The Australian Journal of Clinical Hypnotherapy & Hypnosis
Vol. 1 No. 1 (March 1980)

CONTENTS

What is Hypnotism? A Proposal
J. Hariman 2

The Non-directive State of Hypnosis and Subsequent
Dream-work in Resolving a Long-standing Fear/Anxiety State
J. Marriott 8

Hypno-Behavioural Therapy for the Treatment of Stuttering
Z. Kelemen 12

The "Vitamin Pill" From a Clinical Hypnotherapist
W. J. Stewart 18

Hypnosis and Learning Theory
A. V. Wood 23

A Rapid Induction Technique: My Approach
J. Hariman 28

Positive Mental Bulldust
G. Turner 31

Hypnotic Susceptibility and Age Regression
G. Haimer 35

Case Notes and Techniques Conditioning for Hypnosis
via Telephone in a case of Dental Phobia
J. Kingsbury 39

Case Notes and Techniques
Senoi Dreamwork
K. Wallis 42

WHAT IS HYPNOTISM? A PROPOSAL

J. Hariman

ABSTRACT

A theory of hypnosis as essentially a state of concentration is proposed and defended. The issues discussed include: the place of the will in the theory, the hypnotic phenomena of everyday life, the induction procedures, the principles of 'Conditioning', 'Pre existent element of choice' & 'Retroactive inhibition'; the dominance of psyche over soma, regression, T.A. and Dissociation. It is concluded that the theory is promising, both theoretically and empirically.

1. INTRODUCTION

What is the state of mind of a good hypnotic subject like?

It is clear that a good hypnotic subject is deeply interested in whatever the operator is saying. He steadfastly concentrates on his instructions and holds them fast before his mind. In case conflicting ideas come to consciousness, he may bring his willpower into play, to exclude the irrelevant idea so that the idea imparted by the hypnotist becomes the sole idea in his mind. William James calls this 'acting in the line of stronger resistance'.

According to the theory to be defended here *(the concentration theory of hypnosis),* the production of hypnotic phenomena is secured through this motivational condition. They are obtained through the subject's willingness and ability to concentrate exclusively and intensely on the hypnotist's suggestions (concrete or symbolic). To state the point differently: the principle claim of the theory is that what is essential in hypnosis is deep concentration in the manner conceived above.

Although the theory itself requires considerable unpacking, it is, I believe, essentially a plausible position to take. It is empirically 'corroborated' (this term is due to Popper, 1976) and theoretically fruitful. It is the major objective of this essay to show that this thesis may be true, and to carry out the necessary analysis. Additionally, related issues will be discussed.

2. SOME IMPLICATIONS OF THE THEORY:

(a) THE HYPNOTIC PHENOMENA OF EVERYDAY LIFE:

If the 'concentration theory of hypnosis' is correct, hypnotic phenomena should not be confined to clinical settings alone since the active auto hypnosis is the primary phenomenon. They should appear (at least to some degree) whenever 'deep absorption' as conceived earlier takes place. There are innumerable observations to support this implication.

i) Engrossed in a detective story, oblivious of his surroundings, one may forget his toothache (analgesia) or fail to hear the telephone ringing (deafness).

ii) As the literature of 'self deception' (e.g. Fingarette, 1972) shows only too well, a significant number of people disavow certain aspects of their engagement in the world through sophisticated covering tactics. Consequently, these experiences remain shut off from clear consciousness (amnesia).

iii) When someone turns his attention inside himself (e.g. in meditation) too frequently, 'hallucination' is apt to occur (Benson).

Apart from providing data in favour of the theory, the common observation above indicates at least two things.

Firstly, the so-called hypnotic state is quite variable (c.f. the internal representation of i, ii, iii and within itself).

Let me also support this contention with a strictly clinical observation.

On awakening; a subject may report an out of body experience, the other fell asleep; some say that they experienced the mystical unity of 'no mind'; a few experienced strong hypnagogic imagery; ad infinitum.

Despite the variability of hypnotic state, it can be plausibly maintained that the subject does feel different in some unspecified way (in comparison with common ordinary waking state).

