piece on the essence of therapy. Getting a bit long in the tooth myself, I have come to feel that therapy is best practised by just being myself, while I focus on the unique person in front of me. While I did benefit from learning all the systems of therapy in those early years and emulating a few practitioners that seemed to have it, it is really much simpler — as Harry so eloquently wrote.

The question is how to teach our younger colleagues what we have learned or is it just a good road map pointing out the eventual goal in their becoming ...

Regards,  
Peter Bloom

## WAKING DREAMS: HYPNOTICALLY FACILITATED PSEUDO NEAR-DEATH EXPERIENCES

Paul W. Schenk

Private practice, Tucker, Georgia

*The literature on near-death experiences is consistent in describing how such events are typically transformative. Utilising standard hypnotic techniques, therapists can approximate many of the therapeutic aspects of such experiences, without the life-or-death crisis, to facilitate both first and second order change in psychotherapy. This article explores the use of hypnotically facilitated waking dreams as an interactive projective technique. The focus is on the varied ways that the dream components which correlate with near-death experiences can evoke durable change.*

The literature on near-death experiences (NDEs) is consistent in describing how such events are typically quite transformative (Moody, 1991; Ring, 1980, 1984; Sabom, 1982). The attractiveness of a single event growth experience such as an NDE was the basis of the 1990 movie *Flatliners*. In the movie, a group of curious medical students use technology to artificially induce near-death experiences in each other. Unlike the medical students in *Flatliners*, of course, psychotherapists are not free to induce literal NDEs. However, hypnosis provides a tool that allows them to come much closer than might seem obvious.

This article explores the use of hypnotically facilitated waking dreams to approximate many of the therapeutic aspects of NDEs without the patient being in a life-threatening situation. For two decades, the author has helped patients utilise trance phenomena in a variation of Sacerdote's induced dreams (Sacerdote, 1967). Instead of discussing the patient's recall of night-time dreams, the author works with dreams that are generated by the patient's unconscious during the therapy session, while in the trance state (Schenk, 1999, 2006).

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This article is an updated and condensed version of an article originally published in the *American Journal of Clinical Hypnosis* in 1999.

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## WAKING DREAMS

In waking dreams, as in Sacerdote's induced dreams, the hypnotised patient can be said to be dreaming while conscious. He or she actually *experiences being someone else* in the dream, with all of that person's values, beliefs, emotions, and self-perceptions. The differences in these aspects of personality from the patient's everyday personality can be striking.

Initiating a waking dream in trance is straightforward. After induction has been accomplished,<sup>1</sup> the patient is asked to imagine being in a movie or story whose main character's life will contain experiences which the patient will find clinically relevant. For example, the therapist might say, "As you continue to relax and go even more deeply within, you might find yourself beginning to imagine being someone in a movie; a person whose story will contain experiences that will be *safe, constructive, timely, and useful* for you in your own life." While more specific suggestions can be offered, the risks of biasing or confounding the process are minimised when the therapist is as non-specific as possible. One way of phrasing this opening suggestion is to ask the patient's unconscious or higher self "to generate a story [perhaps from another time and place] in which the events will provide you with greater understanding [of the presenting problem] that will be safe, constructive, timely and useful in helping to resolve [the presenting problem.]"<sup>2</sup>

In practice, the movie/dream is almost always experienced in the first person rather than the third person, so the dream is richly emotional and not just a cognitive experience. In fact, when the patient does experience the dream in the third person as an observer, it seems to serve a protective function analogous to the screening room dissociative technique sometimes used when

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<sup>1</sup> As used here induction is meant to mean whichever permissive process the therapist employs to facilitate development of the kind of altered state associated with trance. Deep trance is not needed.

<sup>2</sup> For years I have used a variation of the "hallway of doors" induction for this purpose. The client walks down a hallway lined with doors corresponding to each year in his/her life. At the end of the hallway, beyond door #1, it opens into an atrium. It can be an indoor or outdoor place endowed with qualities that make it feel exquisitely safe, peaceful, etc. A suggestion can be offered that there are numerous other hallways branching off from the atrium, analogous to corridors in a large movie theatre. To initiate a waking dream, the client can let his mind/unconscious/higher self select one of the other hallways. On entering that hallway, like entering one of the theatre's screening rooms, the waking dream will begin.



dealing with traumatic memories.<sup>3</sup> Note that waking dreams are not used to access real memories from childhood. Indeed, if a history of childhood trauma is suspected, any use of hypnosis must be undertaken with considerable caution (see Brown, Schefflin, & Hammond, 1997).

For some, the dream begins with an experience of being a child. For others, the person is already an adult. The age at entry point is not critical. Because the dream content is defined as fictional, it is even workable to have the patient intentionally make up an initial scene. Most waking dreams follow a chronological progression over the life of the main character, although sometimes events are experienced out of sequence. If emotionally intense content is encountered, it can be handled using a variety of standard trauma treatment strategies such as the screening room technique.

When the life of the person in the dream seems to be nearing its end, the therapist can suggest, “If it is okay, I’d like to ask you to move ahead in time to the end of [this person’s] life.” If needed, additional anchoring suggestions can be offered such as, “You might notice the circumstances, where you are, whether anyone else is present, or what is happening.” In practice, an actual death of the person is seldom suggested, and the specifics of how the person in the dream dies is never suggested. When invited to explore the final part of the life of the person in the dream, most patients spontaneously include the death of the person. The author has found that it is rare that he has to intervene as the “character” dies. Patients rarely report emotional distress of such intensity that they are reluctant to let the process continue.<sup>4</sup> Without any suggestion on the author’s part, most clients spontaneously report moving out of the person’s body (OBE — ot ut of body experience) when he or she dies. The rare patient who seems to be in distress (acute anxiety symptoms) can be invited to view what is happening to the person “from a safe distance.” This is more likely to happen if the death was violent or the result of an accident such as a drowning. In such situations, the use of hypnotic treatment techniques for titrating affect is helpful. I typically remind the patient that he or she is physically safe in the office, and need not experience, in the physical body, any discomfort that is

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<sup>3</sup> In the screening-room technique, the patient is typically asked to imagine being seated in a small theatre, sometimes with the therapist present. In front of the patient is a control panel similar to a VCR remote device. As the patient relives some memory, he or she can use the controls to do what a VCR remote can do: fast forward over a difficult scene, pause the action, advance it in slow motion, mute the sound, etc.

<sup>4</sup> As a part of routine intake procedures it is advisable to discuss with patients the risks associated with any proposed treatment plan.

happening to the body of the character in the dream. Suggestions such as this serve to quickly abate acute anxiety symptoms.

## **NDE CORRELATES**

When my therapy patients experience the death of the person that they were in a waking dream, they report experiences very similar to those reported in the NDE literature (e.g., Ring, 1980; Moody, 1977). These occur independent of either the person's religious background or prior knowledge of NDE phenomena. Not all of the phenomena are experienced by each patient, but the pattern includes the following effects:

1. Patients report a sense of floating out of the body (OBE) at the moment of death. They typically report looking down at the body.
2. Patients report an intense calm, tranquillity and/or peacefulness. While the intent of waking dreams is not to deal directly with the patient's belief system about death and dying, such experiences seem to have an implicit impact, independent of the person's religious background.
3. They are able to engage in a life review experience in which they survey the dream character's life.
4. For many, if not most, there is a sense of the presence of a guide or angel or significant other person who facilitates the life review and helps provide important insights or perspectives. This non-judgmental interpersonal hypnotic experience is quite a contrast for patients who have a long history of being criticised both by others and by their own superegos. The willingness to be introspective is enhanced by this complete absence of any judgmental tone to the experience.
5. Some report profound experiences of insight, unconditional love or forgiveness by self and/or by these guides or angels or "God." The author emphasises care in letting the patient define this experience, avoiding superimposing his or her own beliefs, labels or interpretations.

## **WORKING WITH THE DEATH OF THE PATIENT IN WAKING DREAMS**

At the exact moment in the dream when the OBE transition occurs at death, many patients report a significant shift in how they feel. This is particularly true if the death was secondary to some kind of accident or other trauma. Independent of the nature of the death, they report feeling very calm, tranquil,

at peace, etcetera. Because this part of the experience is so consistently associated with the absence of any judgmental tone or attitude, it lends itself as an emotionally safe environment within which the patient may review and self-critique the dream content. As is the norm in the NDE literature, patients seem very open and non-defensive as they explore the content and implications of the dream content from this OBE perspective.

The exploration may be done in a variety of ways:

- The patient may review major decisions or conclusions, especially those made at the very end of the life.
- The patient may notice pre-existing assumptions which were found to be invalid in the dream content.
- Analogous to colour anchoring,<sup>5</sup> the patient may establish an operant conditioning signal based on the dream to be used in the future to facilitate a desired behavioural change.
- Based on the life outcomes of the dream content, the patient may return to a critical decision point, enact a different choice, and live out the consequences of this new alternative as a way of experimenting with new solutions.
- After the death of the person in the dream, the therapist can propose a dialogue between the person and the patient. The OBE person can be asked if he or she has any suggestions for the patient regarding the patient's own presenting symptoms based on the life experiences from the dream.
- The therapist can use a split-screen image to suggest that the patient notice correlations between the dream life and the patient's own life. Many patients will report personality parallels between other people in the dream life and current relationships in the patient's life. These can be worked with in various ways to tease out faulty assumptions, to reframe aspects of the relationship, or to dialogue with the people involved in the dream about alternative solutions to the problem.
- If the presence of guides or angels is experienced, the therapist can focus on the emotional healing potential of a relationship which has unconditional positive regard as its foundation.

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<sup>5</sup> To help a patient deepen trance the therapist may have him or her notice a colour in the internal imagery which symbolises the tranquillity or peacefulness he or she is experiencing. Then, while remaining in trance, the patient is asked to open his or her eyes and find something in the room which closely approximates that colour. When it is found, the suggestion is offered that, "when your eyes close, you can let your mind carry you twice as deep into trance."

## **CASE EXAMPLES OF THE CLINICAL APPLICATIONS OF WAKING DREAMS**

The remainder of the article explores applications of these possibilities.

### **Case 1: Patient Review of Major Decisions or Conclusions Which Are Relevant to His or Her Presenting Problems**

After the person in the dream has died, the therapist can suggest, “Notice any final thoughts or decisions you made just before you died.” These very often have an obvious connection to one of the patient’s presenting issues. As a part of this review, I suggest that the patient have a dialogue with the person (who just died). Functionally, the review and dialogue seem to provide the patient with an internally generated way to reframe the presenting problem. In turn, this allows new solutions to emerge. Because the dialogue/critique is internally generated, I find that the patient rarely evidences resistance to the content.

One female patient, an only child, reported that she was able to be compassionate at work, but did not fare as well in her personal relationships. In one of her waking dreams she experienced herself as a young woman, “Janie,” who eventually murdered her younger sister out of jealousy over a man she loved and adored. Soon after, she took her own life with an overdose of sleeping pills. The story had clear parallels for the patient regarding her own theme of still searching for someone whom she could similarly love and adore. For the next several therapy sessions, Janie and the patient continued to periodically dialogue about their respective experiences. In this symbolic way, the patient as Janie was able to work on several important personality traits including stubbornness, feeling “owed” by others, and problems with compassion for others. Janie agreed to serve as a behind-the-scenes coach for the patient. Whenever the patient was acting “bull-headed,” Janie would signal her with an agreed-upon visual cue (an operant conditioning cue). Immediately following those sessions, the patient reported experiencing the agreed-upon cue on a number of occasions. She concurred that her behaviour at those moments was indeed stubborn or bull-headed. The cue gave her an opportunity to shift her emotional posture in those situations. She reported having received positive feedback from friends and co-workers regarding the changes they had observed since then.

## **Case 2: Assumptions the Patient Finds Are Invalid as a Result of the Waking Dream**

One male patient from a Jewish background had grown up with the belief that women possess magic and men do not. Therefore, he believed that in order to have access to it, a man has to be close to a woman. As a result, when the patient found himself between relationships, he experienced considerable anxiety. In his waking dream, the man experienced himself as a nun who lived her life in a convent. Even as a child, the woman had understood that her father was afraid of power and of misusing it. He had brought her to the convent, in part, so that she might pray for family fortune, the success of people close to him, etcetera. As might be expected, her early memories of the convent were of feeling excluded from the world outside.

As the dream continued, the patient reported a major shift: the young woman had experienced separation as a kind of exile, but suddenly had the experience “that God missed me.” The patient periodically interjected his own observations about correlations between physiological aspects of the hypnotic experience and memories of some of the Psalms from the Old Testament which had long held meaning for him. As he experienced being the nun, he described a kinaesthetic sense of his throat area knowing what was true (“love”), as contrasted with his mouth area (“fear”) which he described as trying to dismiss what he was experiencing. He reported being quite moved by the parallels between his emotional reactions to the old Psalms, the young nun’s emotional experiences as she prayed, and his own physical reactions. In this context the nun commented at one point “All songs are the same song.”

When I asked if the patient was willing “to explore the rest of [the nun’s] life,” he briefly reported on the tone of the nun’s adult life, and then had a spontaneous OBE experience following her death. The nun, who had since become the Mother Superior of the convent, found herself talking with Jesus and Mother Mary. In a dialogue involving the patient, the nun and the other two, the patient reported further insights. He had seen magic as something external to himself; something you have to go and find and then get incorporated into *it*. As the nun, he had the experience of having created a space *within himself* into which the magic could enter. He also suddenly had the realisation that power is just another form of magic. Taken together, these insights served to shatter his (faulty) assumption that only women could have magic (i.e., power). As he internalised these experiences and insights, he reported being “flooded with light.” Following the trance work, he commented about the power of the contrasts of the two religious traditions,

but even more so about the masculine–feminine contrast. He commented again about the “aha!” shift from perceiving power as something external to something internal.

### **Case 3: Creation of an Operant Conditioning Signal Which the Patient May Use to Change Target Behaviours**

One patient who was working on issues of jealousy had a waking dream in which she lived a royal life, but was married to a man who was blatantly unfaithful to her. For a number of years she was angry, jealous, and vengeful. Eventually, she turned her attention in mid-life to an enjoyment of nature. She spent time travelling and enjoying the out-of-doors. An unintended consequence was that her husband found her much more pleasant to be around and began joining her on her trips. Following her death, the woman began a dialogue with the patient at my suggestion, offering to help the patient as she works on her own jealousy. The two of them agreed to use an image of “an October blue sky” as a signal to help her recognise when she was beginning to act in a jealous manner. This colour anchor would also serve as a quick relaxation response, enabling her to re-focus on other aspects of her life and relationship with her boyfriend. (In her real life, there was no indication that her boyfriend was being unfaithful to her.)

### **Case 4: Behavioural Rehearsal of an Alternative Solution to the Major Problem in the Dream Which Recreates a Presenting Problem or Dynamic**

“With what you have learned, if you could live this life (in the dream) over again, is there anything you would change?” If the patient indicates something he or she would change, the therapist can suggest, “If you’d like, imagine what it would be like to go back to the moment when you would change what you did. Notice how things turn out doing it this different way.”

One female patient reported a history of holding back emotionally in relationships because of having been hurt in prior ones. As a young adult woman in one of her waking dreams, a man with whom she was very much in love left her to follow his career calling. A few years later she met a man whom she eventually married. Throughout the remainder of her life, however, she was aware of never fully opening up to his love for her. Following her death, she reviewed this choice with considerable regret. I suggested the idea of returning to the point in her life when she decided not to risk being fully

open with her husband. She did so, this time choosing to be fully open in the marriage. In the dream, she then re-experienced the life having made this choice. Following her death once again, she contrasted the two life experiences. As one might expect, she had a clear preference for the second alternative. I then suggested that the patient and the woman in the dream talk with each other. As they talked, the woman found that she could remember what she had learned from her previous relationships, and use it to help her make even better choices in the present tense, without having to hold on rigidly to the decision made years before that she would hold back in future relationships in order to never be hurt that badly again. The dream content seemed to provide her an emotional, experiential affirmation that it would be worth the risk of being more fully open in her current relationship, beyond what any cognitive rationalisation alone could provide.

### **Case 5: Internally Generated Solutions While in Trance That Bypass the Patient's Normal Ego Defences**

As an example of therapeutic dialogues between the patient and the dream figure, one patient reported the person in the dream playfully advised her to “lighten up!” and not take things so seriously. This was similar in function to the two patients described above who created internally generated operant conditioning cues to stem moments of stress.

Another patient met a spirit type figure in one dream who cautioned that her efforts to help her aging mother were well-intentioned but misdirected. She was given concrete suggestions about ways she might redirect those efforts that would not only be more helpful for her mother, but would help the patient get unstuck from some of the longstanding dynamics in their relationship. Because of the loving, non-judgmental tone of the figure, she was able to internalise these much more easily than might have been the case in traditional cognitive therapy. In the months which followed, she began implementing the suggestions with gradual improvement in their relationship.

### **Case 6: Emotional Healing Facilitated by the Trance Phenomenon of Contact With an Angelic Being (Unconditional Positive Regard)**

One of the more profound aspects of the death experience which patients report during waking dreams is the NDE equivalent of the sense of being in the Light, or in the presence of some kind of guide or angel or spirit. In my

experience, this occurs spontaneously for the large majority of the patients. If it does not happen after the character has died, the therapist can make a comment such as, “If you turn around, notice what you see. Let me know whether you become aware of something or someone you had not noticed before.” At this point, most of the few who have not already begun to have this experience report seeing a light or someone coming towards them. Patients report that the emotional concomitants of this are almost always very positive. There is a complete absence of judgment, combined with a wonderful sense of unconditional acceptance. To the extent that one of the goals of therapy is to create for patients this kind of corrective emotional experience, I have found this part of the waking dream experience to be particularly helpful. This is especially true for patients with overly critical superegos or years of unresolved guilt, and a series of these experiences in trance can be part of their gradual transformation of self-perception and self-worth. At this point in the experience, it is common for patients to cry tears associated with such emotions as joy, relief, and feeling connected.

One patient who was wrestling with sexual identity issues had a waking dream in which the woman she was died while lying in a hospital bed. She reported, “I am lying in the bed. The walls look kind of tan, the light is low. It is peaceful, quiet, like the sound is shut off. I’m just looking at the ceiling, at those foam squares with the little holes in them. I’m not thinking much about my physical life. I’m just enjoying the room. It’s so quiet. I’m not thinking about life being over because it’s really not anyway. It’s like you take a taxicab and you get out and you’re somewhere else like at the museum, so you’re not really thinking about it.”

A moment later she added: “I’m trying to go back in [the body] and I can’t. It’s like I’m looking at the top of the head and I’m trying to go back in, sort of, but I can’t. It’s like a brick wall now. When the light comes I don’t see the room anymore, I just see the light. That’s kind of funny. I see a bunch of people floating around. This one is funny because she’s wearing something like a sweatband. She has pretty long blond hair with curls. She looks like an angel, but she’s wearing a sweatband. I can’t see the face very well. It is kind of distorted. It’s a ‘she’ and she has very pretty hair, long and curly.”

The angel then helped the patient review the life of the woman. The patient reported the following messages as she sought to understand the meaning of what was taking place: “To learn about loving unconditionally. [Pause] To find strength, to endure, to be strong, to have faith. She [the angel] is just saying all these things. That was weird: For just a second I relaxed and it felt like I wasn’t



saying it ... They are here anyway [the angels]. [Laughs] It feels like there are more than I have met. Like there's a whole bunch of them, all warm and fuzzy. They said [laughing], 'Yea, they love me very much' ... They feel tingly. Mostly my arms from my elbow up to my shoulder as if I have a big, warm, tingly blanket around me. That way I can feel them as if they're standing all around me ..."

This kind of unconditional love and support stood out in marked contrast to the patient's childhood experience of religion and religious schooling, which had been quite harsh and constricting. It provided a first, richly emotional experience indicating that exploring the spiritual dimension of life might be worth a second chance, despite the negative history she had had with organised religion as a child.

## **CONTRA-INDICATIONS FOR THE USE OF WAKING DREAMS**

The same general cautions that apply to the use of other fantasy or imagery tools are applicable here. The use of waking dreams may be ill-advised with patients who have difficulty distinguishing between fact and fantasy. Patients who already escape into fantasy too often to cope with stress may be poor candidates. Patients with a dissociative history such as in dissociative identity disorder (DID) may find the experiences too threatening or disorienting because of the tendency for altered states to weaken or lower the protective barriers of dissociative amnesia. Because of the common assumption by patients that hypnosis involves surrendering control to the therapist, patients who have experienced a significant abuse of trust (physical, sexual, emotional, etc.) may not be good candidates for this (or any) hypnotic work until their trust of both the therapist and hypnosis reaches a higher level.