It is therefore sensible to conceive hypnotic state as a member of a family of altered states of consciousness. In this view, there is no significant phenomenological difference between hypnotic

state and altered state of awareness obtained through other psychological endeavour (e.g. Gestalt therapy, Zen meditation, etc.).
Secondly, generally speaking, hypnotic phenomenon cannot be a consequence of abnormal condition (e.g. as Charcot and Janet maintained). The hypnotic capacity is latent in every individual, and with some training it can be energized. This corollary is consistent with the finding that a large majority of people are susceptible to at least mild hypnotic trance (Hilgard, 1965).

(b) INDUCTION PROCEDURE:
Again, if the 'concentration theory of hypnosis' is correct, the various induction procedures can be expected to possess the tendency to foster a state of deep absorption. They should be inclined to pull the subject's attention completely to the task at hand. The truth value of this implication is well known.
Firstly — laying down on a couch (away from direct sunlight), quiet surroundings, several deep breaths certainly help to relieve unnecessary strains. Secondly — the prestige of the hypnotist, the confidence which the subject places in him, the subject's high level of expectation are prone to remove antagonistic thoughts and responses. Thirdly — hypnotic disc, the various 'confusion' methods (e.g. Erickson, 1979) are likely to turn the subject's attention inward. And finally — the stubborn repetition of an idea is inclined to increase its chance of acceptance.

3. THE FOUNDATION OF THE THEORY: THE EXISTENCE OF PSYCHOLOGICAL PRINCIPLES:
There remains the task of explaining why, given such exclusive attention, should hypnotic phenomenon occur at all. To paraphrase the question: Are there principles (presumably psychological) which would explain the occurrence of hypnotic phenomenon under a state of selective attentiveness? I believe there are. Four of them will be mentioned below.

(a) The Principle of 'Retroactive Inhibition' *(see section 5)*
(b) The Principle of 'Conditioning'.

The 'ideomotor action' is possible because the subject has, through a process of conditioning, associated a word (or pattern of words) and the motor embodiment of its (their) content.
For example pattern of words 'Let your arm levitate' may, at the beginning, remind the subject of the phenomenon of 'arm levitation'. After a while, his arm starts to raise. (This phenomenon is well understood by W. James, 1950. He wrote: "Every representation of a movement (e.g. a sentence: my note) awakens in some degree the actual' movement which is its object and awakens it in a maximum degree whenever it is not kept from so doing by an antagonistic representation present simultaneously in the mind" P. 526). As the procedure is repeated over sessions, the subject becomes more and more responsive to the suggestion. Finally, the response becomes automatic so that the mere attention to it is enough to elicit 'arm levitation'. (This reflex action is comparable to a blink (due to a sharp puff of air on the eye), knee jerk (due to a tap on the patellar tendon), etc. In learning jargon, the subject has learned to respond favourably to CS.

(c)The Principle of "The Pre-Existent Element of Choice**":**
K. R. Popper (1972 p. 46) has written:
"Twenty five years ago I tried to bring home the same point to a group of physics students in Vienna by beginning a lecture with the following instructions: 'Take pencil and paper; carefully observe, and write down what you have observed!' They asked of course what I wanted them to observe. Clearly the instruction 'Observe!' is absurd. Observation is always *selective.* It needs a *chosen object,* a *definite task,* an *interest,* a *point of view,* a *problem.* And its description presupposes a descriptive language, with property words; it presupposes similarity and classification, which in its turn presupposes *interests, points of view,* and *problems.*
I agree with Popper. It is a plain matter of fact that one's intention regulates his attention. And pursuing the matter further, it can be maintained quite plausibly that the initial decision to view something in a certain way (the *pre existent element of choice) can make all the difference.* It determines every phenomenon of which one becomes aware. It narrows one's vision immediately

and sharply. It reinforces an aspect of reality and distorts another. What is perceived is the direct result of taking that path.
Recently, Buckhout (1974) reviewed a large number of empirical studies on 'eyewitness testimony'. He concluded:
"Perception and memory are affected by the totality of a person's abilities, background, attitudes, motives and beliefs, by the environment and by the way his recollection is eventually tested. He reaches conclusion on what he has seen by evaluating fragments of information and reconstructing them. He is motivated by a desire to be accurate but also by a desire to *live up the expectation of other people* and *to stay in their good graces* (p. 24). (See also Miller & Loftus, 1976).
The principle outlined here can, I believe, explain the occurrence of 'hallucination' and analgesia under a state of deep attentiveness.
Thus for example — to transform the picture of a witch into a beautiful woman, the subject can be instructed to concentrate with the whole of his being on the image of the latter. If the subject fully co-operates and has a vivid imagination, the dichotomy of outer world (witch) and superimpose image (beautiful woman) will eventually be negated. As far as the subject is aware of, there is only one reality in his phenomenal field, i.e. a beautiful woman.
Furthermore, due to the volume and complexity of stimulation with which a person is continually bombarded, one's perception of the world is not global — it is selective. And when one pays attention to an aspect of reality, he tends to become less aware of the other. At the extreme side of 'selective perception', attaching excessive importance to an experience can make other experiences non-existent as far as the individual is concerned. Thus, if a subject concentrates exclusively to his right hand and has the ability to do so, it would be possible to insert a needle into his left hand without any feeling of pain. Since the organic sensation of the needle does not serve his intellectual need, it is discarded and is not allowed to raise to the level of awareness.

(d) THE DOMINANCE OF PSYCHE OVER SOMA:
That 'mind' can influence 'body' has now become a commonplace fact that primitive people and young children live in hypnotic state. What is implied is simply that they live more in the mode of primary rather than secondary processes. Such a concept can be clinically very useful, since any gesture which would call for 'regression' will prepare the subject for the concentration essential for the production of therapeutic effects.
Should this be the case, it would be possible to *integrate Hypnosis and Transactional Analysis into an overall therapeutic endeavour.*
In T.A. there are three ways the person can feel or behave (there are three *'ego states')* i.e. as a *child* (archaeo psychic); as an *adult* (neo psychic) and as a *parent* (extero psychic). (Berne 1973).
As a child, the person is emotional, impulsive, hating, spontaneous, loving and creative. As an adult, he processes data rationally and bases his decisions on facts. (This ego state is similar to the Freudian ego. It synthesizes the activities of the psyche). As a parent, the person is protective, supportive and full of understanding.
T.A. makes good use of units of communication between two people called 'contracts'. One of the many types of contract is called 'complementary'. It refers to a two way contract between two ego states e.g. parent: child, child:
child, etc. It is the kind of contract which is of interest to us here.
In the form of therapeutic endeavour proposed here, the hypnotist starts from the parent ego state and the patient from the child ego state. As in the ordinary T.A. practices, both the hypnotist and the patient work together to achieve behavioural changes on the part of the client by mutual consent (i.e. by means of contract). The client agrees to change his behaviour in a specified observable way e.g. removing his fear.
From the point of view of T.A., prior to induction the client's adult ego state must give full consent and is fully aware of the goal. (This is important, since this ego state will have to sustain the changes). Only then could the therapist employ trance to cathect the patient's child ego state and to help him to become aware of the determining forces that have affected his present life — thereby giving him more control over them. For the reason given above, each time a progress is achieved, it will be necessary to stop and ask the patient's permission before proceeding further.