## **SUMMARY**

The techniques involved in the therapeutic applications of waking dreams are straightforward extensions of standard hypnotic principles combined with dream interpretation, trauma treatment strategies, strategies used in cognitive therapy and family/systems therapy, and having a basic understanding of OBE and NDE phenomena. A single such hypnotic experience does not produce the intensity of second order (personality) change which characteristically follows a true life-threatening NDE. Yet based on two decades of reports from my own patients and a growing body of research (e.g., Almeder, 1987; Lucas,

1993; Stevenson, 1977), I continue to find that a series of such experiences can have real therapeutic impact on a variety of presenting issues. Although not a focus of this article, waking dreams can also be applied to specific Axis I target symptoms such as fears, phobias and other symptoms of anxiety or depression. As discussed here, waking dreams can have important impact on the patient's understanding of personality, existential and spiritual issues. I recommend further investigation of the replicability and therapeutic potential of these hypnotic techniques.

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## **A CASE STUDY OF CHRONIC POST-TRAUMATIC STRESS AND GRIEF: HYPNOSIS AS AN INTEGRAL PART OF COGNITIVE-BEHAVIOUR THERAPY**

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*Post-traumatic stress (PTS) at a chronic level complicated by the presence of chronic grief resulting from the trauma presents a challenge to any clinical interventions. As an integral part of cognitive-behaviour therapy (CBT) for treating chronic PTS and grief, hypnosis could be utilised as a vehicle for the treatment delivery and enhancement of treatment efficacy due to its unique therapeutic phenomena. The following case study therefore addresses the application and effectiveness of hypnosis in combination of CBT for the treatment of chronic PTS and grief.*

DF, a 64-year-old gentleman married with children, was referred by his nephrologist for distressful memories relating to a motor vehicle accident (MAV) which resulted in the death of his daughter, called Q hereafter. At the assessment, DF revealed that his wife had instigated the referral due to concerns about his wellbeing. He was, nevertheless, willing to seek professional help on this matter.

### **PRESENTING PROBLEMS**

Upon the clinical assessment, DF presented with two problems: a recent intensification of the persistent stress relating to the MVA and insomnia. Since the MVA, DF has been experiencing recurrent, yet not-frequent, dreams and memories of his deceased daughter. These symptoms, which had been causing physical exhaustion in DF, had intensified and become more frequent since his recent retirement. In general, DF would be easily saddened by the memories, either pleasant or unpleasant, of his deceased daughter or by any conversation

about her. Irritable mood, distress, and avoidance of the road where the MVA happened were also reported.

DF has suffered from insomnia for about five years since he was diagnosed with sleep apnoea for which he received medical treatment at the time. His insomnia had worsened lately, in that he was no longer able to fall back asleep when awoken. Also, throughout the night he would start to ruminate on the memories of Q and the MVA, whereas in the past his worries were mostly work related.

### **Clinical Presentation and Personal History**

DF presented as a well-groomed elderly retiree of medium build with grey hair, dressed in a short-sleeved shirt and shorts with long socks, and wore glasses. During the assessment, DF appeared to be cooperative, pleasant, and approachable.

DF had been married for 36 years and lived with his wife. DF had one son and two daughters including Q, who had been the elder of the two. His son was studying at a prestigious academy and his surviving daughter was living in Melbourne. DF reported that his relationships with his wife and children had been good and that he maintained frequent contact with his children. Q was born with a congenial heart disease, twisted feet and a high palate that caused speech problems. She was operated on at two months of age. At the age of nine, she received further corrective surgery. She died in the MVA at the age of 11. At the time of the MVA, DF was driving a car following his wife's car that also contained all of his children. He witnessed the accident unfolding in front of him through his car's windscreen and he once likened the experience to watching a movie.

DF had few close friends whom he enjoyed spending time with. Some, who were older than DF, had died. DF reported that since his retirement he had maintained an active lifestyle, attending various activities including workshops, gardening, hunting, and fishing. He also received considerable social support from his family and friends. DF's childhood was, in general, pleasant without major trauma or psychological problems. He did, however, describe his father as a traditional and dominant male with whom he had a poor relationship.

DF suffers from hypertension, Type II diabetes, a stent in his blocked coronary artery, and declining renal function. His medications included Pressin 5 mg, Diabex 500 mg, Aldactone 25 mg, Avapro 300 mg, Dapa-Tabs 2.5 mg, Norvasc 10 mg, Noten 50 mg, Aspirin 300 mg, Tritace 10 mg, Novorapid 100ml, and Monotard 100ml.

Although DF reported no history of any psychiatric problem, his description of his experiences after Q's death, including increased arousal, avoidance, and re-experiencing the trauma in memories and flashback, were characteristic of symptoms of post-traumatic stress disorder (PTSD) (APA, 1994). His symptoms appeared to be at a severe level for about two years. DF gradually learned to manage the symptoms by employing coping skills comprising distractions, rational thinking, and focusing on his work.

When the extent of his grief over Q's death was being assessed, DF denied that he had suffered from such grief. He felt that he had not grieved for at least two reasons. First, his daughter would have died sooner or later, if not in the MVA then maybe through her medical problems. Second, he was not responsible for the accident and had done everything he could to help Q.

DF reported that in 1975 — prior to his daughter's death — he saw a hypnotherapist, at the suggestion of a friend of his wife, for about eight sessions for relaxation training. The experience was described as beneficial. DF had also read books on hypnosis and practised self-hypnosis for some years. DF, however, was not sure if he still practised self-hypnosis after the MVA.

## **CLINICAL FORMULATION**

DF was diagnosed with post-traumatic stress (PTS), chronic type at the time of the assessment. PTS is defined as persistent stress experienced subsequent to a traumatic event, with symptomology resembling PTSD yet without its debilitation (Rothschild, 2001). DF's clinical presentation of PTSD matched the three broad categories of symptoms used for the diagnosis of PTSD — the re-experiencing the event, avoidance and numbness, and physiological hyperarousal (APA, 1994) — at a moderate level. It appeared that his PTS symptoms had been well managed for many years, through the use of his several coping skills, until the recent relapse which coincided with his retirement. DF's PTS was viewed as chronic and moderate, because of its long duration and moderate level of interference to his life and overall functioning at the time of the assessment. However, the intensity of his PTS symptomology had increased recently, possibly due to his recent retirement and subsequent changes in his lifestyle.

Although DF denied his grief over Q at the time of assessment, circumstantial evidence suggested otherwise. DF had had constant memories and dreams about her since the MVA. And he felt very distressed and saddened whenever Q was talked about, as was evidenced during the clinical sessions.

In fact, his avoidance of the memories of Q was apparent and he would not tolerate any conversation regarding her. These observations pointed towards DF's unresolved grief, which might be further exacerbated by the loss of work which in turn might have led to a loss of effective coping strategy and the loss of purposeful life. Therefore, it was hypothesised that DF suffered from chronic unresolved grief exacerbated by recent losses and changes in his life.

### **Suitability for Hypnosis and Application of Hypnosis to the Conditions**

The appropriateness of the use of hypnosis in the case of DF was supported by his previous hypnosis training, his practice of self-hypnosis for about six years with great benefit, and the absence of any contraindications. Although no formal hypnotisability test was conducted, his hypnotisability was believed to be satisfactory given that he had had years of experience in self-hypnosis and that he responded satisfactorily to pre-induction suggestions, which were waking suggestions mimicking the types of behaviour commonly elicited under hypnosis (Udolf, 1981).

The literature shows that the recent effective treatments for PTSD are prolonged exposure (PE) and cognitive processing therapy (CPT) (Resick & Calhoun, 2001). Both treatments require individuals to be exposed to the original traumatic event for a relatively long period of time. CPT further stipulates that new information incompatible with the fear structure must be provided to assist individuals in forming new memory and to resolve any conflicting or distorted trauma-related cognitions. Therefore, careful reconstruction, exposure, and reinterpretation of the trauma are essential components of successful treatment.

Hypnosis is considered an effective vehicle for delivering and enhancing these two treatments, especially for individuals with high hypnotisability, because of its unique therapeutic phenomena, including: influencing attitudes, altering sensory perceptions, affecting affect and cognitions, and facilitating individual conviction in experiences (Barabasz & Watkins, 2005). Through hypnosis, every facet of the original trauma would be vividly reconstructed and re-experienced. The use of hypnosis would then facilitate other treatment components consisting of searching for new information regarding the trauma, restructuring the trauma memories, and resolving their cognitive conflicts or distortions. Furthermore, new meanings regarding the trauma created during the treatment process would be submitted to DF in hypnotic suggestions.

The application of hypnosis integrated with CBT is predicted to facilitate and fasten the therapeutic process. Furthermore, in DF's case, exposure treatment was still considered effective and necessary, as his recent re-experiencing of the MVA was fragmented and was not processed meaningfully.

In regard to DF's grief, hypnosis is often regarded as an ideal means to provide individuals with the opportunity to meet the deceased person and achieve a closure to their bereavement (Andreas & Andreas, 2002). It was also predicted to be a useful tool for testing the hypothesis regarding DF's grief by observing his responses when re-reliving his experiences with his daughter during hypnosis.

### **Hypnotic Techniques**

Progressive muscle relaxation technique was used as induction, because it was DF's preferred way of achieving hypnosis. Counting and walking down a flight of stairs were used as deepening techniques. A "safe-place" technique was used to promote calm and relaxing feelings which were thought to be effective in improving his sleep and building up psychological resources for later hypnotic work.

For the prolonged exposure to the MVA, the theatre of mind was selected as a hypnotic technique (Andreas & Andreas, 1989). It was chosen for three reasons. First, this technique is consistent with DF's description of the MVA, namely, seeing it unfold through the windscreen as if watching a movie. Second, it could reduce an individual's initial anxiety by initially increasing the psychological distance between themselves and their memory, and then gradually reintegrating the two. Third, new meanings and feelings could be searched for and created from first- and third-person perspectives during the re-experiencing. Indeed, this technique is an interactive approach rather than a passive one. Watching the movie of the MVA, reinterpreting the MVA, and bridging were all done in response to DF's feedback at the time.

Regarding DF's grief, an empty-chair technique was employed first (Naranjo, 2000). DF was instructed under hypnosis to hallucinate Q sitting in an opposite chair and to converse with her. Through this, DF was encouraged to achieve a closure to his grief and to relate to unresolved issues — for instance, that Q was no longer suffering from medical illnesses — and to solicit Q's acknowledgement of his effort to save her. Post-hypnotic suggestions for promoting positive and intimate memories of Q were also given, so that DF

could still treasure his memories of Q in a more positive way (Andreas & Andreas, 2002).

## **THERAPEUTIC GOALS**

The therapeutic goals were threefold:

1. Desensitisation and reinterpretation of the MVA and/or memories of Q,
2. Improving DF's sleep, and
3. Resolving his grief.

## **Comments on Therapy Application**

Fortunately, the induction and depth of hypnotic state were easily achieved with DF, as hypnosis was familiar to him and he had practised it for many years. Therefore, the main focus was the establishment of the therapeutic alliance and trust between DF and the therapist, rather than educating and familiarising him to hypnosis. DF's understanding of hypnosis was still double-checked in case there were any misconceptions of its use.

Although the theatre of mind is a standard and well-documented procedure and a therapist could easily conduct it by following a script (Andreas & Andreas, 1989), interaction and cooperation between the therapist and DF were essential for its success. During the sessions, DF's continuous invaluable feedback during the delivery of the techniques determined the therapeutic pace, duration of exposure, number of repetitions of exposure, bridging forward to positive feelings, and reinterpretation of the MVA.

The empty-chair technique was used not only for therapeutic effect, but also for testing DF's grief responses on the prediction that DF would appear to be very sad when speaking to Q if the hypothesis was accurate. As was hypothesised, DF responded sadly and cried when he was directed to hallucinate Q sitting in the chair and to speak to her. It was apparent that DF had experienced unresolved grief to some extent. It was then suggested to DF that he take this opportunity to resolve any issues about Q that concerned him and to say goodbye to her.

Self-hypnosis was suggested to DF for relaxation, and to treat his insomnia and stress. There was no difficulty for DF to commence the self-hypnosis practice. He gained enormous benefit through using self-hypnosis to manage his sleep. Thus, further training was not required.



## **OUTCOME**

After the first three sessions of treatment, DF had already reported improvement in his sleep. When the treatment was completed in five sessions, DF reported continued improvement in his sleep, and a reduction in his dreams and memories of his deceased daughter. He did not feel sad about remembering Q, nor did he avoid memories of her.

At the one-month follow-up session, DF reported that he had slept better, waking only to go to the toilet, and had no trouble falling back to sleep. He slept well and woke early. His improvement in his grief and PTS were evident in the recent incidents and observations. First, his memories and dreams of his deceased daughter and the MVA had reduced significantly. Second, for the first time, he was able to treasure his memory of Q positively. He stated that his memories of her were 95% pleasant and 5% unpleasant. As for the negative 5%, he was able to stop them at will. Third, his other daughter observed that he had been more relaxed than she had seen in many years. Fourth, during the Christmas season he had been able to sit down with his family and, for the first time, talk about Q without feeling overwhelmed or upset, and actually enjoyed the family talk very much. Since the recent improvements, DF has been able to commence woodwork and renovation projects at his and at his daughter's houses. He has been planning to enjoy his life more and visit his daughter in Melbourne in the near future.

## **GENERAL DISCUSSION**

There are several noteworthy features of this case. First, DF's readiness and willingness for hypnotic treatment due to his prior experiences are considered a rare circumstance and were considerably helpful in the treatment. In this therapist's experience, a considerable amount of time would often be required to demystify hypnosis to other clients, and strong therapeutic rapport and trust between the therapist and clients are needed for instigating hypnotic treatment. However, there was no such problem for DF. He willingly agreed to hypnotic treatment, and gave his full cooperation and trust. This raises an interesting issue of whether a client's readiness is a significant determinant of success in hypnotic interventions. If so, increasing clients' readiness, education, training, and experience of hypnosis would be helpful prior to actual hypnotic interventions. As Hammond (1990) argued, a certain depth of hypnotic state seems necessary for effective hypnotic changes to occur. It is the therapist's belief that education and training in hypnosis for clients are as important as the actual interventions.

Second, as predicted, hypnosis could hasten the therapeutic process. In the case of DF, the number of sessions required for completing the treatment was relatively few. Noticeably, hypnosis was not a stand-alone treatment, but an integral part of CBT. On one hand, the CBT provided a sound theoretical framework, while on the other hand, hypnosis enhanced the treatment delivery and efficacy, and provided a wide choice of treatment techniques at the therapist's disposal. It would be very interesting to know how many sessions would have been required if hypnosis were not employed. Moreover, the shorter therapeutic process may also be an indication of DF's readiness for hypnotic interventions and the moderate severity of his symptoms. Fortunately, there were no other stressors — for example, family distress or marital problems — that might have hindered treatment or required interventions before the hypnotic work.

Third, it is widely believed that effective hypnotic interventions are not passive and conducted merely from a therapist's perspective. Clients are not sitting in a chair or lying on a couch passively waiting for the all-powerful therapist to give suggestions for change. On the contrary, clients' feedback and collaboration are always an essential component of therapeutic success. With DF, his constant feedback was an integral part of the therapist's hypnotic interventions. In fact, it is inconceivable that the theatre of mind or empty-chair techniques could be effectively completed without knowing what DF was experiencing at the time. It is therefore believed that interaction and collaboration between therapists and clients are as important as the hypnotic techniques themselves.

Fourth, another interesting issue is the discrepancy between the therapist's assessment of DF's grief and his self-report of it. On one hand, DF appeared to deny his grief experience and rationalise his responses to Q's death without being in touch with his feelings; on the other hand, DF had attempted to distance himself from all memories of Q, both good and bad, and showed avoidance behaviours and marked distress for Q's memories. These indicate that DF might have experienced the grief and coped with it by denial and rationalisation. Since any direct challenges to his denial would damage the therapeutic alliance, a clinical experimental test by employing the empty chair technique — in which DF would be instructed to reunite with Q in hypnosis — was designed to measure his grief responses, to lower his defence, and to raise his awareness.

However, as there was a risk of triggering full-blown uncontrollable grief response, some cautionary steps were taken before conducting the test.

These included having an exploratory discussion to examine DF's losses, his memories, and his relationship with Q; providing the rationale of the test and technique; providing forewarning of the possible apprehension; and obtaining DF's consent. Moreover, the technique would aim to assist DF to re-experience both positive and negative feelings towards Q, and to shift the emphasis onto the positive intimate feelings that he had in his relationship with her. In other words, the negative feelings toward her death needed to be processed, and his relationship with Q needed to be re-experienced in a positive and resourceful way (Andreas & Andreas, 2002). Fortunately, and surprisingly, there was no apprehension during the test and the technique on its own was sufficient for resolving DF's grief. Perhaps his grief was not as unprocessed after all, or perhaps restructuring or reframing his perspectives on the memories of Q was effective in shifting DF's focus from loss to positive resourceful memories of Q which he could treasure forever.

Finally, it is worth noting that DF's motivation was an initial concern of the treatment, as the referral was instigated by his wife. This could indicate the possibility of lack of motivation on his part for treatment. His motivation was especially assessed and enhanced before the actual hypnotic work. The fact that hypnosis was chosen as the treatment of choice was due to his familiarity with it. Undoubtedly, the client's motivation is as important in hypnosis as in other therapeutic approaches.

## **CONCLUSION**

The present case indicates the utility of hypnosis integrated into CBT for the treatment of chronic PTS and grief. Although hypnosis can be employed as a stand-alone therapy, its versatility and unique therapeutic phenomena can also enable it to be an integral part of other therapeutic approaches.

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## **INTRODUCING HYPNOSIS FOR PAIN MANAGEMENT TO YOUR PRACTICE**

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*An outline is provided of the issues and concepts relevant to the introduction of hypnosis for pain management into the practice of an appropriately trained professional. The article is particularly aimed at new hypnosis practitioners or those who are just moving into pain management areas. After providing a definition of hypnosis, it is cautioned that pain should not be treated by hypnosis without appropriate liaison with treating medical experts and that hypnosis not be used to mask undiagnosed pain. Contraindications are summarised. History taking is emphasised and different components of hypnosis are set out: suggestibility, ideo-motor experience, imaginative involvement, and dissociation. Issues involved in treatment of acute and chronic pain are discussed. What follows is a discussion about what is possible in dealing with pain in clients.*

### **WHAT IS HYPNOSIS?**

For the professional already competent in its use, and with clients responsive to the technique, hypnosis can be a most effective, flexible and enjoyable modality in the management of pain. I define hypnosis as an altered state of consciousness produced in the context of a special interaction. The person being hypnotised (the subject/client) hands over directing of consciousness to the hypnotist (a unique situation of trust), absorbs the suggestions of the hypnotist, and allows them to create the content of consciousness and experience. The change from normal alertness to hypnosis involves shifts along at least three dimensions: an increase in suggestibility, increase in absorption or subjective reality of what is imagined, and increase in dissociation-proneness. The shifts in consciousness involved in hypnosis can be very useful

in promoting learning of pain management techniques. Hypnosis for pain management is appropriate for those clients who are moderately to highly hypnotisable; that is, those who are already more suggestible than the average population, more prone to imaginative involvement/loss of self in experience, and more dissociation-prone. Some references that readers may find useful and which are still valid are those of Ernest and Josephine Hilgard (1975), Fred Evans (1999), and Chapman and Nakamura (1998.)

### **Initial Caution**

When a client comes to you directly or is referred for hypnosis for pain, it is of central importance that the source of the pain be properly diagnosed medically before attempts at hypnotic pain relief are tried. So if a patient comes to you wanting help, for example with headaches, you must either have the patient attend his/her GP for checking and possible further medical referral, or you (with the patient's consent) should liaise with the patient's GP. The reality is that, in some cases, hypnosis can be so effective that it can mask the pain from heart attack, and even childbirth. Remember that pain is a useful signal of real or possible danger. Further, in teaching patients hypnotic self-control of pain, they must be taught to have any new pain checked by their GP before they mask the effects of it with self-hypnosis. Only some patients (a subgroup of the highly hypnotisable) are capable of extreme levels of pain control, but what they are capable of can be astonishing (see Walker, 1989).