In the preceding discussion, I have tried to show the importance of the interpersonal relationship between the hypnotist and the client for trance work proper. It can elicit the *co-operation, curiosity* and *desire on the part of the client to comply* (c.f. Reyher & Pottinger, 1976).
But, it does not necessarily mean that there must be a hypnotist to induce trance, for, if the theory defended here is correct, the subject's ability to concentrate and his eagerness to do so is all that is important. There is *no need for an operator as long as the subject is highly motivated to do the task.* This corollary receives support from investigation in several areas of hypnosis. Firstly, there is evidence that hypnosis can be induced through tape recorder (Barber & Calveley, 1964 reported that live and taped instructions were equivalent with respect to both objective and subjective scores). Secondly, there is evidence that inexperienced subjects were as able to hypnotise themselves as to be hypnotised by others; factor analyses showed that the experiences were generally similar and the procedures labelled self and hetero hypnosis were indeed similar in most behavioural and phenomenological effect (Johnson & Weight, 1976). See also Ruch (1975) and Shor & Easton (1973). And finally, there are well known hypnotic like states such as accidental trance states (William, 1963) and meditation states (Tart, 1969).
The findings cited above present insuperable difficulties for theories of hypnosis which include 'interpersonal interaction' with a physically present hypnotist during trance work as a necessary factor (e.g. the role theory, the Freudian theory). Since there is no room for strategies or manoeuvres by either the subject or the hypnotist in 'taped instructions', 'auto hypnosis' and 'hypnotic like states'; it is *hard to justify the contention that an interpersonal relationship is a necessary component of hypnosis.*

5. HYPNOTIC DISSOCIATION:
Since continual concentration is needed, it is imperative that *some degree of awareness be maintained throughout the trance work proper.* Hypnosis should then be more akin to the waking state — a state in which the subject is *hyperacute* rather than somnolent. Hypnosis is *neither sleep nor unconsciousness.*
Should this be the case — during dissociation the unconscious part of the mind cannot assume a fully independent role as the old theory of dissociation (e.g. Janet 1925) suggests. Both the unconscious and conscious mind must *interact with each other at some level.* The subject must, in some queer sense, *be aware of the operation of his unconscious mind. Indeed, a reconceptual-isation of the issue may be needed in which deep concentration is seen as the primary phenomenon and dissociation as arising out of it.* If this reasoning is correct, maintaining dissociation should logically require *cognitive effort* since dissociation is an active psychic effort. *It is something which the agent does rather than something which happens to him.*
An experiment recently conducted by Knox, Crutchfield and Hilgard (1975) has corroborated this point. Only subjects who, prior to real testing, demonstrated the ability to carry out the required tasks without conscious awareness were used. They were asked to perform two different tasks namely *'colour naming'* and *'key pressing'* simultaneously. Two sources of interference were found. Firstly, an interference was produced when a task practiced in the conscious state was to be carried out subconsciously. This observation suggests that *there is a cognitive cost involved in keeping a task out of awareness.* Secondly, an interference was produced when both tasks were carried out consciously and simultaneously. This is a well known phenomenon. Since one's cognitive capacity is limited, his performance tends to deteriorate as he adds tasks at a given time. The maximum interference was produced when one of the two simultaneous tasks was kept out of awareness. If the old dissociation theory is correct, this result should not have come up at all. For, the two tasks are *absolutely separable.* Each of them was done by an *independent* component of mind i.e. *conscious* and *unconscious* mind. The fact that they produced maximum interference indicates that perhaps the two sources of interference above were somehow *added to increase the difficulty of the task* (c.f. Stevenson, 1972 — cited by Knox, Crutchfield and Hilgard, 1975).
The finding that maintaining dissociation (keeping something out of awareness) requires cognitive effort, hence adding to task interference calls to mind the question of the availability of the forgotten materials during dissociation (hypnotic amnesia); since *materials that are totally*

unavailable to awareness should *not interfere with conscious task.* Some studies have recently grappled with this question using a *'retroactive inhibition'* design.
In this design, subjects are asked to learn a list of words prior to hypnosis. During trance, the second list is to be learned to create 'retroactive inhibition' and an amnesiac suggestion given. On awakening, the subjects are asked to recall the first list before the amnesiac suggestion afflicting the second list is removed. *If the amnesia is complete, the forgotten materials should have no effect at all upon the first list recall.* But — in general the empirical studies indicate that *the forgotten materials are still available at some level,* during amnesia (Coper, 1972; Graham & Patton, 1968). This is inferable from the fact that the so called forgotten materials still exert retroactive effects on the recall of the first list.
A recent study by Nace, Orne & Hammer (1974) supports this interpretation. After studying recall after amnesia was removed, they concluded that *hypnotic amnesia is an active process, involving a reversible disturbance of memory retrieval.* A similar finding has been reported by Coe, Basden, Basden & Graham (1976) using 'free recall learning' as the response (c.f. Steward & Dunlop, 1976).
The studies cited above once more suggest that hypnotic dissociation (amnesia) is an *active psychic process.* There is a *cognitive cost involved.* The subjects had apparently *paid exclusive attention to other matters in order not to remember the forgotten materials.* But, since an intense concentration uses up one's energy, it interfered with his conscious task.
If this hunch is correct, the principle of *'retroactive inhibition'* and the *absence of an agreed upon cue* can be expected to explain the occurrence of amnesia, both in daily life and during trance under conditions of deep absorption.
An example would be as follows. A subject has strongly associated the answer to a question to a certain cue and set himself to concentrate on other matters when the question arises in the absence of the cue. Thus — the Q, 'What is your name?' may immediately elicit concentration to the thought, 'I don't know'; the Q 'Where do you live?' triggers a concentration to a particular part of the house, etc.
But, once the cue is communicated, the above mentioned mode of functioning disintegrates. Consequently, the subject is now able to communicate the correct answer. Beforehand, the correct answer to a question was not available because the subject *had learned to respond differently to the same stimulus sentence in the absence of the agreed upon cue.*
This is probably what Coe, Basden, Basden & Graham (1976) had in mind when they wrote:
The proper question, then, to ask about the process of posthypnotic amnesia is, *"What does the subject do in order not to remember?"* rather than, "What happened to the subject that he cannot remember?" Research efforts as a consequence will turn to examining what dissociated subjects do to become unaware of certain events (p. 457).

6. SUMMARY AND CONCLUSIONS:

A theory of hypnosis as essentially a state of intense concentration is proposed and defended. After a preliminary statement, some immediate implications of the theory are explored. Four conclusions arise out of this exploration. Firstly — hypnotic phenomena are apt to occur under a state of deep concentration, in the clinical setting or otherwise. Secondly, there is no significant phenomenological difference between the state of hypnosis and altered states of awareness obtained through other means. Thirdly, as a rule, trance cannot be properly regarded as an expression of pathological conditions. And finally, the various induction procedures do tend to foster a state of deep attentiveness.
In section 3, a pertinent question is asked: Are there principles (presumably psychological) which would explain the occurrence of hypnotic phenomena under a state of exclusive attention. In reply, four laws are proposed: the principle of 'retroactive inhibition', the principle of 'conditioning', the principle of 'pre existent element of choice', and the dominance of psyche over soma.
In the next section, the possibility of viewing trance as a regressed state is mentioned, and its relationship to T.A. is explored. Despite the significance of 'interpersonal relationship' in trance work proper, it must be seen as nothing more than an optimising factor for some subjects since for highly motivated subjects the presence of an operator can be disregarded.

And finally, the view of dissociation arising out of the theory is shown to be consistent with the current findings.
It may therefore be concluded that the theory has empirically been corroborated and is theoretically fruitful.

REFERENCES:

Barber,T.X. and Calverley, D.S. *Comparative effects on 'hypnotic like' suggestibility of recorded and spoken suggestions*. **Journal of Consulting Psychology, 1964, 28, 384.**
Berne, E. *Transactional Analysis in Psychotherapy,* NY: Ballantine Books, 1973.
Buckhout, R. *Eyewitness Testimony*. ***Scientific American,*** **1974, 231 (6), 23-31.**
Coe, W.C.; Basden, B.; Basden, D. & Graham, C. *Posthypnotic amnesia: Suggestions of an active process in dissociation phenomena.* **Journal of Abnormal Psychology, 1976, 85(5), 455-8.**
Copper, L.M. *Hypnotic amnesia.* **In E Fromm and R. E. Shor** *(eds):Hypnosis: Research, Development and Perspectives***. Chicago: Atherton, 1972.**
Erickson, M.H. and Rossi, E.L. *Hypnotherapy: An exploratory casebook***. *NY: Irvington,* 1979**.
Fingarette, H. *Self Deception***.** London: **Routledge and K. Paul, 1972.**
Graham, R. and Patton, A. *Retroactive inhibition, hypnosis and hypnotic amnesia*. **International Journal of ainical and Experimental Hypnosis, 1968, 16, 60-74.**
Hilgard, E.R. *Hypnotic Susceptibility,* NY: **Harcourt, 1965.**
James, W. *The Principles of Psychology,* V 2, NY: **Dover, 1950.**
Johnson, L.S. and Weight, D.G. *Self-hypnosis vs hetero-hypnosis: Experiental and behavioural comparisons*. ***Journal of Abnormal Psychology,*** **1976, 85 (5), 523-6.**
Knox, V.J.; Crutchfield, L. and Hilgard, E.R. *The nature of task interference in hypnotic dissociation: An investigation of hypnotic behaviour*. **The International Journal of Clinical and Experimental Hypnosis. 1975, 23 (4), 305-23.**
Meares, A. *A System of Medical Hypnosis***. Philadelphia: Saunders, 1960.**
Miller, D.G. and Loftus, E.F. *Influencing memory for people and their actions*. ***Bulletin of the Psychonomic Society,*** **1976,7(1), 9-11.**
Nace, E.P.; Orne, M.T.; and Hammer, A.G. *Posthypnotic amnesia as an active psychic process: The reversibility of amnesia*. ***Archives of General Psychiatry,*** **1974, 31, 25 7-60.**
Popper, K.R. *Conjectures and refutations: The growth of scientific knowledge.* **Routledge and K. Paul, 1972.**
Popper, K.R. *Unended quest: An intellectual autobiography.* **London: Fontana/Collins, 1976**.
Reyher, J. & ***Pottinger, J.*** *The significance of the interpersonal relationship in the induction of hypnosis.* **The American Journal of Clinical Hypnosis. October 1976**.
Ruch, J.C. *Self hypnosis: The result of heterohypnosis or vice versa*. **International Journal of Clinical & Experimental Hypnosis, 1975, 23, 282-304.**
Shor, R.E. and Easton R.D, *A preliminary report on research comparing self and heterohypnosis.* **The American Journal of Clinical Hypnosis, 1973, 16, 37-44.**
Solovey, G. and Milechnin, A. *Concerning the nature of hypnotic phenomena*. **The International Journal of Clinical & Experimental Hypnosis, April 1957.**
Steward, C.G. and Dunlop, W.F*. Functional isolation of association during suggested post-hypnotic amnesia.* **The International Journal of Clinical & Experimental Hypnosis1976, 24 (4), 426-34.**
Tart, C.T. (ed). *Altered states of consciousness: A book of readings.* **NY: Wiley, 1969. William**, **W.W.** *Highway hypnosis: A hypothesis.* **The International Journal of ainical & Experimental Hypnosis, 1963, 11, 143-41.**

THE NON-DIRECTIVE STATE OF HYPNOSIS AND SUBSEQUENT DREAM-WORK IN RESOLVING A LONGSTANDING FEAR/ANXIETY STATE. A CASE STUDY

J. Marriott

ABSTRACT

A twenty nine year old woman, while attending a course in breast enlargement through visual imagery and hypnosis was able to successfully overcome a fear! anxiety state sustained for thirteen years by gaining sufficient ego-strength to face the repressed emotions and subsequently dealing with them through symbolic dream-work in the hypnotic state.

THE CASE STUDY

Wolberg (1964) has suggested that dreams which follow the first attempts at hypnosis are significant and may contain the essence of the patient's problem. Hypnosis can be an excellent method of allowing old forgotten memories to flow back to consciousness (Ambrose & Newbold 1968), and it appears that as a person develops greater self-esteem that the deeper, often traumatic, memories will come from the subconscious at a time when the client has more resources to deal with the repressed facts (Wallis).