### **Finding out About the Patient and His/Her Pain**

Unless it is an emergency situation (such as someone being trapped in wreckage after a car accident) the checks for suitability for hypnosis must be carried out before using hypnosis for pain relief. One does not use hypnosis for pain relief with persons who are psychotic (functional or organic) or with non-psychotic persons with strong paranoid tendencies or severe personality disorders (just as with the use of hypnosis in general). Persons suffering a current episode of major depression are not suitable subjects because of the very real risk of suicide. Do not use hypnosis with persons if their religious beliefs are not consistent with its use. Do not use hypnosis for pain relief just because a respected colleague has referred the client; remember it is your responsibility to carry out your own assessment.

I like to spend one or two full sessions assessing and getting to know the patient, explaining openly to them that I want to check that hypnosis is a

suitable option and that in gaining a good understanding and communication before hypnosis, we will be able to tailor hypnotic methods to suit the individual. I routinely carry out personality testing (Beck Depression and Anxiety Inventories, Clinical Analysis Questionnaire), as these are measures that, over many years of practice and research, I have found produce meaningful and useful results.

I take a life history and medical and psychological (or psychiatric) history. I gain a picture of the patient's current lifestyle and relationships. I take an account (as precisely as possible) of the nature of the pain, when it occurs, what activities the pain intrudes on and what it means to the individual. I believe that a collaborative relationship is the most powerful therapeutic one and leads to the most lasting results. I use my time getting to know the patient to foster this collegiate relationship.

## **Suggestibility**

Suggestibility is one of the components of hypnotisability; it can mean either doing what you are told to do or taking into your concept of yourself evaluative comments by others. Hypnotisable persons tend to be more suggestible than non-hypnotisable ones and responsiveness to suggestion increases as one goes into hypnosis. Whatever other component of hypnosis is the central focus of hypnotic treatment, always be aware of the effects of your suggestions.

Part of suggestibility is the concept of self-suggestion or self-talk and this can also be a powerful component of one's "hypnotic spell" for pain relief, even if the apparent focus is on imaginative involvement or hypnotically produced analgesia.

Suggestion in hypnosis (and self-talk in everyday life) can be powerful in increasing confidence and self-esteem, and in "suggesting away" experienced chronic pain. Suggestibility is always part of going into hypnosis and of responding when the patient/subject is there.

Direct suggestion can be used to erase awareness of pain, and in crisis situations (such as a major accident with someone trapped in a damaged vehicle) repeated direct suggestion even without hypnotic induction can hold attention and gradually stop awareness of pain. In such situations, which tend to produce shock and dissociation, people are very responsive to suggestion.

## **Ideo-Motor Response/Experience**

As a result of suggestion in hypnosis, the patient/subject can experience movement, sensation, and loss of sensation which are experienced as non-voluntary; for example, hand levitation, glove anaesthesia, skin sensation of warmth or cold. In moderately to highly hypnotisable subjects, these responses and experiences are not difficult to produce and suggestion (or later self-talk) is the modality by which they are produced.

This component of hypnosis can be very useful in pain control. For example, a patient who has learned to produce glove anaesthesia in him/herself can use this knowledge to manage his/her own pain in the following sequence: (1) has troubling pain in lower back; (2) produces glove anaesthesia as taught by therapist; and (3) transfers this to his/her lower back as taught by therapist.

## **Imaginative Involvement, Loss of Self in Experience**

This is my magical dimension of hypnosis and can be very useful in the control of pain, especially in the management of chronic pain. It can be simple or elaborate. The well-known “Secret Room” technique of Diana Elton can be modified so that in the secret room, not only does one not experience anxiety, anger and other negative emotions, but it can also be suggested that one does not experience *pain* when one enters it. Instead of simply producing anaesthesia, just lack of feeling including pain, I prefer to teach my clients to incorporate a component of imaginative involvement with suggestions of accompanying positive emotion: “As the burning pain dissolves away, you experience first a sense of relief and control, and then a sense of light-hearted optimism which continues quietly over time. Every time you manage your pain in this way, you quietly become more confident, you find that increasingly you focus outside your body on things that give you joy.” Thus one of J.S. Bach’s flute and harpsichord pieces might ripple through the mind and body like bright running water sparkling in the sun and might fill the mind and body with energy and lightness — why not? Or a piece of ballet or ballroom dance music congenial to you and your patient might fill the mind and body with harmony, delight, grace, and balance — again, why not?

Suggestions I use for treatment of PTSD with baroque music (i.e., that the emotional debris from the past trauma/s will slowly dissolve and be swept away in the brightness and the beauty of the music) can be readily modified for pain control — the instructions then being that as the bright music plays on, takes possession of the mind and sweeps it along on the joyous trip, it will



bit by bit dissolve the pain, the anxiety and the worry and leave the mind as clear and bright as the music ... For the use of post-hypnotic suggestion, teach the client, with repeated practice in hypnosis, to get lost in listening to tracks of pleasant music, practised in hypnosis with suggestions that, “As you go further with the music, you will find that it will dissolve away awareness of pain and instead produce the light feeling of energy and joy” (or whatever is appropriate). Provide written instructions if this seems helpful and refine the script in collaboration with the client.

### **Dissociation Proneness**

The term “dissociation” has overlapping but different meanings. It can be used, for example, when the affective components are split off from an idea. My damaged highly hypnotisable patients commonly have their fears and rages split off from the object of the feelings. Dissociation can also refer to running parallel streams of consciousness and this can be a perfectly normal phenomenon for the dissociation-prone, who tend to be highly hypnotisable. Examples of such double-tracking in hypnosis would include automatic writing and the “hidden observer” phenomenon. The term dissociation can also denote a maladaptive defence mechanism of the personality, when whole parts of the self (or ego system) become separated by amnesia and go on more or less independently. Examples of abnormal and rather “theatrical” dissociations are some fugue states and some multiple personalities. Hypnosis can be quite central as a treatment modality in overcoming amnesia barriers between parts of consciousness and personality and in achieving a sense of unity for the person. Dissociation-proneness can be utilised effectively and creatively in pain management. A most dramatic example, possible only with the very highly hypnotisable, is abdominal surgery without anaesthesia.

### **DIFFERENT SORTS OF PAIN**

#### *Acute Pain*

Hypnosis can be used for the control of acute pain, and this can be central in situations (like bad accidents) where chemical control is not available or possible. This would involve connecting with the victim, getting his/her attention and using quite powerful, repeated suggestions of pain relief, safety, and confidence.

For acute pain, undiagnosed, medical diagnosis is the necessity not hypnosis, except in situations like accidents until medical help arrives. For well-trained subjects, hypnotic control of acute pain (even of things like abdominal surgery) can be achieved but this would seem reasonable only in situations of risk to the patient from analgesic/anaesthetic chemicals.

However, there is a huge component of *anxiety* involved in the presence or anticipation of acute pain (just as anxiety and depression are typically involved in chronic pain) and hypnotic training and methods are of great relevance here. I would not consider having hypnosis *instead of* a local or general anaesthetic for surgery, nor would I recommend it; however, the anxiety *before* and *after* surgery can be eradicated very pleasantly by some self-hypnosis training before the event (see Walker, 1985)

### *Chronic Pain*

Hypnosis in the management of chronic pain is a less dramatic, but involves very important use of hypnotic techniques. Often increased by the iatrogenic effects of our compensation system, chronic pain is a plague in the workforce following orthopaedic injury, and can contaminate the quality of life of the sufferer. Often by the time I have had patients referred, they have done the rounds of assessments, treatments, and various therapies. Left with residual pain and a lot of anxious focus on the pain, with accompanying depression, the therapeutic task is not simply achieving pain relief. It includes re-focusing the patient on meaningful living, which in my book includes having fun — not just the absence of pain but experiencing positive feelings like joy, enthusiasm, love, and laughter.

In planning such therapies, I do a lot of work before hypnosis, encouraging the person to engage in relationships and activities (obliquely and very diplomatically), establishing a warm and collaborative rapport and building self-confidence. I typically use hypnosis for this first, explaining that pain control works best when one's mood has lifted and anxiety is more manageable. After perhaps half a dozen (in all) treatment sessions, I might then focus on the pain itself and teach specific pain management techniques (preferably ones with a bit of flair, style and polish). With highly hypnotisable subjects (my unpredictable favourites) by the time we have had a few bursts of hypnosis and J. S. Bach, there is often not too much pain left and I do a lot of education as well in the waking state, about how the experience of pain is amplified by attention and anxiety. At no stage, however, do I imply

any criticism of the patient for his/her miserable focus on the chronic pain. And because pain from chronic conditions typically varies over time, and is exacerbated by certain factors (e.g., arthritic joints are more stiff and sore in the cold) I teach active self-management of pain in a general setting of interest, creativity, and enthusiasm.

I also emphasise the importance of being involved in life and I get people to keep notes of their activities — I set homework and people often come to realise (not told by me) that their pain is worse when they are bored, miserable, tired, and angry, which is useful, adding to the evidence that our experience of pain is partly dependent on focus of mind and concurrent emotion.

## **CONCLUSION**

Hypnosis has a genuine role in the management of acute and chronic pain, but it is not a universal panacea. It should not be used until the professional has appropriate competence in clinical hypnosis and the professional should be aware of contraindications and limitations.

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## HYPNOSIS TO ENHANCE TIME LIMITED COGNITIVE-BEHAVIOUR THERAPY FOR ANXIETY

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*This case demonstrates the use of CBT and hypnosis in managing the symptoms of anxiety experienced by a retired registered nurse. Her symptoms included panic attacks and heightened blood pressure when she visited medical specialists. Therapy was time limited to five sessions under the Enhanced Primary Care program. A research question was posed about the possibility of achieving success in this time frame, using CBT enhanced by hypnosis for exposure to both the symptoms of panic and situational anxiety. On completion of the sessions, there was a marked decrease in anxiety symptoms, and the patient was able to visit her doctors without undue elevation of blood pressure.*

The cognitive theory of anxiety maintains that a person will experience anxiety when there is a stimulus from perceived threat of physical or social harm (Clark, 1999; Salkovskis, Clark, & Gelder, 1996). The stimulus acting is interpreted as a personal threat in order to provoke the anxiety reaction (Salkovskis et al., 1996). In its extreme, threat perception is related to panic disorder where certain stimuli cause feelings of imminent catastrophe (Clark, 1986). The cognitive theory of panic proposes that panic attacks result from those who interpret bodily sensations in a catastrophic way, such that they will have distorted beliefs about the danger of a situation (Clark, 1986, as cited in Ost & Westling, 1995; Clark, 1999). Patients may present with a list of physiological symptoms including appetite loss, weight loss, loss of energy and drive, fatigue, insomnia, sweating, high pulse rates, dizziness, tightness in the chest, palpitations, and shortness of breath (Beck & Zebb, 1994).

A paradox noticed in patients with anxiety and panic disorder is that repetition of experiencing no harm in feared situations fails to correct their fear beliefs (Clark, 1999). In behavioural terms, the fear or panic response is not extinguished by repeated and unreinforced presentations of the conditioned fear-provoking stimulus (Salkovskis et al., 1996). In cognitive terms, the fear

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continues, even though the patient is able to indicate understanding of the irrational nature of the fear reaction (Salkovskis et al., 1996). In spite of this understanding, thoughts or self-imagery of fears being realised are said to be a potent source of information used to reinforce feelings of imminent disaster (Clark & Wells, 1995). For instance, patients with health anxiety are able to describe recurrent images of rapid health decline and even death (Clark, 1999). These recurrent images in themselves become threats to the well-being of the individual experiencing them because they provoke increasing levels of anxiety and even panic.

Clark (1999) posits that a logical response to the imagined threats is to enlist safety seeking behaviour to avert the feared situation. Such behaviour is commonly seen when an individual suddenly leaves social company to seek a cooling breezeway, or leans against a wall seemingly to avoid fainting. In this case study, the example of a safety seeking behaviour in health anxiety would be thought suppression of the recurrent images of disaster related to health problems. The hypothesis is that the apparent safety gain of thought suppression maintains anxiety and panic because it prevents the person facing the imagined fears which, if faced, would assist in disproving the feared imminence of catastrophes. In effect, a simple act of thought suppression is said to maintain negative beliefs.

Thus, interventions to modify catastrophic conditioning suggest challenging fear cognitions directly by having the patient experience the feared situations until the sense of anxiety reduces to sub-clinical levels (Clark, 1999). In cases of health anxiety, eliciting fears using imagery is one method of cognitive-behavioural treatment for anxiety and panic disorder, and it has demonstrated significant successful treatment outcomes (Clark, 1999; Ost & Westling, 1995). Additional management techniques such as teaching breathing control and relaxation have also been used to assist the patient to build behavioural confidence (Ost & Westling, 1995).

Hypnosis is also a probable additional management technique because it has been shown to be effective as an adjunct to cognitive-behaviour therapy in treatment of anxiety disorders (Evans & Coman, 1998). It has been posited that hypnosis supports the mechanism of action in therapy to proceed more rapidly. First, hypnosis is suggested as a technique for securing a vivid, clear and strong image of the feared situation that needs to be cognitively challenged. Second, the client is able to build their confidence to manage anxiety symptoms by facing the fears in trance and obtain reinforcement of the cognition of their

ability to cope, which enhances their self-efficacy and strengths (Evans & Coman, 1998, p. 71).

The specific research question in this case study is whether the number of treatment sessions can be reduced to below the number of sessions generally supported by empirical studies when hypnosis is introduced as a support to therapy. Without the support of hypnosis, 12 sessions were used in research studies supporting the treatment applied in this case study (Clark et al., 1997; Ost & Westling, 1995). Reduction in sessions while maintaining efficacy was considered by Ost and Westling (1995) in their group study comparing applied relaxation and cognitive therapy techniques. Subsequently, Clark (1999) successfully reduced the number to seven treatment sessions in a controlled trial for panic disorder. It is hypothesised that, for this case, the number of treatment sessions required to achieve measurable treatment effect will be reduced when hypnosis is used as an adjunct to CBT.

## **CASE HISTORY**

Ms M was referred by her GP for chronic anxiety management, which he felt was interfering with her ongoing health prognosis related to cardiovascular problems. The referral was made under the Enhanced Primary Care program, which allowed five sessions with a part rebate being given by Medicare.

Ms M presented as verbal and cooperative, although she described herself as shy and anxious. She reported a happy marriage and family over 35 years and a nursing career with retirement at age 55. This career was maintained in teaching hospitals and in her last appointment she cared for cardiac and stroke patients. She acknowledged that her work experiences may have contributed to her anxiety state.

## **Psychological Symptoms**

At age 64, the client presented with symptoms of panic and anxiety related to fear of stroke due to high blood pressure. Symptoms of anxiety were dizziness, light-headedness, sharp 'shard-like' pain in her brain, plus a sense of pins and needles in the scalp, increased heart beat, rise in pulse rate, difficulties in concentration, stomach cramps with toiletry urgencies, nausea, and excessive perspiring. Problems in falling asleep and wakefulness were also reported. The somatic symptoms were increasing in intensity and frequency and were beginning to support the onset of agoraphobia.

## **Medical Symptoms**

The client reported feeling more vulnerable to health problems since menopause. This vulnerability was reinforced when she developed hypertension and was diagnosed with a blood thickening disorder at around retirement at age 55.

At age 57, the patient experienced symptoms of back pain, dizziness, and reported feeling cold and sweaty. She attended specialist referral for review. During an angiogram the client overheard a comment which led to her belief that she was going to die, especially since the only person she had ever observed having an angiogram had died during the procedure. At this point, her blood pressure escalated dramatically.

Indeed, the tests revealed blocked arteries and a quadruple bypass was performed. She reported she had a transient ischemic attack (TIA) or mini-stroke immediately after her operation; however, the TIA left no long-term measurable cognitive effects. Since the procedure, the client had regular checkups, which involved travel to Sydney to consult with specialists. Five years later the client had to have urgent surgery to clear her carotid artery. At the time, her blood pressure was measured at 200/100. These real health issues, together with her special health career knowledge, sensitised the client to possible negative health outcomes and caused catastrophic fears of specialist appointments.

## **SUITABILITY OF HYPNOSIS IN THIS CASE**

A verbal history was taken. There were no contraindications to the use of hypnosis in the treatment design. The client was not clinically depressed or suicidal, and had no indicators of psychosis. The client's motivation and interest in pursuing hypnosis was taken as the first step in the suitability of use of hypnosis. She was able to relate to the explanation of hypnosis being an altered state of consciousness, such as being lost in a book, and indicated that she had good visual imagery. She was curious about the process of hypnosis and willing to experience it as part of her treatment.

Because of time limitations, the Arm Drop Test as described in Barabasz and Watkins (2005, p. 94) was used to give a rapid indication of the patient's potential response to hypnosis. Ms M's hand moved about 10 cm, indicating that she was responsive to suggestion and probably capable of reaching a light to medium trance state. This level of potential hypnotisability was considered sufficient for treatment as planned.

## **THE GOALS OF THERAPY**

The goals of therapy were to:

1. Assist the patient to manage the physical symptoms of anxiety and panic and to develop a sense of mastery over catastrophic thought processes, which fuel anxiety.
2. Reduce the situational anxiety felt when she attended doctors' appointments.
3. Increase Ms M's sense of self-efficacy and enable her to cope.

## **DIAGNOSIS**

A differential diagnosis using DSM-IV was made of situationally bound panic attacks (APA, 1994). This was discussed with the client. A behavioural analysis revealed that symptoms of anxiety and panic increased when she anticipated going to the specialist. In these instances, the client described anxiety and fear reactions, hyper-vigilance, heart palpitations, headaches, and difficulty breathing, together with negative and catastrophic thoughts about what might occur. Anxiety and panic levels were reported to have generalised to other situations, such as going shopping.

## **METHOD**

### **Design**

A five-session program of cognitive-behavioural therapy (CBT) and hypnosis was designed to address specifically the prime therapeutic needs of the client, which were to reduce disabling anxiety and panic reactions to feared stimuli. The clinic sessions were to be supplemented by homework. The first element of treatment was to build coping skills and self-efficacy in order to control the physical symptoms of her anxiety. The second element of the treatment was to expose the client to her identified fear-provoking stimuli and to provide hypnosis to allow the facing of the specified fears during trance. The mechanism of action in the treatment was hypothesised to be exposure that was explicitly used to test the client's beliefs and predictions about the dangerousness of a situation.



## **PROCEDURE**

The client's indicated levels of depression, anxiety, and stress were measured with the Depression, Anxiety and Stress Scale-21 (DASS-21), a 21-item instrument normed in Australia, to enable self-report of symptoms of depression, anxiety, and stress over the previous week (Lovibond & Lovibond, 1995), in two time periods — at baseline (the first assessment consultation) and at the end of treatment (fifth consultation).

### **Session 1**

A history for assessment was taken. The process of CBT was explained after providing psycho-education regarding physiological stress and anxiety response as well as the role of cognitions (thoughts) on anxiety. The benefits of using hypnosis as an adjunct to CBT to increase the efficacy of therapy were discussed.

In the first treatment session, the client's breathing rate was measured at 18 breaths per minute. Next, she was given breathing exercises for controlled breathing, which brought down the rate to normal levels of around 10–12 breaths per minute (Andrews, Crino, Hunt, Lampe, & Page, 1994). This exercise was practised several times with the therapist. She was given homework to practise the procedure regularly. The Subjective Units of Distress Scale (SUDS) (Andrews et al., 1994) was introduced as a way of expressing the degree of anxiety experienced at any time.

For homework, the client was asked to commence to note her levels of anxiety throughout the day, using the SUDS, and to notice her thoughts at the time.

### **Session 2**

Ms M reported some positive success in managing symptoms by using the breathing exercise. She was able to use distraction techniques to reduce triggering to anxiety; for example, using her hobby of spinning on the spinning wheel and knitting. The homework exercise of noting anxiety and her thoughts enabled the client to begin to link her negative thoughts with the anxiety she was experiencing. Discussion of some of her noted thoughts enabled the commencement of the process of challenging irrational thoughts. The drop arm test was performed, indicating a positive response to suggestion. Relaxation exercise using progressive muscle relaxation (PMR), deepening by

counting, and safe place visualisation was presented. Soft background music was chosen to focus the attention and assist relaxation (Walker, 1998). The client appeared to relax quite well after a few minutes. The therapist suggested that her ability to relax would improve with practice, which she was encouraged to do between sessions using the CD of the relaxation session.

### **Session 3**

Ms M reported that she found she had been able to analyse her thought processes during the week, and was challenging negative self-talk. The client reported increased self-belief and confidence in managing her anxieties. She reported practising breathing and relaxation daily and was keen to try hypnosis albeit with a little apprehension.

Naturalistic induction was applied following the Havens and Walters (2002, p. 70) model, which is recommended for patients who are anxious. The client was responsive to the induction, a visualisation of a lovely garden was used, followed by suggestions of becoming more able to cope, becoming more confident, being able to overcome her fears. The symbol of peace suggestion was included (Newton, 1998). A CD of the session was prepared for practice and feedback from Ms M was that she felt very relaxed and heavy.

### **Session 4**

Ms M reported increased confidence in hypnosis and thus it was decided to induce an anxiety state/panic in the therapy session to demonstrate to the client her ability in managing and reducing the physical symptoms. This technique was adapted from Marlene Hunter's script on "Defusing Panic" (Hunter, 1994, pp. 110–114) and the rationale for this process was discussed with the patient. Prior to the hypnosis, Ms M was able to describe her symptoms in the order they occurred and how she felt physically with each symptom, so that the therapist was able to adapt the script to suit her unique context.

The induction that was used was an adaptation of the naturalistic induction as used in Session 3 that the client had said she had particularly enjoyed. The adapted defusing anxiety script was then presented (Hunter, 1994) and Ms M was able to create the symptoms of anxiety in the session and reduce these as the script suggested. The use of ideomotor signalling by index finger during the process and the use of deep cleansing breath when anxiety symptoms had abated proved a sound method of communication. As per the script, the experience of raising anxiety to a higher level, and then lowering it, was

repeated. Ms M expressed surprise and happiness that she had been able to achieve this result and reported feeling confident in her ability to manage her anxieties.

For homework, the client was to practise relaxation. In addition, she was to make a list of the steps involved in visiting the specialist and having her blood pressure taken, so that we could work on hierarchical desensitisation in the next session.

## **Session 5**

Ms M reported that her panic attacks had substantially reduced in frequency and intensity. She said she was feeling some anxiety regarding her impending visits to the specialists, with concern that her blood pressure would be high. However, she had prepared a list outlining the steps involved in visiting the specialist.

In this session, a brief PMR induction was utilised, followed by deepening using the counting method. Ms M was then asked to visualise the visit to the specialist, and as each stage on her list was visualised her SUDS levels were monitored. Ms M was encouraged to remain at each stage, using her skills of defusing and positive affirmation, until she signalled that she was calm and in control and the SUDS levels had significantly dropped to acceptable levels. Therapist observation of her breathing rate and posture also enabled feedback.

Her stages were as follows:

1. waiting in doctor's waiting room,
2. being taken into doctor's examination room,
3. doctor coming in, talking to her,
4. doctor putting blood-pressure cuff on,
5. doctor pumping cuff (positive affirmations: it's okay, my pulse is normal, it's usually very low), and
6. doctor releasing cuff, listening.

The client's response to the exposure was positive and Ms M was given a CD of the session to practise if she wished; it was suggested that she continue to practise her relaxation.

## RESULTS

Ms M responded positively to CBT/hypnosis for her anxiety. Two weeks later, she attended specialist appointments and reported remaining calm prior to, and during, the visits. She said she used affirmations to strengthen confidence and told me her blood pressure had not become elevated as it had on former visits, and was measured at 170/70. She said she felt further encouraged by the specialist commenting favourably regarding her relaxed demeanour. Ms M reported that anxiety and panic responses brought about by fears triggered by thoughts of medical appointments were substantially reduced to acceptable levels.

The client's DASS results at Session 1 for depression and stress were in the severe range and anxiety in the extremely severe range; however, by the end of session 5, her scores on depression, anxiety, and stress were in the normal range.

## DISCUSSION

This case partly answers the research question of whether a limited number of treatment interventions could demonstrate treatment effect. However, although hypnosis was used, it is not possible in one case study to form a nexus between its efficacy in treatment support and a consequent reduction in the number of therapy sessions. The client's compliance in completing homework exercises and her strong motivation were also likely factors in treatment success.

However, with these limitations in mind, it appears that the use of hypnosis enhanced the CBT to enable the management of anxiety within the limited sessions available. The client certainly responded positively to hypnosis by suggesting it as a main component responsible for her treatment outcome and the process of induction and deepening generally relieved anxiety (Hammond, 1990). Moreover, the use of hypnotic trance to work on exposure allowed the imaginal exposure to be more realistic, and the resulting lowering of anxiety symptoms more rapid. It has been found that enhanced scene visualisation using hypnosis produced better and quicker results during the desensitisation process than with traditional behavioural desensitisation (Glick, 1970, as quoted in Hammond, 1990).

In some way, this case study has added to the literature that supports the addition of hypnosis as an adjunct to a specific model of cognitive and behavioural treatment of anxiety with panic disorders. The prime element of this treatment is that clients learn strategies to manage physical symptoms and

understand how specific triggers of their anxiety produce negative automatic thoughts that falsely predict catastrophic outcomes. The treatment ingredients included in this case study were education, verbal discussion, imagery modification, attentional manipulations, exposure to feared stimuli (Clark, 1999), and breathing control inspired by the success of Ost and Westling (1995). Hypnosis was able to enhance the efficacy of treatment (Evans & Coman, 1998, p. 97).

## CONCLUSION

The use of hypnosis as an adjunct to CBT was shown to be a successful, brief, solution-focused approach to provide relief from anxiety and panic. Hypnosis enabled benefits to be experienced quickly, and the adherence to practice between sessions reinforced these benefits. Further research would be needed on a larger scale, however, to be able to generalise from the findings of this case study.

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## **“I’VE NEVER FELT LIKE THAT BEFORE” — HYPNOSIS FOR SLEEP PROBLEMS AND DEPRESSION IN A 10-YEAR-OLD BOY**

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*This report describes a case of hypnosis used as an adjunct to psychotherapy for problems of poor sleep and low mood in a 10-year-old boy, here called AJ. The client first presented with issues of anger and self-harm, and was brought to therapy by his mother. AJ responded well to individual counselling and to some suggested changes in family management. The hypnotherapy was designed to address AJ’s sleep disorder. At the end of therapy, AJ’s mood was within normal limits. Sleep questionnaires indicated that AJ’s arousal before sleep was also improved. The client expressed his appreciation for being given the opportunity to quickly learn a method to place himself in a pleasant trance state.*

### **PRESENTING PROBLEMS, 2002**

AJ’s mother phoned to refer him for counselling in December 2002 over issues of anger and threatened self-harm. When his wishes were thwarted, AJ would engage in a tantrum and then speak of hurting himself. He had just turned seven years of age.

Two assessment sessions were held in December 2002, and three counselling sessions were conducted in early 2003. I found that the family was under significant stress and there was low mood in at least one family member.

A variety of approaches were used, but hypnosis was not attempted at this time. The family was happy with the intervention provided and noted improvements in AJ.

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The author wishes to thank the client’s parents for giving permission for the publication of this case, and to acknowledge the assistance of Dr Kris Kafer, Professor Rod Tiffen, Ms Maria Nolan and Mr Don Maxwell.

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## **PRESENTING PROBLEMS, 2006**

AJ returned for further counselling in mid-2006, when he was aged 10½. Since early in the year he had been suffering nightmares and sleep problems, and was coming into his parents' bed at 5 am. During first term at school, he had been particularly unhappy and thus the relapse seemed to relate to difficulties at school. He was underachieving and was reluctant to attend school. His parents were principally concerned about AJ's renewed threats of self-harm.

AJ was then seen for six sessions from May to September 2006, during which counselling was offered to AJ and his mother, and focused on supporting parenting skills for anxiety and self-esteem. By August 2006, these problems had resolved. The hypnotherapy was designed to address AJ's sleep disorder. It took place over two sessions in June 2006.

## **HISTORY**

AJ is the youngest of three children, and has two older sisters. There were deaths on his mother's side of the family some years ago, including one when AJ was aged two. His mother works in a professional position, and his father is a self-employed manager of his own business.

AJ's neonatal history includes hypoglycaemia at birth; he was delivered by planned caesarean section. His milestones were normal, but he suffered ear problems at 2 years, including ear infections and a ruptured eardrum. He had a burn at 6 years, and had always suffered headaches.

At the time of the intervention, AJ had two or three friends and did not have any significant peer problems, although he had experienced bullying at school in the past. He saw his school counsellor at a young age, but did not require any other psychological attention. The counsellor gave AJ the WISC-III test when he was aged 6.5 years and found that he had above average cognitive ability. He was identified by his teachers as being in the top 3% of the students academically.

He attended the local primary school and was in Year 5 in 2006 and had been booked into a nearby private school for his high school education.

## **PRESENTATION**

In the sessions in 2002 to 2003, AJ presented as a somewhat immature boy who was clearly depressed and exhibited flat affect. During his sessions in 2006, AJ again initially presented as flat and listless in mood. However, in later



sessions he was lively, showing a quirky sense of humour. At the beginning of the second hypnotherapy session, he was fidgety and hyperactive. (His mother attributed this to the session being scheduled in the afternoon — he was calmer in the mornings.) Physically, he presented as a healthy boy of pleasing appearance, of average height and weight.

## **THERAPY SESSIONS**

### **2003: Sessions 1–2, Initial Assessment**

Assessment was carried out via family and individual interviews, a genogram was taken, and the following questionnaires given: the Child Behavior Checklist (CBCL), the Children's Depression Scale, the Ravens Controlled Projection and the Children's Depression Inventory.

AJ appeared to be suffering depression and anxiety as a result of several factors. In 2002, his mother had seemed depressed and over-extended, and his father was busy with work. In the family context, AJ appeared isolated as the only boy, yet somewhat favoured as the youngest.

### **Initial Interventions**

Immediate safety advice was given to AJ's parents regarding his suicide threats. Recommendations were made regarding parental attention — how to deal with tantrums and suicidal statements, and the importance of giving quality time. I recommended an appointment with a paediatrician, in case anti-depressant medication was indicated.

### **Session 3**

This session began with a parent interview, in which the book *Helping Your Anxious Child* (Rapee et al., 2000) was given to his mother to assist with AJ's fears and nightmares. An individual session with AJ followed; we discussed his computer games and his frustration that he could not save his favourite game if interrupted. We also discussed a recent episode when AJ tried to choke himself and I explained to AJ that his body "has a will to live," and thus wants to keep on breathing. I offered simplified cognitive-behaviour therapy regarding debating suicidal thoughts and I gave suggestions that his nightmares would cease.

**Session 4**

This was an individual session with AJ. I gave him the Children's Depression Scale (Lang & Tisher, 1983), involving active "posting" of responses. During the interview with AJ, it emerged that he was most at risk of self-harm when his wishes were thwarted. I interviewed AJ's mother regarding some school difficulties (especially school resistance, and AJ telling untruths). I also provided her with Triple P Parenting Tip Sheets: Lying, and Behaviour at School, for later reading.

**Session 5**

This was a father-son session — and at my request the interview consisted only of myself, AJ, and his father. The session largely consisted of AJ and his father devising activities that they could do together. This was a form of relationship counselling to strengthen a bond that had been somewhat lacking. Their list of potential activities was as follows:

- Having lunch together, e.g., MacDonald's,
- Going camping.
- Going to pony club,
- Going for a run at night,
- Going to the bush,
- Going to hockey,
- Going to dad's work,
- Going to a movie,
- Watching a video (e.g., *Age of Vampires*), and
- Looking at AJ's dragon book together.

**2006: Session 6, Review**

Three years later, AJ's mother presented as happy and settled. However, AJ had developed emotional problems and hated school. His teacher was in her first year out of training and AJ's parents felt she was not offering a high enough standard of educational environment. AJ had been accused of bullying another child, and had then become suicidal. He was regarded as under-achieving, given that his assessed IQ was high, but he was not performing at a high standard. In fact, he had to be forced to go to school. He was taking hours to fall asleep, and could not tune out. He was refusing to go on family outings, but on a positive note, his nightmares had ceased.

*Reassessment — New Goals* Goals were set to address the new problems identified by AJ and his mother:

- Sleep disturbance — AJ had problems falling asleep (taking up to two hours to fall asleep), and early morning waking (coming into his parents' bed at 5 a.m.).
- Low mood — AJ was feeling unhappy most of the time.
- Headaches had persisted in the last few years.
- Underachievement? While AJ had been identified as gifted, he was not performing at this level.

The Child Behaviour Checklist confirmed significant anxiety and depression, and aggressive behaviour. DSM-IV diagnoses were significant for affective problems, anxiety problems. They were borderline significant for somatic problems and oppositional defiant problems. The Children's Depression Inventory, given individually to AJ, showed a significant clinical depression.

The Pre-Sleep Arousal Scale (Nicassio et al., 1985) was used to assess the precursors to sleep in AJ) and a sleep hygiene practice sheet was used to gauge his routine before bed.

*Formulation in Preparation for Hypnotherapy* AJ appeared to have a predisposition to low mood and his sleep disorder tended to perpetuate the low mood. The 2006 episode of depression appeared to be precipitated by an unsatisfactory school environment. In the view of his parents, AJ's teacher was not able to provide a welcoming environment for him. It also appeared that AJ was a gifted and talented child who may have felt social ostracism at school. This accounted for the relapse of depressive symptoms. Mediating against these risk factors, his mother was providing a secure family environment.

## **Session 7, Interventions**

In this session, interventions included:

- Self-esteem tip sheets and video (Triple P).
- A "sleep fairy" technique suggested at session 6 was working (i.e., a reward system whereby AJ received a coin under his pillow for staying in his own bed all night). This technique is my own invention, and often works well.

AJ presented as happier and his mother reported that he had been staying in his own bed. AJ is saving for a new computer game with his rewards.

- A discussion about AJ's intellectual functioning with his mother.

*Suitability for Hypnosis* At this point, hypnosis was broached with AJ and his mother as a possible technique to assist with sleep onset problems. AJ's suitability was gauged via the success of the "sleep fairy" technique, in which a fantasy combined with reinforcement helped him to stay in his bed, knowing that a reward would ensue next morning.

I judged AJ to be suited to hypnosis due to his imaginative ability and the strong therapeutic alliance we had forged. As a 10-year-old, he was at the mid-point of the youngest ages considered suitable to hypnosis (Lipsett, 1998). AJ and his mother both willingly gave consent for the hypnotic procedure.

Educational extension activities were suggested for AJ, including learning the drums, and extra tuition in computing (e.g., constructing a computer game).

### **Session 8, First Hypnosis Session**

In this individual session with AJ, we discussed his past sleep strategies. He said he had tried counting sheep to 257, without success. He said he tended to lie awake for hours. I explained what hypnotherapy was and the fact that it might be good if he were able to put himself to sleep at night.

I advised AJ that I would tape the hypnotherapy so he had his own technique to fall asleep at night. My rationale was that self-hypnosis would both address AJ's depressive symptoms and prevent future relapse (Yapko, 2001).

I advised AJ that I wanted him to learn at least two self-hypnosis techniques and to practise them at home. I believed that he needed to find the technique most suited to his temperament. Two different hypnotherapy tapes were provided — the first at this session and the other at the following session. A transcript of the second tape is included in the Scripts section of this journal at pages 77–79.

The induction involved an eye fixation method — in his bedroom, AJ was to focus on some luminescent dinosaur pictures on his ceiling. I asked him to focus on my voice. I gave him guided imagery which included a bush walk, followed by flying like a bird to a cave in which there was a special place for him (Oaklander, 1988).

The narrative then involved going up in a spacecraft (after Elkins & Carter, 1991) to the count of 20, becoming weightless, and then falling asleep. I then provided more deepening, with a further count to 20 and a reminder to turn the tape off if he was going to sleep. The de-induction in the session was done by counting backwards from 3 to 1.

During debriefing, AJ said he'd "never felt like that before" (indicating that he had been in a pleasant trance state).

### **Session 9, Second Hypnosis Session**

This was another individual session with AJ. This was the first occasion on which I had met AJ in the afternoon after school, as most of the previous sessions had been in the morning. He was noticeably more fidgety and restless at this session. It seemed that he needed an approach suitable for ADHD youngsters (Donney & Poppen, 1989; Dunn & Howell, 1982). He was so active and fidgety that I asked him to imagine that he was running and that his muscles were active.

I debriefed the previous week's hypnotherapy. AJ said he has been successfully using the eye fixation on his luminescent dinosaurs. He said he had been routinely falling asleep "while in the cave."

At this second hypnosis session, the induction consisted of the instruction to "drop." I told him to run till he dropped and then to sink into the bed, to imagine his arms dropping, his legs dropping, his whole body dropping. (We had predetermined that the use of the word "dropping" was comfortable for him.)

For the deepening of hypnosis, I had AJ imagine he was going down in a lift and sinking softly into a feather bed. While he was in a hypnotic state, I gave him suggestions that he was in a mist or fog and that my voice was becoming distant (after Karle & Boys, 1987). Then I suggested that he was drifting off to sleep. Again, I taped the hypnosis for him to use at home. He appeared to be very relaxed during the session.

After the hypnosis, I interviewed AJ's mother, giving her more information about the procedures and asking for feedback. She was very pleased with his progress, stating that there had been a dramatic cure of his sleep disorder after a few nights.

We discussed the book *Helping Your Anxious Child* (Rapee et al., 2000) that I had lent her. She said AJ was now less troubled by "premonitions" (i.e., fears of disasters) and she remarked that the "sleep fairy" technique was helpful.

### **Session 10, Cognitive Assessment**

AJ's mother brought the school counsellor's report on his WISC-III testing in 2002. His assessed IQ then was in the high average range. At session 10, I gave AJ the WISC-IV, Australian Standardised Edition (Wechsler, 2003). He gained a full IQ in the range 98 to 110, which is average. His Perceptual Reasoning

IQ was in the range 103 to 119, which is high average. His sight word reading level was found to be average. At the parents' request, I provided a report for the school.

### **Session 11, Review**

Upon review two months after the hypnotherapy, AJ reported no difficulty falling asleep and said he used the tapes on about three occasions and thereafter was able to induce sleep himself. He said this now took only five minutes. He used self-hypnosis to "look at nothing" and then imagine the stories such as going up in space. He enjoyed the feeling of weightlessness ("It's like you're not really there"). His mother said she had used the tapes on AJ's cousin (who was "very busy and active") and this boy "went out like a light" when he recently slept over. I diplomatically explained that the tapes needed to be kept for AJ alone, as other children may have different reactions to them.

I discussed AJ's IQ results with his mother and it was agreed that teachers' and parents' expectations of AJ may have been too high. AJ tended to opt out of gifted and talented activities at school, and we agreed that expectations should be more realistic. I reissued the Children's Depression Scale to AJ at this session, and found that his mood was now within normal limits. The results of his sleep questionnaires indicated that AJ's pre-sleep arousal was now improved, although some mental activity and muscle tension remained.

## **DISCUSSION**

Hypnosis was an extremely useful adjunct to this therapy for a boy with symptoms of depression and sleep disorder and there is evidence of its effectiveness for persons suffering sleep problems (Yapko, 2003). Children aged between 7 and 14 appear to be particularly suited to hypnosis, due to their capacity for absorption, enjoyment of fantasy, and openness to new experiences (Hart & Hart, 1998).

Hypnosis provided a dramatically successful technique in addition to the solid gains made through behavioural and cognitive methods. Hypnosis was partly responsible for the improvement in mood and it increased the boy's self-efficacy in terms of regulating mood. His capacity for self-hypnosis is likely to help prevent any future risk of relapse into depression.

Two different inductions were provided for AJ, but the first one was deemed the more effective. AJ was physically active during the taping of the second induction, and he used this tape less than the first one. The most effective

ingredients of the self-hypnosis for AJ were eye fixation, guided imagery, and suggestions of flying and of weightlessness.

## CONCLUSION

This case illustrates the added power of including hypnosis in a multi-modal therapy. The outcome was successful, and the family was satisfied with the improvements in mood and sleep. This is gratifying in a young person for whom medication was not considered an option. The gains were substantial, given that there had been strong intent on self-harm. It was a pleasure to witness this cheerful, bubbly boy at our last session.

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## PROTRACTED HYPNOTIC REST

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*This paper outlines the background to the concept of prolonged hypnotic rest, refers back to the earliest studies of it, and discusses the principles underlying the concept. An outline of a Prolonged Hypnotic Rest Workshop which was successfully conducted by the N.S.W. Branch of the Australian Society of Hypnosis is provided. The author advises that only highly experienced practitioners in psychotherapy and hypnotherapy, under the guidance of a medical practitioner, should attempt such a method, as close medical monitoring is necessary in such procedures. Further details can be obtained from the author.*

Sleep and rest for recuperation have been the standard medical advice given to patients for a very long time. It was Aristotle who suggested that “sleep ... is the restorative function of senses,” and since then every physician has ordered patients to bed in order to recuperate, invigorate and conquer disease, and to rest after becoming tired.

However, natural sleep and rest can be elusive for some people and medications are often prescribed. It is not always possible to rest, especially when rest is most needed, and we are all familiar with drugs such as sodium amytal, Nembudeine, Valium, Surmontil and hundreds of others being used in order to facilitate rest. By mentioning the drugs, sedatives in this instance, I am abstaining from a criticism of users and prescribers, but I do like to emphasise that the value of rest in normal functioning individuals is of paramount importance, and even more so in the event of illness, and hence the need for the use of sedatives, tranquillisers and hypnotics. Moreover, without the use of medication, what is the value of hypnotic rest as a remedy for emotional and physiological rehabilitation?



## EARLIEST MENTIONS IN THE LITERATURE

An early mention of this kind of rest therapy was made by the Swedish psychiatrist Otto Georg Wetterstrand, who in 1893 published his paper, "About Protracted Hypnotic Rest in the Treatment of Hysteria and Epilepsy," in which he reported that, by inducing patients into a deep trance, and in keeping them in the trance for many hours and sometimes days, he obtained good results in the treatment of chronic vomiting and in skin conditions — and he achieved especially good results in the treatment of hysteria and epilepsy.

The next record came from Prusenko from the Ukrainian Psychoneurological Institute, who in 1926 obtained very good results in the treatment of adolescents suffering from an "increased excitability of the nervous system" by protracted hypnotic rest. This was reported by Platanov in 1959.

The following instances were all also recorded by Platanov: Schilder and Kauder (in 1926) and Rottenberg (in 1928) had both applied protracted hypnotic rest in various psychosomatic conditions, while Kapil-Levina and Tswetkow reported success in restoring strength in women after protracted and difficult parturition. Kashpur had achieved positive results in the treatment of neurotics, while Petrova in 1945 had proven its effectiveness in treating eczema and ulcers in neurotic dogs; and Strilchuk (in 1951) reported positive results in the treatment of dipsomaniacs with protracted hypnotic rest.

Platanov himself summarised the benefits as follow (1959, pp. 234–238):

long suggested sleep is particularly indicated in cases in which exhausting factors affected the nervous system for a long time, e.g., after most distressing experiences, serious surgical operations, difficult protracted parturition, grave somatic ailments, general fatigue, high nervous excitability etc. Surgeons may make wide use of protracted suggested sleep during the pre and post operative periods ...

There are reasons to believe that long continued suggested sleep may be of considerable practical importance in the prophylactics of hypertension, in treating ulcers, in the early stages of tuberculosis, generally in all cases in which it is necessary to restore to the maximum of the patients' health in a short time.

As for neurotic ailments, protracted suggested sleep is one of the most important therapeutic methods used directly after the removal of the basic pathogenic factors of the given ailment by verbal suggestion.

He noted that, before protracted hypnotic rest could be utilised on the patient, first a detailed medical history must be taken, appropriate psychotherapy instituted on conscious and hypnotic levels as appropriate, and then, if indicated, consolidation obtained with the assistance of protracted hypnotic rest.

## **EARLIER REPORTED STUDIES**

Among the earlier of more recent detailed clinical reports were those by the Japanese physician Kazuya Kuriyama (1968) who, in “Clinical Applications of Prolonged Hypnosis in Psychosomatic Medicine,” presented a very detailed clinical and experimental account of his use of this procedure as a desired therapeutic tool in ambulatory conditions or in a hospital setting.

Kuriyama defined prolonged hypnosis as “a therapeutic method which, by keeping the patient in a hypnotic trance for many hours or days, aims to exert the patient’s potential, strength inherent in the so called trance to the fullest extent” (p. 101). He made the following assumptions:

1. The human organism is endowed with spontaneous healing power, with which to restore healthy mind and body.
2. The so-called hypnotic trance serves the function of enhancing the healing force in the organism.
3. Especially in prolonged hypnosis, the self-recovering force is reinforced and the organism is set free from the strains of mind and body caused by the stress of the inner and outer world, and is helped to restore health.
4. Prolonged hypnosis stimulates the patient to develop an attitude to accept therapeutic approaches, such as suggestions and hypnotic working relationships, and to respond to them in an active and self-regulatory manner.

He has trust that the human organism is capable of self-healing and invigoration in appropriate conditions such as protracted hypnotic rest, be it for physical or for psychological disorders.

Kuriyama also maintains that in many cases “a mere induction into hypnosis can bring out marked improvement ... or disappearance of symptoms without any therapeutic suggestions or interpretations ... Often simply being in the trance seems to be very therapeutic” (pp. 101–102).

One can assume that a patient coming for therapy consciously or unconsciously has some desire to get well and the skilled therapist detects

and utilises that which in fact is a hypnotic or post-hypnotic suggestion. This reflects the 1893 view of Otto Georg Wetterstrand that the first duty of a skilled psychotherapist is to detect and to utilise anything that a “*patient brings to the situation and can be used to lift up, get well, and to utilise it appropriately*” (author’s italics)

Kuriyama (1968) points out also, that prolonged hypnosis “keeps the patient away from the stimuli and disturbances of the outer world and eliminates the tension state created by wrong learning, the inherent self-recovering force and the effect of the trance will be enhanced to an optimal level. Also the feeling of security and satisfaction that come from the fact, that the patient is treated well and *long enough*, add to more favourable results” (p. 102).

He differentiates his strategies as follows:

1. Short-term prolonged hypnosis, which amounts to a trance of two or three hours duration.
2. All-night prolonged hypnosis, where he hypnotises a patient at night and maintains the trance until the patient goes into a natural sleep through to the following morning, when an instruction to wake up from hypnosis is given only after he washes his face.
3. All-day prolonged hypnosis — following the all-night hypnosis — already mentioned in point 2.
4. Long-term, prolonged hypnosis to “maintain the trance all the day long and moreover, preserve it as long as the subject wishes, that is, until he feels confident that he will recover. If necessary, the trance is to be continued for a few days or even for several weeks” (p. 102).

Strategy 1 could be applied for outpatients as well, but methods 2 to 4 require in-patient hospitalisation. Strategy 4 requires very careful preparations and may be used only for specific conditions.

The patient must understand that he can safely drink water, go to the bathroom, and to do anything he requires *under hypnosis*. Visitors should be prohibited during the time the patient is in trance.

Some of his instructions included the following: *From now on you will be on the bed hypnotised for a long time. You are lying on the bed with your mind and body so relaxed and comfortable. If you want to go to the bathroom or drink water, you will have no trouble doing so under hypnosis, and after coming back to bed, you will automatically go into a hypnotic state which is much deeper than when you left the bed. You are so comfortable, that you will never feel that you woke from hypnosis, but rather, that you wish to go into deeper hypnosis.*

For night patients, his suggestions are as follows: *You will be under hypnosis for a while and then you will gradually go into deeper sleep. You will not wake up until tomorrow morning when you will wake up from hypnosis only after you have washed your face. At that time your head is clear and you feel very good. You will enjoy breakfast very much.*

Kuriyama suggests that prolonged hypnosis could be used in a situation when a favourable outcome is expected and when a treatment has reached a deadlock. He favours using protracted hypnotic rest for:

1. bronchial asthma, organ neurosis and anxiety neurosis, in which attacks occur daily particularly during the night,
2. angina pectoris, and chronic stomach ulcers in which no immediate psychogenic factors are detectable and where a good balance of mind and body seems to play an important role at present in bringing out favourable therapeutic outcomes,
3. cases of chronic anxiety and tension where delayed psychosomatic symptoms are perpetuated, and
4. cases where no positive effect can be expected, or obtained, by drug therapy or by the ordinary short-term hypnotherapy.

He presents the following clinical cases as treated by him with very good results:

- eight cases of bronchial asthma, with only one patient not improved,
- eight cases of anxiety neurosis, with only one patient not improved,
- six cases of organ neurosis — all improved,
- two cases of conversion hysteria — both improved,
- one case of angina pectoris — improved, and
- two cases of chronic stomach ulcers — both improved.

It is reasonable to expect that during the group's prolonged hypnotic rest, one will encounter hypnotic behaviour of different modalities — passive, active and sleeping — which will raise the old academic questions: “Is hypnosis induced sleep?” as the Pavlovian school suggests, or is it “anything but sleep,” as suggested by Western hypnologists. The different modalities of trance experienced here will be of practical value.

But even more important are questions put by Stanislav Kratochvil (1970, pp. 25–39):

1. Are hypnosis and sleep phenomena somehow related or can they be fully independent of one another?

2. What will happen if hypnosis and sleep are developed independently by different means at the same time: Will they interfere, mix together or displace one another, or can they be sustained both at the same time, each following its own rules?
3. Is it possible that normal sleep with its usual laws can take place in the hypnotic state without disturbing it?
4. Is it possible that the subject might “live” in hypnosis with his normal waking sleep rhythm preserved?

To throw some light on these questions, Kratochvil conducted an experiment involving 10 subjects (5 patients and 5 students) using the following method:

1. All subjects had to achieve a somnambulistic state so that they would be indistinguishable from others in the normal waking state.
2. Distinguishing all subjects with clear control mechanism indicative of his hypnotic state.
3. Distinguishing subjects in hypnosis for more than 12 hours including night hours.
4. Collecting data about behaviour of the subjects from observers and a subjective report written by the subjects themselves during the hypnotic trance.
5. Occasional examination of rapport.

Subjects were instructed as follows:

1. *You will remain in hypnosis until I repeat three times the word “zero.” You cannot return to a normal state without this signal. Another person would only be able to bring you back to your normal state by repeating this word 10 times.*
2. *You will behave and live in the hypnotic state in the same way as if you were not in hypnosis. You will be engaged in your everyday activities, talk with other people, eat and sleep normally at night, so that nobody will be able to find anything strange in your behaviour; you won’t be aware of any change either.*
3. *With me, you will be able to speak quite normally too. My words will act upon you as a direct command only if I change the intensity of my voice, that is, if I whisper or speak more loudly than usual.*
4. *As long as you remain in hypnosis, you won’t be oriented in time. You will answer each question concerning the date, “January 1st,” being convinced that this is true. This is the only date you know from this moment, in your hypnotic state.*

5. *You will write a diary noting legibly and exactly what you have done from this moment, what you have spoken about, from what time to what time you have slept and all you have thought about.*

The results were as follows: Normal sleep and normal awakening in the morning did not interfere with the induced hypnotic state that lasted from the hypnotic induction until the terminating signal. These results constitute anecdotal evidence that hypnosis and sleep are processes which can be independent of each other and that sleep is only an accidental attribute or an artefact of the relaxing induction technique.

The experiment lasting from 16 hours to seven days demonstrated also that it is possible to develop a waking prolonged hypnosis with preservation of the normal rhythm of waking and sleep.

*Before you consider the idea of the use of prolonged hypnotic rest for a group, you need to know a number of things and you need to be qualified to do so.*

One must carefully consider personal values and the effect of “group dynamics” upon the therapeutic result and to formulate and administrate prehypnotic *suggestion*, as outlined by Schneck (1975). Particularly helpful is the article by Serlin (1970), “Technique for the Use of Hypnosis in Group Therapy.”

Participants can be encouraged to use self-hypnosis following the prolonged hypnotic rest workshop and are recommended to read, if necessary, “The Phenomena and Characteristics of Self-Hypnosis” by Erika Fromm and colleagues (1981).

Incorporation of Stanton’s “Ego Enhancement” (1989) is beneficial. This consists of:

- physical relaxation – by concentrating on the breath, relaxation, detachment;
- mental calming – by concentrating on water and stillness;
- disposing of rubbish – dumping of mental obstacles; fears, doubts, worries, guilt;
- removal of barriers; the negatives in life, the self-destructive thoughts, mental obstacles, self-imposing limitations, forces of failure and defeat, prevention from enjoying life; and
- enjoyment of a special place where one feels content, tranquil and still.

As well, incorporation of Hartland’s (1965) “Ego Strengthening Routine” is recommended. This script contains suggestions of profound relaxation, receptivity and lasting impression on thoughts, feelings, actions, continuation,

on power, strength, fitness, and on interest in life: distraction away from oneself, stronger and steadier nerves, calmness, clearness, better composure, placidity and tranquillity, clarity of thought, better concentration, direction of one's attention, improvement of memory, clearness of thought, emotional calmness, complete relaxation and confidence, greater independence, greater personal well-being, safety and security, happiness, contentment, optimism and self-reliance.

Particular attention must be given to pre-hypnotic suggestions. Participants must bring to the workshop and operate within it that which has been agreed upon, lest other underlying undisclosed motivations take over.

## **SUMMARY**

Needless to say, as practical psychotherapy reveals, most of the rules, when dealing with a human being's behaviour, have some exceptions and this should be kept in mind while reading this summary.

People who come for hypno-therapeutic interventions are usually very much resigned and exhausted, following unsuccessful, intensive, and prolonged "wrestling" with their maladaptive behaviour. They have a very long history of silently (in private) trying to hide, and to conquer their "inadequacies." They have had many reproaches from members of the family, and "full of wisdom" instructions from various "helping" institutions, but they still are suffering, and "at the end" of the road. They await miracles from the hypnotist, but at the same time they dread his/her endeavour to "uncover the trauma and the unconscious" and then let them go, with clever instructions, to face their own realities.

Some patients (at least), due to previous "intensive analysis," remain "stuck" (and some even pleased) with the analytic process, blaming their parents for mishandling them at the "oral, anal or genital periods," and teachers, community leaders, employers and the society in general for being unjust and cruel; with the consequence that all this leaves them no time and energy to think, to plan, to look forward to future achievements — the things that will make them happy.

The positive answer to the condition will be forthcoming only when the therapist strongly believes in the capacity of the patient to deal with himself adequately, and when a milieu of mutual trust, security and respect is established. Asking questions will only prompt the patient to hide his most inner secrets and giving any advice may well be contrary to the patient's personal principles.

The therapist should tell the patient the truth; namely, that the patient has the capacity to deal with himself in all situations just by trusting himself and his judgments and by respecting his personal values and principles.

While recognising that the patient is exhausted, he will draw his strength from complete and deep hypnotic rest, accompanied by pleasant background music which will stimulate therapeutically appropriate emotional intensity, without “verbal pollution,” and will enable him to move forward creatively with his life.

Protracted hypnotic rest is therapeutic in itself; rest is essential in any therapeutic process, including psychotherapy, where the process is initiated and guided by the inner voice present in every human being, thus allowing a person to be more authentic. By means of pre- and post-hypnotic autosuggestions, the therapeutic process could be condensed and could also be extended, thus preventing internal and external stimuli from triggering off undesirable processes.

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## APPENDIX

### PROLONGED HYPNOTIC REST WORKSHOP

(Conducted by Dr E. Hlywa with the assistance of Mr Will Pitty and Mrs Zaharah Braybrooke)

#### **The Objectives of the Workshop**

To enable participants to experience the benefit of protracted hypnotic rest for the enhancement of well-being, social and professional status, the quality of life, self-assertiveness and self-image.

It should be noted that strong reassurance was initially given to each participant individually and then in the group, that no person would be asked, nor would be encouraged, to impart anything intimate or personal. The reason for this assurance *is the group's and the individual's rights to privacy*.

The primary suggestion given was to enter into a deep hypnotic trance.

It was planned that appropriate measures would be adopted in the event of spontaneous abreaction and it should be noted that Mr Will Pitty was on hand for the duration of the workshop.

Soft music (not songs), appropriate for relaxation, was played all the time.

In a prolonged hypnotic rest, music is a very valuable non-toxic adjunct: It helps to maintain constant rapport with the therapist, it promotes valuable imagination and emotional intensity without verbal pollution, and it provides a chance for a therapist to have a rest (Walker, 1991).

The instructions to participants were as follows:

1. Bring your written positive goal/s with you, which will be your post-hypnotic suggestion (for this session up to three goals will suffice).
2. Dress casually as you will, in fact, have a prolonged rest on a mattress.
3. Bring with you a pillow, sheets and a blanket.

### **Format of the Workshop**

Participants first had a private interview with the workshop leader before the Prolonged Hypnotic Rest workshop started. They were given the opportunity to mention anything that they felt to be necessary to mention and that conversation was appropriately/therapeutically treated at that interview. The goals which each participant brought to the workshop were discussed in this personal interview and it was agreed upon that they would become the post-hypnotic suggestions. Also in this personal interview, the HIP was administered to assess the degree of hypnotisability and a certain degree of psychopathology, in accordance with Spiegel and Spiegel (1978). Participants were then led to their mattresses with the instruction, to “drift into a deeper trance with every breath you will exhale.”

Then, to the group with the music softly playing, the workshop leader gave a short talk covering the historical development of the concept of protracted rest as per the beginning of this article; the theoretical bases; clinical and experimental justification for some practical approaches; rehypnotisation and deepening of the trance; and instructions about self-hypnosis.

With the participants still on their mattresses and already in trance, the workshop leader then gave the following pre-hypnotic suggestions in accordance with his existential philosophical point of view.

1. Whenever I will be suggesting to you, that you will achieve your tasks, your objectives, and your goals — you will think about *your written goals*, and they will constitute your post-hypnotic suggestions.

Together with Sartre, Marcel, Heidegger, Binswanger, Boss, Van Kaam, Merleau-Ponty, Rollo May, Jaspers and others, I believe that every human being is *master of his own destiny* — he is constantly in the making; he is forced upon with “*the freedom to decide and to make his own choices*,” and his choices must reflect his profound *self*; his principles, his likes, his loves, his desires — not anybody’s desires, but his own; he must be true to himself — *he must be authentic*.

*People lacking authenticity* are constantly placing themselves — just below, just behind somebody, and as a result of this, they constantly feel “second,” inadequate, tired, exhausted, even hopeless and may stop trying to achieve, and will leave themselves empty of desires, of dreams, of ideas, of wishes and of goals, and thus will make their lives desperately lacking rewards, and in some instances, even not worthwhile living.

Therefore, whenever I shall mention that you are more *authentic, respecting your own wishes, likes, loves and your dreams* — it will mean, that you are having *complete trust in yourself and, that you are **making your own decisions for your own good and your own benefit.***

2. The next suggestion is — that you are *open to experience*; not infrequently people tend to wrestle with a problem, loaded with a feelings of shame, regret, remorse, guilt and others, to a degree that they fail to notice and to appreciate that things around them “are happening,” and that many of the things are directly concerning them. But, being embedded in their problems, they are likely to miss out on participating in the creation of their own present and future, thus denying themselves a chance to build and to shape their own world in the way that they would like it to have. As a consequence, they are feeling that they are being unwillingly “*sucked into a situation,*” which is not of their own making, choice or liking, just because they are missing out on the chance of shaping their own “cosmos,” from which, as a result of a failure to be open to experience, they feel more alienated, estranged and unhappy.
3. The practical message is: *Stop tormenting yourself because of any inadequacies you feel you may have, and stop being chained to the feeling of misery — but, be positive, and confidently get on with your life.*

Remember that every moment in your life gives you a possibility and a choice to use it for your own benefit and good.

4. You will appreciate and you will have a respect *for the reality*; existential philosophy teaches us that all the freedom which a human being has, is delineated by reality, and that without appreciation of the reality, existence is doomed to failure. These realities could be physical, social, economic, cultural, educational, and indeed some of them may be of a permanent nature such as the physical make-up of a man and a woman and many others. But many of them are mutable, and the change itself, frequently, may depend on the recognition of the reality.
5. Another important message is that *happiness is the greatest gift* that a human being can possess and can share with his loved ones and with his friends,

but happiness is not attainable as a goal in itself; happiness is a *by-product* of human achievement — for we feel good, if we realise that we have *achieved something*.

Many of us sometimes feel that we ought to sacrifice ourselves for the sake of our spouses, children, not realising for the moment that our children treasure our happiness much more than our tears. But the worst thing is to chain ourselves to the misery of guilt, because “we are not up to the standard, or we have failed, or we make mistakes.” Human beings, although being ingenious, are liable to, and in fact do make mistakes, but it does not mean that we are to glue ourselves to being unhappy forever.

The way to get away from misery is to *watch out for the possibilities* to achieve and to make proper decisions to this effect rather than to remain pondering about our failures and our mistakes.

6. A very important message is that the human being is *born to care*: We care about the fate of our neighbours, our nation; we care about the fate of refugees throughout the world, about people being killed, about hunger and starvation; we care about flora and fauna; and with human emotions, we are able to care for the universe distant in time and in space. We definitely care about the future of our children and about our own happiness here and now.

With this propensity to care we do have a certain amount of anxiety and this is a perfectly normal state of the human existence.

In order to be able *to care, to achieve, to be in touch with the reality, to be open to experience, to be authentic, to be able to choose and to make decisions and to be happy* — a human being must be able to maintain a *proper lifestyle*, which means that, apart from work, he must rest, play, eat, drink, and sleep.

It is important *that we separate work from rest, sleep and recreation*, otherwise our rest and sleep will be disturbed and our work will be adversely affected — I do suggest that you firmly delineate your work from the rest, recreation and from sleep.

Following that for the next two hours, intermittent suggestions were made, according to Walker (1979,1992):

- “You will let the music become the moving pathway of sound, that carries you into hypnosis ... a delightful scene will form itself around you, and you will become more absorbed in the experience ...
- “Your body is light and comfortable and floating ... let the music take over your mind and lead you into hypnosis ...

- “As the imagery and music become more vivid and absorbing — you will absorb my suggestions.”

Also the post-hypnotic suggestions which were agreed to in the private interview were administered.

At about 12 noon, ego-strengthening suggestions were given following Stanton (1989) and Hartland (1965).

At 12.30 p.m. participants were brought out of trance for lunch and for informal reflection upon their experience so far.

After lunch, the workshop recommenced at 1.30 p.m. with a debriefing on the pre-lunch experience in which participants were encouraged to make submissions, to engage in discussion, and to ask questions.

Participants then continued with the prolonged hypnotic rest with the administration of the suggestion of “a complete rest” at least half an hour before termination of the session at 5 p.m.

The consensus of the informal evaluation from participants was that the workshop was successful and that they felt refreshed and well rested from it.

## **HYPNOSIS IN THE TREATMENT OF SOCIAL PHOBIA**

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*This case illustrates the successful use of hypnosis with a 55-year-old client suffering from a 30-year history of social phobia. The client had been diligent in attempting a variety of therapies for most of that time, practising the use of typical phobia treatments such as systematic imaginal and in vivo exposure. Due to their lack of success, these treatments were not emphasised in this instance. Relaxation and breathing training were taught to lower anxiety. Ego strengthening was used, followed by age regression, and the affect and somatic bridges to access the past. Future-orientation with imagery enabled the client to visualise success, while anchoring was taught for quick access to a relaxed state. The trance state was utilised to discard unwanted thoughts and emotions.*

### **PRESENTING PROBLEM**

Richard self-referred with a diagnosis of social phobia, as assessed by a number of clinicians over the previous 30 years. It was interfering with his work and social functioning, but he was otherwise in good health. The client's shyness began to worsen after leaving university at age 25. Over the years, he had sought treatment from many specialists, university courses, workshops, private psychologists and psychiatrists. He had tried medication unsuccessfully, and now used alcohol to lower anxiety prior to perceived "difficult situations."

On presentation, he appeared shy, made very little eye contact, and spoke hesitantly. He reported that just prior to coming to see me, he ran away from an impromptu interview with the media, which would have meant significant free advertising for his business. He also reported using alcohol if he knew he was going to meet new people or socialise, although he only ever drank enough to calm himself. However, he had a new girlfriend and was finding the need to drink as embarrassing as being in the social situations. There were no associated depressive symptoms, and the anxiety was not generalised. Richard reported no other relevant psychiatric or psychosocial stressors.

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## **HISTORY**

Richard was a 55-year-old man with three adult children. He had separated from his wife two years ago, but said it had been by mutual agreement and he was happy with the arrangement. He had a current girlfriend. He ran his own lucrative business making and selling water coolers. He was brought up as a strict Christian in a wealthy family. He said his mother was always pregnant and ill, and his father was hard to please. He was one of seven children, but his parents picked him as “the one that would become a priest.” He was sent to private boarding school at aged 12, and recalled his time there as being the best years of his life. He excelled at school, becoming Head Boy and winning medals for high academic and sports achievement. He was popular with both males and females. He was highly successful in several sporting arenas. He completed two degrees at university and eventually became a sporting coach at a number of schools.

Richard reported that he had always been a little shy, but the shyness progressively worsened after he left university. After some discussion, it soon became apparent that he knew a great deal about phobia treatments, such as medication, cognitive–behaviour therapy, meditation, and systematic desensitisation. He had been seeking treatment on and off for 30 years from “top professionals” and was frustrated with his lack of progress. Another dilemma was that nobody had ever been able to tell him why he had developed social phobia. There seemed to be no specific trigger. I discussed hypnosis with Richard. He was very enthusiastic, as it was something different from previous treatments. He expected to find it useful because he was good at meditating. Perhaps both his own and my enthusiasm for hypnosis were already predicting successful treatment outcomes.

## **DIAGNOSIS**

From Richard’s description of his symptoms, he qualified for a DSM-IV diagnosis of social phobia, which has the essential features of a marked and persistent fear of social or performance situations in which embarrassment may occur (American Psychiatric Association, 1994). However, I kept an open mind because I found Richard’s description of his youth to be in stark contrast to symptoms of social phobia. I assessed the possibility of secondary gain, because his symptoms had persisted despite his desire to get well and after seeking so much professional treatment.

## TREATMENT

### Session 1

Rapport had been built with Richard during some previous consultation sessions. As he was well informed about relevant treatments, I wanted to use the knowledge and skills he already had. I asked him how he relaxed for meditation and what his favourite scene was. I taped a relaxation session, and encouraged him to practise daily at home, as clients who take part in their own therapy have been shown to respond more quickly than controls (O'Neill, Barnier, & McConkey, 1999). I began with progressive muscle relaxation and incorporated breathing training, encouraging the use of slow, rhythmic, shallow breathing. I suggested that Richard imagine sinking deeper into the sofa every time he exhaled. I also asked if he could focus specifically on how different a relaxed feeling was to an anxious feeling, to enhance familiarity with calmness. Richard went to his favourite place in his imagination and I encouraged the use of his other senses to take in the environment. The first session ended without formal hypnosis, induction, or deepening taking place.

### Session 2

Richard said that he had listened to his tape and had none of his usual symptoms for two days following our first session. However, he was disappointed that the effects did not last the whole week. During those first two days, he went to a nightclub and was introduced to new people. He stated that he did not drink alcohol before going out that night. There was a moment when he felt panicky, but he was able to slow breathe and “let it ride over” him. I noted that Richard was making more eye contact, and his speech was less hesitant than before.

I decided to use a non-directive approach to the hypnosis session, since phobic clients frequently express fears about losing control (Andrews, Crino, Hunt, Lampe, & Page, 1994). I also suggested that if I said anything that did not suit him, he would be able to make it fit. At this session, Richard was able to progressively relax quite quickly as an induction. After deepening by suggesting that he could feel himself sinking deeper into the chair every time he exhaled, I used ego-strengthening techniques to begin building self-esteem. Richard focused his thoughts and feelings on past and present life successes as reminders of his capabilities.



### **Session 3**

At this visit, Richard reported having felt much calmer in company for the entire week. He said that he still had not used alcohol, and was pleased at his girlfriend's acknowledgment of his rapid progress. His sleep had also improved. Twice he discovered himself feeling comfortable in a situation that would previously have produced anxiety. Planning to use the technique of anchoring during the hypnosis session, I asked Richard which hand would represent the problem and which would represent his solution. I also gained permission to touch his hand. He agreed to age regression with the intention of being able to go back to his college days. Using imagery, I encouraged the use of Richard's sub-modalities to re-experience past success, pleasure, popularity, accomplishment, and lack of fear. Future imagery was then suggested, so that Richard could transport thoughts and feelings from his successful past to future social settings. He was able to visualise himself in many situations, just the way he wanted to be. At that point I anchored the positive feelings and thoughts to his chosen "problem-free hand."

### **Session 4**

Richard was still extremely well and excited about his achievements. He said he was beginning to feel like a successful person. There had been no embarrassing moments and no alcohol consumption to alleviate anxiety. Little things that were hassles were "just not there any more." He had socialised a lot and reported that phobic symptoms were no longer on his mind.

Due to the fact that Richard was still keen to find the reason for adopting socially phobic behaviour, he agreed to age regression using the affect and somatic bridges to revisit pre-boarding-school days. He said he could often hear his father's disapproving voice in the background, encouraging hard work without his becoming bigheaded. It was Richard's idea that we imaginably tape his father's words, remembered during hypnosis, so that he could later destroy the tapes and throw them away. I was encouraged by his creativity. During the age regression, he began to experience anxious symptoms when remembering his father's voice. He perspired, became agitated, and said he was experiencing inadequacy and confusion. However, he became absorbed in visualising the taping of voices, and the affective and somatic symptoms of fear passed. It was suggested that Richard could fill a receptacle of his choice with the unwanted tapes and discard them. He found this technique relieved his anxieties.

## OUTCOME

It was originally my intention to discuss, outside of hypnosis, the subject of secondary gain. Richard and I theorised that perhaps he had developed symptoms to keep himself humble and to please his father. Being proud of success in boarding school and university, away from his parents, was allowable and even rewarded. However, when he left university he was back in an environment where excellence was often ignored, or was never enough. His own suggestion that perhaps “inside me was an extrovert trying to get out” was certainly plausible. Part of his personality was being inhibited by the words of his father. Anxiety could come from such internal polarities. I asked him if it was okay to be extroverted now, and if his coping skill of suffering with social phobia had served its purpose. I asked if he had become a successful man who was not conceited. Richard smiled and said he had. He then spoke of his decision to get fit again, stating that he had been running and surfing every morning for the past couple of weeks.

Richard cancelled his next appointment saying that he had had no symptoms for three weeks and had not used alcohol to be with other people. He said he would contact me if he needed to.

## CONCLUSION

This case study has highlighted the successful use of hypnosis for treatment of social phobia. Hypnosis was useful in uncovering the beginnings of phobic behaviour and facilitated attention on past and present life successes as reminders of the client’s capabilities. It also assisted with imagery of the way the client wanted to be in various situations. Richard’s familiarity with other treatments could have contributed to the successful outcome. Lastly, according to Lipsett (1998), when symptoms persist despite repeated and relevant treatment, it is likely that the client still receives some benefit from the behaviour. A discussion about secondary gain proved very useful.

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## SCRIPTS

### THE ROBOT STORY

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#### PREAMBLE

Interest in science fiction and science fantasy as a subject has been around for a long time and never more so than now, with films such as *Star Wars*, and with books such as *Lord of the Rings* becoming feature-length movies. My interest in this genre began as a high school student. The closer the exams, the more sci-fi paperback novels I would read. Doubtless this could be called displacement activity or substitution. I did not realise my interest and enjoyment of these would play a role in my professional work many decades later. What follows is a description of how one of the themes of science fiction was adapted for clinical use within the context of therapy in hypnosis.

A recurring idea in many of these stories is the discovery of the importance of self-belief by a principal character, often the hero or heroine. Remember the *Star Wars* scene in which Yoda instructs Luke Skywalker to raise his spacecraft up out of the swamp. Luke tries but cannot achieve it. He watches despondently as Yoda closes his eyes, appears to focus his mind towards the sunken spaceship and effortlessly lifts the craft onto the land. Luke exclaims, “I don’t believe it!” Yoda shakes his head and responds, “That is why you fail.”

In clinical work, often the hardest task is to persuade the patient or client to assume responsibility for their lives. The psychological explanations for how human responses develop are numerous. They include concepts such as locus of control (Julian Rotter, cited in Myers, 2004, p. 602), social cognitive theory (Albert Bandura, cited in Atkinson & Hilgard, 2003, pp. 472–473), learned helplessness (Martin Seligman, cited in Atkinson & Hilgard, 2003, p. 501), and attribution theory (Carr, 2003, p. 200; Myers, 2004, pp. 696 ff).

Fortunately, as clinicians we do not have to teach our patients these psychological explanations in order to help them overcome their symptoms and problems. After history-taking and a tentative formulation has been made most therapy or treatment proper commences with the clinician offering information about the condition to be managed. This psychosocial educative stage assists the therapeutic alliance to evolve. Without this alliance, therapy may not progress. By the acceptance of the information provided, the likelihood of a successful outcome is increased.

## **OUTLINE OF THE PROCEDURE**

The patient is led into a trance using any standard induction, followed by deepening. A special safe and/or happy place is found or created utilising all the senses, visual, auditory, kinaesthetic, etc. It is also useful at this stage to create a key phrase consisting of two words which describe how the patient is experiencing the special place; for example, “warm and relaxed,” “safe and secure,” etcetera. This phrase can then act at other times as a short cut to entering trance quickly or as a reinforcing cue for rapid deepening. Ideomotor finger signals are also helpful to have in place by the end of this phase.

The Robot Story is told to the patient after they have experienced trance once or twice and have indicated they are comfortable with this approach to therapy. After trance is achieved, and the patient has entered his or her special place, they are told they are going to hear a story while they are there. It does not matter what the special place consists of, because the patient is going to modify it sufficiently to enable them to take part in the story.

The script is delivered in the clinician’s usual tone and style of speech.

*Now that you are comfortably enjoying your special place, I am going to invite you to expand your experience. Look around and a little way off you will see a small clearing. As you walk towards the clearing, you might notice a shimmering haziness in the centre. As you get closer the shimmering stops and in front of you there is now a large sphere. You walk closer and an aperture opening appears in the side of the sphere. A gentle sloping ramp leads into the sphere. You are standing there with your curiosity growing, but otherwise you are surprisingly very calm.*

*You are wondering what to do when a figure materialises in the opening. It looks like a mechanical man, a robot. The robot raises an arm and motions you inside the sphere. Simultaneously, inside your head you “hear” an invitation: “Please come inside, you are very welcome.” The “voice” imbues you with a sense of trust and confidence, and so you step into the sphere.*

*The interior of the sphere is much more spacious than it looked from the exterior. Perhaps it is like Dr Who's Tardis. There is a soft glow of light enabling you to slowly glance around. It looks like a control room but there are very few instruments. In the centre of the interior, there is a recliner couch. The voice in your head is saying, "Welcome to my home, please rest." Again it must be the robot speaking, because its arm motions you towards the recliner. You slide onto the recliner and it gently moulds itself to your body. You are feeling supported and secure. So far, the experience has been fascinating. You are surprised you continue to be so calm and relaxed.*

*The robot seems to be speaking to you again: "I sense you are a seeker and that you have had some troubling times. Perhaps I can help?" If you wish me to continue, raise the finger that indicates yes as we determined at the start of the session ...*

The robot story can then be told.

## **THE ROBOT STORY**

*Once upon a time, there was a machine called a robot. The robot knew many things, such as the data held in its computer "brain," but the robot did not know how it had become a robot. So it sought out this knowledge and discovered much. This is the robot's story, and what the robot found.*

*There are some very fundamental differences between humans and machines such as robots. For instance, a human can:*

- (a) think thoughts,*
- (b) experience emotions,*
- (c) communicate verbally and non-verbally, and*
- (d) can act and behave.*

*These four primary functions operate on the principle of free will.*

*A machine, a robot, cannot function at all without instructions in its computer brain. Humans have a brain, but it is the functioning of the brain which gives rise to a human's mind. It is this which makes humans the most powerful creatures on earth.*

*Perhaps a simple story may make this clearer.*

*There was a human who wanted to have fresh vegetables to eat. However, robots do not have to eat. The human was not very good at digging gardens and was happy upon seeing an advertisement for a gardening robot in a hardware catalogue; and so the human decided to buy one of these machines. The robot was brought home and assembled, and instructions were programmed into its computer to dig up a section of the garden plot and turn it into a vegetable patch.*

*The human went inside and looked through the window to watch the machine working. The robot picked up the spade, walked over to the window and smashed it!*

*When the window was smashed:*

- (a) What did the human think and how did he or she think it?*
- (b) What emotional reactions did the human experience?*
- (c) What communications did the human produce?*
- (d) What actions did the human take?*

*Having answered these questions, who is responsible for the thoughts, emotions, communication and actions the human had? There is only one correct answer — the human himself or herself.*

*The “voice” continued: “Change the scenario and see if the answer to these four questions changes”:*

*The human wanting the veggie patch did not go to the hardware store and buy a gardening robot. The homeowner went to Centrelink instead and hired another human who said he was a gardener. Back at the first human’s home, the gardener was given instructions to dig the section of garden and turn it into a veggie patch. The homeowner went inside to the window to watch the gardener working.*

*The supposed gardener picked up the spade and smashed the window!*

*As before:*

- (a) What thoughts did the homeowner have and how did they think them?*
- (b) What emotions did the human experience?*
- (c) What communications did the human produce?*
- (d) What actions did the human take?*

*Having answered these questions, who is responsible for the thoughts, emotions, communication and actions the person had?*

*Once again the only correct answer is the human himself or herself.*

*Many humans at this point would be blaming the robot, or the pretend gardener, for the thoughts, emotions, etcetera going through their minds; or they would be saying it is the robot’s fault or the gardener’s fault, for causing the mental processes in their minds.*

*This conclusion would be an error owing to the fact that the human has judged the question of responsibility from the perspective of the bad consequences, that is, the broken window. What if either the robot or the gardener had dug up the garden perfectly and planted lovely rows of vegetable seedlings? Would the homeowner still blame the machine or the man for what is now going through their mind? Probably not.*

*So what is the learning here? There is a tendency for humans to avoid responsibility when things go wrong. They usually tend to find fault, to blame someone else or apportion*

the guilt elsewhere. By contrast, humans are very quick to accept the compliments and congratulations when things turn out well.

It is an error to believe it was the fault of either the gardening robot or human gardener. In fact, neither the robot nor the man caused the thoughts, the emotions, the communications or the actions in the homeowner's mind.

### **Humans are Always Responsible for Those Processes**

To clarify this concept, ask, would the window been broken if the human had not wanted a veggie patch in the first place? Logically, neither the robot nor the human from Centrelink would have been in the garden, if the homeowner had not wanted a veggie patch. It was the homeowner who initiated the whole sequence.

The reason for this lies in the fact each and every human has free will. Therefore no matter what happens inside a human's mind, they are responsible for it.

What happens though if something happens which the human did not start? As the "rain story" which follows demonstrates, it makes no difference.

There was this human called Wong, who came to South Australia because it is the driest state on the driest continent. Having been a tennis fanatic for a long, long time, Wong knew you cannot play when it is wet. So having a dry climate was attractive. And for 25 years or more, Saturday afternoon had been Wong's tennis day when he plays social tennis.

Imagine you are in Wong's shoes. It is Saturday morning and you step out the back door. You look up at the sky and it is raining. You are Wong, so when you see the rain ...

- (a) What thoughts do you have and how do you think them?
- (b) What emotional reactions do you have?
- (c) What communications might you produce?
- (d) What actions do you take?

Who is responsible for these processes? The the only correct answer is Wong. He is responsible for those four processes occurring in his mind. What happens if the script changes slightly?

You are no longer Wong. You are not at his back doorstep. Instead, you are over on Eyre Peninsula, South Australia's cereal grain growing region. You are now Farmer Brown. Farmer Brown has been waiting for the season to break; that is, he has been waiting for the rains to come, so he can plough his land and plant his cereal crop. He has been waiting and waiting because if he does not get a crop planted, then he does not get a harvest and thus there will be no income. Instead, he simply watches his parched soil blow away in the wind. Anyway, you are on Farmer Brown's back doorstep, you look up at the sky and it is raining.

*As you are Farmer Brown ...*

- (a) What thoughts do you have and how do you think them?*
- (b) What emotional reaction do you experience?*
- (c) What communications do you produce?*
- (d) What actions do you take?*

*Again, who is responsible for these processes? The only correct answer is Farmer Brown.*

*Irrespective of what triggers the processes either in Wong's mind or Farmer Brown's mind, either person Wong or Farmer Brown is individually responsible for what happens in each of their minds.*

*This applies to each and every human being you meet. The reason being, every single human has free will. So no matter what happens, the person has to exercise their own mind and eventually reach certain conclusions. The most important step is the first one. Whatever a person thinks, and how they think it, determines the other three processes.*

*Unfortunately most humans have not been taught how to think. All through their developmental years and education, humans have been told what to think.*

*Eventually, humans move into some faulty thinking habits and end up thinking inaccurately, if not completely erroneously, throughout the rest of life. This means, if the first step — that is, whatever a human is thinking and how it is being thought — is wrong, then everything else following is also wrong. This is the only correct logical outcome.*

*An example follows:*

*If you are thinking a happy thought in a happy way, the only emotion you can experience is happiness.*

*If you are thinking sad thoughts in sad ways, the only emotion you can experience is sadness.*

*If you are thinking angry thoughts in an angry way, you can only end up experiencing anger.*

*You could go on adding every kind of thought you could imagine and you can end up with the appropriate logical emotion following from it.*

*Sometimes, however, there are neutral thoughts and therefore there may be no emotion attached to them or created by them; for example, if you state a fact ... "the light is on," or "the sky is cloudy" and so on.*

*If you accept the Robot Story and the principle underlying it, you will start thinking that the letter "R" for Robot, means "R" for Responsibility.*



*If you ask yourself where does responsibility begin and end, you will discover that it begins and ends with you. A human cannot give away responsibility to another, nor can they take responsibility away from another. If you practise the Robot Principle correctly, you will only think in terms of responsibility and you will discard three other words — “fault,” “blame,” and “guilt.”*

*With free will, everyone is responsible for what goes through their minds. The principle applies to all human interactions. No matter what you might think, what emotions you might have, what communications you might produce and what actions you take, the person who receives this information has to do something with it in their own mind. This means, one person can never directly influence another person, in terms of what goes through the other person’s mind.*

*Another way of understanding this is as follows:*

*If something is said to someone in a different language, one they do not understand, the listener cannot react or respond to it. It is only when two people share the same languages that they have any chance to understand. Even so, it is very easy to fall into error because of the principles outlined above.*

*Humans have become very prone to making these thinking errors known as “cognitive distortions.” If thinking is mistaken or inaccurate or erroneous, all conclusions drawn must likewise be in error.*

*Of course, sometimes, humans do not always say what they mean, or mean what they say. But that is another story!*

*So we have the Robot Story and the Robot Principle. In other words, the mnemonic “R” for Robot = “R” for Responsibility. Each and every one of us is always responsible for what goes through our minds. When humans accept this consciousness, they become aware, attentive and focused. Responsibility is what makes the difference between a human and a machine.*

## **CLOSURE**

Depending on how long the storytelling has taken, the patient or client can be left in silence for 5–10 minutes to contemplate the story’s meaning for them. To conclude the session, the person is brought slowly and fully out of trance. This termination phase needs time to complete, as patients and clients often go very deep in response to the story. Leave any debriefing or interpretation of whatever the patient/client may have discovered from the story until the next session. It can lead to considerable discussion.

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## FALLING ASLEEP

Kathryn Tiffen

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This script relates to the article in this edition entitled: “‘I’ve Never Felt Like That Before’ — Hypnosis for Sleep Problems and Depression in a 10-Year-Old Boy.”

*Keeping your eyes wide open and trying not to let your eyelids close, I want you to imagine that you’ve been running and running and running and running, feeling that feeling of maybe running and running, feeling your legs running, feeling your arms by your side, feel how your muscles are going and going and going and going, until you feel like you’re just going to drop because your muscles have been going so much.*

*Now please let your arms drop by your side and let your legs drop down over the chair, or if you’re in your bed it feels like you’re just sinking into your bed because your muscles have been going so hard. Now keep on staring at a spot in the room, never looking away, trying for your eyes not to close, trying to keep them open as best you can, staring and staring, staring so hard until you feel like there’s nothing else in this room except that spot, focusing so hard, looking and looking at that spot, feeling heavier and heavier like you’re going to sink down; imagine you’re in a feather bed, you’re going to sink down, sink down like you’re going down in a power-driven machine.*

*Pretty soon it will become so hard to keep your eyes open that your eyelids will just shut all by themselves, looking and looking, not looking at anything else except that spot because in a little while, you’re going to have a sleep. I want you first to picture that a little mist is drifting in, see the mist drifting by, never looking away from that spot, in fact your eyes are getting mistier and mistier, looking at the spot.*

*Shut your eyes now; now is the time to shut your eyes and see that the fog is getting thicker, foggier and foggier but still very warm and nice; the mist is getting thicker and thicker until you can’t see anything except the soft, warm mist, and notice too that everything you’re thinking about just comes in and out of your mind while you go*

*on listening to my voice with your eyes closed, listening and listening, keeping your attention on my voice, becoming misty and vague; and all sorts of things are floating in and out of your mind becoming more and more misty; it seems as though my voice is becoming more and more distant too, far away, more and more distant and sometimes you can hear me less clearly.*

*In a short while, you'll find yourself drifting off into a natural, comfortable sleep and as you drift away, my voice and what I say, as well as all the other things that come into your mind from time to time will also seem to be vague and misty, not very clear and very far away, slowly and comfortably drifting into a sound and natural sleep. Shortly you will fall asleep and even though you're deeply asleep you will still hear my voice saying your name. At any time when you hear me say your name you may be able to come out of your sleep, but if you don't hear your name you will remain in the sleep, drifting off to sleep, to sleep, to sleep, drifting off, drifting off, drifting off, drifting off to sleep, drifting off, keeping your eyes closed and keeping your attention on my voice. From now on, you'll be able to drift off to sleep at any time you want because you'll be able to imagine yourself just drifting off into this special, relaxed place, this lovely place where you can just sleep and sleep. And each night, as you go to bed you'll be at ease and you'll be relaxed, you'll feel relaxed and calm knowing that every day is another adventure.*

*Even though some days will have problems and things you don't like, every day will be an adventure. Starting now, as you go to bed every night you'll be calm and at ease, your mind and your body will be calm, calm and relaxed, you'll be able to sleep calmly, be at peace and able to sleep the way you did when you were a little baby, so calm, so relaxed, so completely at peace and you'll be able to sleep soundly knowing that in the back of your mind each day you'll be getting to be more and more alive and as time goes on more and more wise and be able to sleep just the way you did when you were a little baby, the way a baby feels — so good and so secure — just that beautiful feeling of sleeping like a baby.*

*Now the next thing I'd like you to do is to imagine that you are going to go down a stairway with a carpet covering it firmly. Shut your eyes and picture the carpet and you're going to go down the stairs and I'm going to count them from 1 to 20; at the bottom of the steps there's a room, it's a special room, it's your room. In a moment, I'm going to count from 1 to 20, and you can shut your eyes, imagining that you're going down the steps — 1, 2, 3 — going down the steps, more and more relaxed — 4, 5, 6 — down the steps — 7, 8, 9, 10 — deeper and deeper still, listening to my voice — 11, 12, 13, 14, 15 — counting slowly — 16, 17, 18, 19 — and 20.*

*Shut your eyes now and imagine the room at the bottom of the steps. As you go into the room, it's the most comfortable room that you could possibly imagine and that room looks exactly the way you want it to be; everything about it is wonderful for*

*you, it has all your favourite things in it, all the things you love to do; just imagine and notice too how comfortable the bed is in that room and you can feel the pleasant drowsiness coming over you, more and more, as you drift off, drift off into sleep; imagine the softness of the room, imagine everything that's good about it. In a moment, it will be time for you to enter a deep sleep and just allow this tape to keep on going as you go off into your sleep.*

## **HYPNOSIS ANTENATAL TRAINING FOR CHILDBIRTH (HATCh): INTERVENTION SCRIPT 3**

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This script is the last of the four to be published, following the publication of scripts 1 and 4 in May 2007 and script 2 in November 2007. Details about the program can be obtained from those editions of the *AJCEH*.

### **HATCh TRANSCRIPT SESSION 3**

*Time to settle down now into enjoying this time just for you, and you can enjoy this time for you, where you don't need to please or impress anyone else, you don't need to solve any problems, you don't need to be anywhere else, this is time for you to settle down, relax and enjoy the ease of going into daydreaming type thinking. And you can just settle down in any way that comes naturally to you, breathing letting go, shoulders sagging, just letting it happen the way it wants to, any adjustments in your posture bringing even more comfort, even more relaxation, watching any discomfort, just as you watch the growing comfort, just letting the comfort develop the way that it wants to.*

*Jaw letting go, shoulders sagging, hands open and easy just letting it happen so the whole body just settles down, deeper and deeper relaxed, just letting go, letting it happen. Outside noises may somehow become a part of your growing sense of comfort, and you settle down deeper and deeper and you know you can become a bodiless mind, that's right, you can get up out of your body, turn around and take a look at yourself relaxing*

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The HATCh trial has received support from the Women's and Children's Hospital Foundation, the Australian Society of Anaesthetists, and the NH&MRC (Project Grant No:453446). Requests for reprints should be sent to Allan Cyna at [allan.cyna@cywhs.sa.gov.au](mailto:allan.cyna@cywhs.sa.gov.au).

there, notice the way your hair is, notice the clothes you have on today, the colours of your clothes, look at yourself settle down and relaxing there, you can be a bodiless mind and leave the body behind, you can just go out the door off and away to your special place, you can leave the body behind and be a bodiless mind. And you can enjoy re-acquainting yourself with all the details of your special safe place, what there is to see, colours, what there is to hear, louder sounds, softer sounds, what there is to do, to enjoy doing, and as you enjoy re-acquainting yourself with all the details of your special safe place you can go deeper and deeper.

And just around the corner from your special place there is somewhere else special for you, a spa, a special spa, and I don't know if it is an indoor spa or an outdoor spa but it is just right for you, so go around the corner to your special spa, and you can see your special place off in the distance, further and further away and maybe you can see yourself back over there in your special place relaxing comfortably in your special place, see yourself quite small and far away, and over there, and over here, here by your spa you can make yourself very comfortable at the side of the spa, maybe there is a comfy chair or couch to settle down into, and go deeper and deeper relaxed and you can enjoy filling in the details of your spa and its surroundings, I wonder what you can see, maybe the water, the colour of the water as those refreshing bubbles just zip around, maybe there are some plants nearby, and if you look at a plant carefully you may notice how every leaf is its own particular shade of green, it's incredible how many different shades of green there are in nature.

I wonder what sounds you might hear, maybe the sounds of the water, maybe some nice music playing. I wonder what nice smells there are, maybe some nice aromatherapy oils, and as you breathe in, you can breathe in that lovely smell and get a sense of refreshment and relaxation travelling all through the body. Maybe there is a nice taste for you to enjoy, something good to eat and drink and as you let yourself settle down very comfortably you might be aware of the textures against your body under your feet and notice how the temperature of the air is just right for you. And as you settle down, more and more comfortably relaxed, you may notice there are some bottles beside the spa, maybe like bubble bath bottles and the liquid inside is a lovely colour, a colour that's just right for you, and this liquid is local anaesthetic and you always have as much local anaesthetic as you need for your local anaesthetic spa. So tip the local anaesthetic into your spa and maybe the water in your spa gets an added shimmer of colour to it as you tip in that local anaesthetic, and in a moment you are going to get into your spa, one step at a time.

So down one step now, down into the spa, your feet and ankles down in the spa, and the temperature of the spa is just right for you, the little bubbles zipping around, the water swirling around the feet and ankles and as the local anaesthetic starts to sink in, down into the skin of the feet and ankles, down into all the tissues, the muscles, the

ligaments, the nerves, all the tissues as the local anaesthetic sinks in, the feet and ankles will start to feel different, start to feel numb and numb means different things to different people, for some people numb is a cool feeling, for others a warm feeling, for some people a tingling feeling, for others a heavy feeling, for some people a fluffy feeling or a fat feeling.

And as the local anaesthetic sinks in the feet and ankles will start to feel different, and when you can feel that different feeling, that numb feeling, you know that this is a useful feeling for you and you can feel even more relaxed and comfortable, and when the feet and ankles start to feel different you can go down another step, down another step into your spa, all the way down the lower legs, down to the knees and the spa can swirl around the lower legs and knees, the temperature of the water just right for you, the little bubbles so refreshing and that local anaesthetic can start to seep in, in through the skin of the lower legs and knees, down into all the tissues, nerves, muscles, ligaments and as that local anaesthetic starts to seep in, the lower legs and knees will start to feel different, that numb feeling starting to happen, and you can be curious about the way this numb feeling can just happen and you can focus on it, this numb, useful, comfortable feeling starting to happen, you can focus on the feeling, this different feeling, and as you focus on it you can feel it even more, and when you feel this numb, useful, comfortable feeling starting to happen, you can go down another step.

The thighs, all the way down in the spa, and so the water of the spa is swirling around the thighs now and the temperature of the water is just right for you and those little bubbles just zipping around are so refreshing and that local anaesthetic can start to seep in, in through the skin of the thighs down into the muscle, into all the tissues local anaesthetic seeping in, and as that local anaesthetic seeps in and spreads, the thighs will start to feel different, that different feeling, that numb feeling will start to happen and that numb feeling is comfortable, it's comfortable and it's useful, focus on it, that different feeling, that numb feeling, starting to happen. And when you feel that numb comfortable different feeling starting to happen, you can go even deeper into your spa and I don't know if you're going down one more step, or if your going to sit comfortably in an alcove, or if you're going to float perhaps in a rubber ring, but the chest is up out of the water, and the hips, the abdomen, the lower back are all down in the spa, very comfortable, comfortably supported, and the water of the spa is swirling around the hips, the perineum, the abdomen, the lower back, the temperature is so nice.

The bubbles are so refreshing, and that local anaesthetic can seep in, in through the skin of the bottom, the perineum, the lower back, the abdomen, down into all the tissues, down into the uterus, the lower spine, down into all the tissues and you can start to feel more comfortable, feeling different, feeling different in the lower back, the abdomen, the bottom, that numb feeling starting to develop as you relax, floating, drifting, comfortably supported by the water of the spa, floating, drifting, deeper and deeper relaxed.



*And you can be aware of that numb different comfortable feeling and you can be confident in knowing that you can produce this useful feeling whenever you wish, whenever you wish for useful numbing to occur, and each time that you get into your local anaesthetic spa and produce this numb feeling you can produce this feeling even better and it will be even more useful for you.*

*Now should any problems arise in the part of the body where you have produced this useful, numb, comfortable feeling, then you will have whatever symptoms are needed for the problems to be accurately diagnosed, and once the problem has been accurately diagnosed you can return to your numb and comfortable feeling, deeper and deeper relaxed. Each time you get into your local anaesthetic spa at some point you must remember to get out of your spa, but for now you may like to continue to drift, float very comfortably here in your special spa, drifting and floating, so comfortably, relaxing deeper and deeper.*

*And you know right here right now you have no need of your cares or worries, you know that you can just offload any cares or worries that you don't need or want right now, offload them into a container, a box, a basket, like any cares or worries about your pregnancy, about your baby about you and how well you will cope, offload them, or any cares or worries about your delivery or after the baby is born and how you will cope, offload them, any cares or worries you don't need or want right now, offload them. And you can enjoy sending the container off and away to the horizon so all those cares and worries seem so small and far away, and as they go very small and far away you can enjoy a wave of release and relief flowing all through you.*

*You know where the cares and worries are, and right now you can just let them rest there, very small and far away and really enjoy the release and relief, and as you enjoy the release and relief you can go deeper and deeper relaxed and you can continue to drift and float, comfortably relaxed, and enjoy perhaps spending a little time thinking about your baby.*

*Because a baby is growing inside you, nurtured by your body and you are coming closer and closer to meeting this baby, your body knows what to do, your body knows how to nurture your baby and your body knows how to deliver your baby safely and comfortably, trust in the body, all you need to do is relax, and let the body do what it knows how to do, let the body flow quite naturally and easily and you can go with the flow and relax into the flow of the body and give birth to your baby safely and comfortably.*

*You have the ability and you have the freedom to do whatever you need to do to be comfortable, you are relaxed, you can relax and you can be confident in your relaxation and deliver your baby safely and comfortably. So let's imagine that we are ahead in time, and imagine that you are in labour and you know you can relax and let the contractions dilate the cervix from nought to 10.*

*Deeper and deeper relaxed as you get closer and closer to the number 10, during a contraction you can breathe in and feel strong and you can breathe out and relax and with every breath in you will feel stronger and with every breath out you will feel more and more relaxed and comfortable, deeper and deeper relaxed with every breath, closer and closer to the number 10 and during a contraction you can drift and float deeper and deeper relaxed and maybe you will drift and float down the stairs, maybe you will drift and float, comfortable in your special place, maybe you will drift and float, comfortable in your anaesthetic spa, during a contraction you can relax, drift and float, and let the body do what it knows how to do, you can drift and float in whatever way that is right for you, wherever it is right for you to be, you can drift and float moving further and further away from the contraction as if the contraction is moving into the distance, moving into the distance and just fading away.*

*And when the contraction is over you can forget about it, because it's done its job, it's brought you even closer to the joy of meeting your baby for the very first time, and when the contraction is over you can enjoy your nice long rest and you can let your labour progress at just the right rate for you and your baby. And as the contractions get stronger the rests between will seem even longer, as the contractions get stronger the rests will seem even longer, and as the contractions get stronger you can feel pleased that knowing they are even more effective and so you are coming even closer to meeting your baby. As the contractions get stronger they are even more effective and they will seem even shorter, that's right as the contractions get stronger they will seem even shorter and you're even closer to meeting your baby. And as the contractions get stronger you can breathe in even deeper and feel even stronger and breathe in deeper and feel even more relaxed, more and more relaxed as the contractions get stronger more and more relaxed as you get closer to the number 10. And during contractions you can continue to drift and float comfortably in your special spa or down the stairs, back to your special place and during your labour should any cares or worries arise, you can offload them into the container and send them very far away off to the horizon very small and far away and go even deeper relaxed.*

*You can use your relaxations for any turn of events, you have the ability to relax no matter what happens, you have the ability and freedom to do whatever you need to do to be comfortable, you can relax you are in control, labour is not always ideal, and you have the ability to use your relaxation for any turn of events, for any intervention you can relax, you are in control.*

*If you choose to use any chemical analgesia you can feel so pleased and proud of your relaxation, because your relaxation will mean much less need for chemical analgesia, less chemical analgesia, later in your labour thanks to your relaxation and you can use your relaxation for any turn of events, you are in control and you can let your labour*

*progress at just the right rate for you and your baby and you can enjoy your nice long rests between contractions, nice long rests, and thanks to all your nice long rests, you will have more energy than you can possibly need for the second stage of labour, when it is time for you to help push out your baby and meet your baby for the very first time and the body knows what to do and when you feel pressure in your bottom the ligaments will stretch and stretch and expand and stretch and you will feel like there is so much room to deliver your baby safely and comfortably and as the skin stretches it will become quite numb and you can deliver your baby safely and comfortably, and you can imagine your pleased and proud feelings as you meet your baby for the very first time, your joy at meeting your baby. And you can relax into getting to know your baby and as you enjoy getting to know your baby you can relax and let your body heal quickly and easily.*

*The placenta will deliver quickly and easily with minimal bleeding and the uterus will contract down tightly, and you can relax and let your body heal quickly and easily. As you relax your blood will flow to those parts of the body that need healing, carrying nutrients to those parts of the body that need healing, and as you relax you will heal quickly and easily without even trying, the body knows what to do, and you can relax into breast feeding your baby, as you relax the blood will flow to your breasts carrying all the breast-feeding hormones and nutrients that are needed and your breasts will fill with just the right milk for you and your baby.*

*And as you relax and breathe and the shoulders sag, your milk will flow at just the right rate for you and your baby, all you need to do is to get yourself comfortable, breathe and relax and your milk will flow like an easy flowing river fed by many streams and tributaries to make an easy flowing river of milk, and you don't even need to try. All you need to do is to relax, let your shoulders sag and let it happen. Your milk will flow at just the right rate for you and your baby. You can use your relaxation to establish a special routine for you and your baby. You can relax into resting when it is time for you to rest or sleep, you can relax into eating nutritious food when it is time for you to eat and you can relax into feeding your baby when it is time for your baby to feed, you can relax into enjoying time with your baby and establishing your routine and as you relax your body will heal quickly and easily.*

*Now you know that you have the freedom and ability to tune in to only what is helpful for you and your baby, you have the control, you are in control, during your labour and after your baby is born, you will only tune into the words, the comments, the sounds that are helpful to you and your baby, you are in control and you can tune out to anything unhelpful. Any unhelpful words or comments from the people around you any unhelpful sounds will seem like a foreign language or seem like the white noise of an untuned TV channel, and you will tune out to anything unhelpful, you are in control and you have the ability to only tune into to what is helpful for you and your baby. And*

*you know that everything helpful that I have said will be there for you when you need it, ready for you to use whenever you choose, everything helpful ready for you.*

*Now in a little while it will be time for you to gently come back to the here and now and so in a few moments you need to get out of your special anaesthetic spa if you have not already done so and your comfortable feelings can stay even when you come out, out of your special spa, so up a level up, up to the thighs, spa swirling around the thighs, up a step up to the knees, spa swirling up to the knees up another step, up to the ankles spa swirling around the ankles and up another step out of the spa, keeping your comfortable feelings with you for far longer than you might expect and then in your own time and your own way, you can gently drift back through time and space back here back into your body, back into your body so that when you open your eyes you feel relaxed and refreshed your senses are back to normal and you're looking forward to this wonderful event that is soon to happen in your life, the safe and comfortable arrival of your baby.*

## **DISCUSSION**

If effective, the audio CDs on hypnosis would be a simple, inexpensive way to improve the childbirth experience, reduce complications associated with pharmacological interventions, yield cost savings in maternity care, and this trial will provide evidence to guide clinical practice (Cyna et al., 2006).

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## METAPHOR DISABILITY

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This script is designed specifically to tap into existing skills the client had learned through relaxation training and to target the fear around movement and exercise. The woman had been involved in a workplace accident and had suffered severe pain for a long time at the point she came to see me.

### “Work” Part

Client has stepped down a flight of stairs and moved into their special place, a peaceful scene.

*You step down now into your “own” place and become aware of just how much relief you feel to be here. This is a place where you are safe; where nothing can disturb you and everything here serves to deepen your feelings of relaxation and calm. Everything here ... every sound ... every colour... every touch ... serves to deepen ... your peace. Scents ... smells ... in the air ... Deepening your peace.*

*Your awareness now moves into your feet and you can begin to feel the texture of the ground beneath your feet. Feel ... its texture ... Is the ground cool under your feet? ... Or perhaps it is warm. Noticing now how the very weight of your body through your feet causes you to feel and become more aware of the sensations of the ground, the earth beneath your feet ...*

*And that very awareness seems to deepen your feelings of safety and peace ... As if the very earth itself ... the very energy of the earth itself touching your feet ... can sustain and heal you as you stand touching the ground ... touching ... the earth.*

*And as you become more and more aware of the earth under your body, you lift your head up towards the sky ... look ... look at the colours ... Feel the air ... The sky stretching out ... out as far as your eyes can see ... and you drop your gaze once more towards the earth, looking around ... Noticing more and more of the scenery*

surrounding you ... every sight ... every colour ... Everything you see ... deepens your sense of peace ... deepening into feelings of such comfort, such ease ... feeling more and more at peace, at one, here in this place.

This is a place where you don't need to do anything at all, don't need to think anything at all. In fact, all thoughts that belong to the past and all thoughts that belong to the future belong somewhere else. This is place where it is so easy to be simply here, simply present ... And this feeling of being here now, of being at peace in a place of ease and comfort serves to deepen and deepen your calm.

You can smell the air and perhaps even taste the air.

Listen ... to the sounds in the distance ... hear ... the sounds that seem closer ... And now, the sounds that seem ... quite close ... All these sounds. The sounds in the distance and the sounds that are closer ... They all serve to remind you that you are in a place of great comfort and ease ... Where the earth below sustains you and where you don't have to do anything, or think anything ... you don't have to be anything other than simply ... be here ... feeling the absolute wonder of being somewhere ... so peaceful, so beautiful that you actually begin to feel free.

Free to simply be ... Here in your place, a place where you choose exactly what and who is here and what and who is not. It is all of your own choice and creation and all for you, [name], to enjoy. And it **is** a place where, somehow you find that you are able to heal.

And in this place you feel so free. In this place you find you are much more free of discomfort and of concerns. Discomfort and worries seem to simply flow away from you as a breeze carries and moves the clouds through the air ... away.

You take a lovely long deep breath in, filling your lungs with cool air ... and as you breathe out, the breath seems to carry away any discomfort from your body, the breath seems to carry away any concerns or worries from your being, from your heart ... each breath out ... letting go. Breath washing away anything that no longer serves you in your life. Letting go.

You feel such comfort and if you haven't already lain down ... with great ease ... you do so now ... stretching out your body, wiggling your toes and moving into a position that feels veerry comfortable. You can hear the sounds of the distance, interrupted by the sounds of close by and the sounds remind you of how your breath moves in and out of your body, easily, without you even having to try.

And with each breath out you notice how you are able to soften and loosen your body ... with each breath out, softening and loosening a little more. Letting go a little more ... And more ... With each breath out. You can hear the sounds and smell the air. And you notice how your body feels gently warmed by the air, yet your face feels comfortably cool. So that you are feeling so very comfortable ... so peaceful ... and it is such a pleasure to be able to enjoy the sensations of comfort and of ease.

Now, you become aware of how the warmth from the sky above seems to somehow

*gently wash into your skin and into your body. As if there is an energy from the sun that can and does wash into the very muscles of your body, the tendons of your muscles, the ligaments joining the bones, the blood vessels feeding your body, feeding the very cells in your body.*

*An energy that breathes into and washes around and through the cells of your body... healing and calming and reminding you of something you thought you had forgotten.*

*And you notice how this energy seems to move into your body, each time you breathe **in**. As you breathe **in**, you draw in this energy and you notice now, how it seems to know where to go, where in your body it needs to go ... moving deeply into your body [name appropriate body part], into the very cells of your muscles in your body [body part], the cells of your bones, washing deeply in and around the joints themselves, into you your [body part], each time you breathe in. This energy is healing you.*

*In this place that is your place ... you find that you are able to tap into a source of healing, a healing energy that **reminds** your body, that reminds your [body part] of how it is to feel well, of how it is to move easily, to glide through its motion comfortably, and easily, without you even having to try. And each time you breathe **in** you are reminded of how it feels to move easily, and effortlessly. You remember. Your cells remember. Your [body part] remembers. You remember.*

*Each time you breathe **in**, it is as if this energy in this place reminds you and reminds your body of how it can heal, naturally and easily. Reminds you that you do know what to do, that your body, your [body part] ... does know how to move more easily and how to heal so that you move more and even more easily ... so that there is less and less discomfort.*

*And you will be surprised to see how much more easily your [body part] is able to move. Each breath is reminding you, reminding your body of how it can heal and how it **can** move comfortably. And each breath **out** is like a letting go. The breath gently blowing away any worries or concerns at all, any fears you might have had at all about moving ... and each breath **in** reminds you that your body knows how to heal, reminds your [body part] of how it feels to move easily, to move comfortably; to stretch with great comfort and great ease ... So that stretching actually begins to feel wonderful, reminding you of how it feels to move with comfort and to move with ease. You will wonder at how easy stretching has become ... So easy.*

At this point, you can guide the client to move back out of special place, etc., with the suggestions around the breath in being healing and remembering more normal movement; the breath out being a letting go of discomfort and concerns (fears).

## REVIEWS

### **Psychotherapy With Suicidal People: A Person-Centred Approach**

*Antoon Leenaars*

Chichester: John Wiley & Sons. 2004. 480 pp. US\$85

### **Suicide: Strategies and Interventions for Reduction and Prevention**

*Stephen Palmer (Ed.)*

New York: Routledge. 2008. 266 pp. US\$34.95

### **Silent Grief: Living in the Wake of Suicide**

*Christopher Lukas and Henry M. Seiden*

London: Jessica Kingsley Publisher. 2007. (Rev. ed.). 224 pp. £13.99

### **Mental Health First Aid Manual**

*Betty Kitchener and Tony Jorm*

Melbourne: ORYGEN Research Centre, University of Melbourne.  
2007. 62 pp.

### **The Silence Surrounding Suicide**

One of the concerns that is raised when teaching professionals (some of whom are new graduates) about the use of hypnosis revolves around the province of suicide. We are warned that it could be possible that the use of certain techniques, such as ego strengthening in someone who has suicidal thoughts



(of which the health professional is aware or not aware), could perhaps give them the strength to go ahead and take that final action to end their lives.

*Indeed before you read any further, if you have personally had any thoughts of suicide or self-harm at any time in your life, then you should seek expert trustworthy therapeutic help or speak to a trusted supervisor about this matter (if you have not already done so).*

Thus the hypnosis literature is almost completely silent about this mental health issue. The question now is, should we be? At least we should know a great deal more about suicidal ideation so that we can recognise it better, because people are very good at concealing this state. The first book reviewed here is included to address just such an issue — the reality that for most people suicidal thoughts will pass and the mood will leave after a certain amount of time. Note that I am not talking here about the other group of people who will persist with their suicidal thoughts and attempts until they find escape or peace. *Psychotherapy with Suicidal People* by Antoon Leenaars takes a person-centered approach to attempting to understand why people suicide; what might be going on in their minds and what type of states might they be in.

Is it possible that, apart from general information on suicide prevention strategies, we could learn more about what the different therapeutic approaches are to prevention? Stephen Palmer has included a section on such ways of treating people who present with thoughts of ending their life in *Suicide: Strategies and Interventions for Reduction and Prevention*.

It is not always the large tomes that we can learn from. Betty Kitchner and Tony Jorm have produced a small compact first aid manual as part of the MHFA training program they designed and which is currently being conducted throughout cities, and towns in rural and regional Australia called *Mental Health First Aid Manual*.

And what about the survivors who live in silence following the great wall of silence that engulfs all those who are left to ask “but why?” Surely there are ways that hypnosis could assist them. Christopher Lukas and Henry Seiden have written about just this condition in their book on *Silent Grief: Living in the Wake of Suicide*. Remember what hypnotherapists are good at? Telling stories. And Lukas and Seiden remind us how to do just that with survivors, whether they be children or adults.

The people who remain behind are not the only survivors; any person who has survived any length of time in which they have been seriously suicidal is a survivor. Is it not possible that very experienced mental health professionals (and I stress that the health professional should have received a lot of training

in trauma generally and suicide in particular) can also help them with expertly constructed therapy into which carefully constructed and measured metaphors are integrated?

But first things first. Antoon Leenaars' 22-chapter book has four parts: Understanding Suicidal Behaviour; Suicide Risk Assessment; Applications; and Psychotherapy and Implications. Part 1 argues for a cross-disciplinary theoretical analysis in terms of attempting to understand the unconscious processes involved, and warns about trying to reduce suicidology to any particular discipline focus. Myths are challenged and replaced by facts (pp. 12–13).

Part 2 takes a creative approach to assessing risk with a combination of standardised tests; Leenaars outlines his own Thematic Guide for Suicide Prediction (TGSP) and discusses the underlying categories of unbearable psychological pain, cognitive constriction, indirect expressions, inability to adjust, and ego, that are contained within the intrapsychic dimension. Interpersonal relations, rejection–aggression, and identification–egression are part of the interpersonal dimension. What I found useful, being a research clinician, was to carefully go through the description of the 35 items that make up the TGSP to learn more about what was going on inside the suicidal person. Examples follow; Item 6: “S is in a state of heightened disturbance (perturbation) and feels boxed in, harassed, especially hopeless and helpless”; Item 13: “S considers him/herself too weak to overcome personal difficulties, and, therefore, rejects everything, wanting to escape painful events”; Item 19: “S’s problem(s) appears to be determined by the individual’s history and the present interpersonal situation”; Item 27: “S is preoccupied with an event or injury, namely a person who has been lost or rejecting (i.e., abandonment)”; Item 35: “S wants to egress (i.e., to escape, to depart, to flee, to be gone), to relieve the unbearable psychological pain.”

Leenaars includes the guide to the TGSP in the appendix along with the Shneidman Psychological Distress Questionnaire. I found the TGSP and the discussion surrounding the dimensions extremely valuable in understanding and dissecting what is going on inside a person with suicidal thoughts and behaviours.

In Part 3, case studies cover suicidal attempts across the lifespan, commencing with the sad story of a 4-year-old boy called Justin through to Joe who is at the other end of the lifespan. It speaks about their attempts and suicidal plans. Part 4 reminds us of the ethical and legal issues involved in this sensitive area and also gives an honest admission that not all has gone well with the research hypotheses.

Next on our list is Stephen Palmer's anthology which concentrates on what must occur in the wake of understanding. Twenty different authors contribute to this book which covers (a) suicide statistics, research, theory and interventions; (b) personal experience of suicide; (c) therapeutic approaches to prevent suicide; and (d) group interventions. As the prelude points out, the inclusion of a Personal Self-Harm Management Plan, along with assessment checklists and a list of organisations with web addresses, are welcome adjuncts.

Para suicide, that is non-fatal suicidal behaviour, is defined along with the differences between suicide, suicidal ideation, attempt, intent, and deliberate self-harm. A table of suicides in the year 2005 indicates that across the world, the suicide rate for males peaks in the 45–54 and 75 plus age groups. Women also seem to have an increased risk post 75. A review of the suicide prevention strategies in the U.K., and in rural areas in the U.K., show interesting trends and differences.

Sheehy and O'Connor discuss cognitive styles and behaviours; they give support for William's Cry of Pain model (see p. 75); that is, "Not only did the measures of defeat/rejection, escape and rescue (i.e. perceived social support) independently discriminate between the Para suicides and the hospital controls but also the relationship between escape potential and the probability of being suicidal was attenuated by social support." They ask if family cognitive style may be implicated in suicide. Ruddell and Curwen also list 14 myths associated with suicide, with the last five referring to myths around child suicide.

These myths (p. 86) include:

- Children under the age of 6 do not commit suicide,
- Suicide in the latency years is extremely rare,
- Psycho-dynamically and developmentally true depression is not possible in childhood,
- A child cannot understand the finality of death, and
- Children are cognitively and physically incapable of implementing a suicide plan.

And if the content of that list does not want to make you learn more about signs of suicidal ideation in children, then the case studies will.

Kapoor professionally addresses the subject of the effect of suicide on the therapist and cites Bersoff's 1999 assertion that normal professionals such as psychologists have a 20% chance to lose a patient through suicide.

The therapies that are presented by Froggatt and Palmer are CBT and RET (cognitive-behavioural therapy and rational-emotive management). This chapter is definitely worth a read if you buy or borrow the book from a library, as it outlines processes, triggers, self-interventions, and what they call a suicide cost-benefit analysis (p. 155) on the differences between ending one's life and staying alive.

Lees and Stimpson also offer a short chapter on a psychodynamic case study, while Sharry, Darmody, and Madden take a solution-focused approach, or in their words — a strengths-based approach to prevention — listening for strengths, finding exceptions, exploring how clients cope, moving from problems to goals and using scaling questions.

Pietila covers suicide bereavement — helping people work through the grief process for a loss that is particularly painful and that research has distinguished as being more painful than a sudden normal death or accident. She opens up the issues surrounding stigma, guilt, anger, depression, and shame and notes that condemnation after suicide only adds to the burden of the survivors. The book ends with a description of a group intervention for adolescents and young adults with recurrent suicide attempts.

While Betty Kitchener and Tony Jorm's book on mental health first aid, which is directed at the general population, has only a small section on suicide, it is practical and straightforward. They give the instructions for The SAD PERSONS suicide risk assessment tool. The steps in the first aids for depression are (p. 13):

1. Assess risk of suicide or harm,
2. Listen non-judgementally,
3. Give reassurance and information,
4. Encourage person to get appropriate professional help, and
5. Encourage self-help strategies.

So what about those left behind? While Pietila attempted to give an overview of the issues involved in this context, Christopher Lukas and Henry Seiden direct their book in a very practical way to survivors. They achieve their aim of helping survivors by giving examples of what is going on in the short term and the long term. Their stories break the silence and the book is worth an award for courage and honesty. If you do nothing else with this book except note the list of self-help groups available, and refer on, you will have helped your clients.

Do you remember the children's statistics early on in the review? Well the authors devote a special chapter to talking with children about what has happened, because children especially feel guilt and are sometimes inadvertently blamed for things for which they are not responsible. The authors explain that belonging to a survivor group seems to help people through sharing grief, overcoming stigma and shame, sharing pain, reinforcing self-esteem, validating grief, and knowing that one is not crazy.

The main theme of the book is the silence that follows suicide and chapter 11, "The Grand Bargain: Silence," notes that "Nobody in the family wants to talk about it. You have to pretend that something terrible didn't happen" (p. 101). The theme of bargains also runs throughout the book — if ..., then ... The authors do warn that mental health professionals can often become a scapegoat for the anger the client feels (p. 63); after all, if it is not you then it may well be another member of the family or group.

The best aspect of this book is that it reminds us that we do have a job to do in terms of suicides and it is with the survivors, as much as it is has to do with prevention and interventions with people at risk.

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**The Breakout Heuristic: The New Neuroscience of  
Mirror Neurons, Consciousness and Human Creativity in  
Human Relationships**

*Ernest Rossi*

Phoenix, AZ: The Milton Erickson Foundation Press. 2007. 473 pp. US\$49.95

*The Breakout Heuristic*, which represents the first volume of Ernest Rossi's collected papers, encompasses 40 years of research. It contains research and hypotheses of chronobiology and genetic expression in psychotherapy and hypnosis, and theories of dream research. A four-stage model of change, which he entitles the "breakout heuristic," is the main theme that weaves throughout Rossi's career. This review underscores that *The Breakout Heuristic* is an important volume for proponents of Rossi's ideas, and those who wish to gain a first time understanding of them.

The work of Ernest Lawrence Rossi covers a great deal of terrain. It includes the study of the function of dreams as a precursor to psychic growth,

the compilation and editing of Milton Erickson's collected works, and work on chronobiology and genetic functioning in psychotherapy and hypnosis. Before now, much of it could only be compiled by gathering it from various and diverse sources. With *The Breakout Heuristic*, Rossi does a great service in collecting many of his most important articles and book chapters from the past four decades.

The book is divided into four sections: *The Breakout Heuristic: Daily Updates of Our Brain*; *Dreams and the Creation of Consciousness*; *The Epiphanies of Therapeutic Hypnosis*; and *Art, Beauty, and Truth in Human Relationships*. Each is prefaced with an informative introduction.

Rossi's earliest papers show that a general theme has underpinned the entire body of his work; that humans are constantly changing themselves by interaction with their environment and through the process of self-reflection.

Throughout the introduction, Rossi mentions the human mirror neuron system and its role in the ability of people to experience elusive "eureka" or "satori" moments, or, as he terms it, the "breakout heuristic." As he contemplates his lengthy career, he makes an intuitive leap from his earliest ideas on the breakout heuristic from 1968 by linking them with one of his current papers that hypothesises the use of mirror neurons in therapeutic hypnosis. Rossi proposes that the mirror neuron system is a major step in a four-stage model of change that he has elucidated in earlier work, and throughout this volume.

For those readers who are mainly interested in Rossi's work with therapeutic hypnosis, the book certainly will not disappoint them. His four-stage model of change is the culmination of that work. The chapters in section three, "Epiphanies of Therapeutic Hypnosis," elaborate on many of the themes contained within this model. Chronobiology and states of consciousness, and their connection to human behaviour and genetic expression, are explored in several of the chapters.

It is often overlooked that Rossi is a Jungian analyst. That he is able to bridge the gap between analytic psychotherapy and Ericksonian approaches to hypnosis may come as a surprise to some readers. Nonetheless, the book's last section features an elaboration on his four-stage model of change as applied to Jungian analysis. The chapter entitled "Creativity and the Nature of the Numinosum: The Psychosocial Genomics of Jung's Transcendent Function in Art, Science, Spirit and Psychotherapy" is mesmerising in its scope and thematic inclusiveness. The section concludes with a dialogue between Ernest Rossi, Katherine Rossi, and Jungians Marian and Ross Woodman entitled

“Blossoms in the Fire.” Reading it allows one a simultaneous understanding and appreciation of the experience of the breakout heuristic among like-minded therapists.

*The Breakout Heuristic* is a welcome volume to anyone interested in Rossi's chronobiological and psychobiological hypotheses of psychotherapy. It can be considered to be a complimentary volume to his earlier works, *The Psychobiology of Gene Expression* (2002) and *The Psychobiology of Mind–Body Healing* (1993). Many of the referenced sources in those titles are available together here for the first time. Likewise, the overview of his ideas will interest those who are adherents of the naturalistic, or Ericksonian, form of hypnosis. Chronobiology in hypnotic states and its connection to early growth genes and neural growth can be seen as a natural extension of Rossi's work with Milton Erickson. First-time readers will also find this book a fascinating introduction to Rossi's ideas.

Mostly, *The Breakout Heuristic* is inspiring reading. Though firmly grounded in a biological model of psychology, and at times difficult to comprehend, a *joie de vivre* runs through all of his writing. Rossi conveys a sense of wonder at the creativity involved in simply being human. For this alone, *The Breakout Heuristic* is a worthy addition to any clinician's bookshelf.

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