The state of hypnosis, combined with ego-strengthening suggestions such as those described by Hartland (1966) could well pave the way out of a fear or anxiety state. It is well known that fear is one of the most common causes of insomnia (Lecron 1977); the insomniac may be afraid to go to sleep because of the fear that something terrible might happen which could not be controlled. Perhaps something terrible did happen in the past and therefore must be prevented from happening again. Regression techniques which allow a patient to relive and abreact a traumatic event often give considerable release of tension, allowing the person to face and accept — this is well documented in the treatment of war neuroses (Hartland 1966). Where age regression or abreaction cannot be induced, Mears (1960) has found dream analysis most valuable.

Dreams can be post-hypnotically suggested, to appear later during spontaneous sleep, or they may be artificially stimulated in some cases, on command during hypnosis (Wolberg 1964). Dreams are usually symbolic, and it does not always seem necessary to decipher or understand the actual content of the dream to resolve the emotion which underlies it. Symbols do not disguise, according to Schuyler (1970), "but rather synchronize, unite and fuse emotional experience and related material images to provide a useful shorthand for thought". Therefore it seems logical to suppose that just as much benefit, or self-awareness, may be achieved by working through a dream in symbol without any attempt to analyse or relate the dream to so-called reality. One dream can contain much material: undoubtedly a cardiac problem in a dream would not be any the less important than a failing love affair. Life would be seen, as far as the subconscious is concerned, as a continuous battle which must be waged simultaneously on several fronts, and therefore no distinction is likely to be made between one evil and another in dreams. (Schuyler 1970).

The following case history illustrates two concepts: one, that as greater ego-strength is acquired through hypnosis, traumatic memories can not only more easily dealt with, but repressed fears may present themselves unasked-for for resolution; and two, that the modified use of Sanoi dream work (as described by Wallis) e.g. the working through of a dream in symbol to gain — or regain — power from the most significant object in the dream, in resolving a deep-seated fear was sufficient to attain such resolution without any attempt to 'interpret' the content of the dream.

CASE HISTORY

The client was a 29 year old married woman with two children. She attended the clinic for a course in breast enlargement through visual imagery and hypnosis. Her history revealed a stable early life and her marriage was satisfactory. In 1978 she had a surgical operation to free adhesions following an appendectomy three years before. After the operation, she has been pre-scribed tranquillizers for "nervous tension". She had now recovered and had not taken any drugs

since that time. She reported that she suffered from insomnia and further discussion elicited only that she felt she needed to learn to relax, and that she would like her breasts to be firmer as she had lost weight after childbirth.

A light trance state was induced easily with an arm levitation method and deepened with the use of a standard structured image 1 (Kroger & Fezler 1976) which is a beach scene containing some dissociative effects. Routine ego-strengthening suggestions were given — as described by Hartland — as well as posthypnotic instructions for a counting back method of relaxation/self-hypnosis to be practiced at home.

At her second visit one week later, the client reported that she had slept well every night during the preceding week for the first time in years. She then related an experience which had occurred in her teens — that of being attacked from behind one night by a man. She had never told anyone about the attack, and had never been able to consciously think about it without breaking out in a cold sweat and shaking uncontrollably. For a long time after, she had been unable to sleep alone and slept with her sister. She always slept with a light on if alone, and always with her back to the wall. She had a great fear of being alone, and never went out alone at night. In the week following the first hypnotic induction, she had been able to discuss the event with her mother and her husband, and although visibly shaking, was now able to discuss it at the clinic. She said she felt her whole life had been inhibited by the fear of such an incident happening again.

When hypnosis was induced on this visit, she reported a tenseness in the buttocks and legs. This was quickly resolved without abreaction with concentration (as described by Cooke & Van Vogt 1956), and the routine ego-strength suggestions given before proceeding with the specific breast enlargement instructions (as per Willard 1977).

At her next visit, one week later, she was more relaxed, able to induce self-hypnosis, and progressing well with the breast enlargement techniques. At the fourth visit, she reported recurring dreams of a disturbing nature relating to the deaths of different people. In response to this, after the routine suggestions pertaining to breast enlargement, the posthypnotic suggestion was given that the dreams would change in symbol so that she would be more able to interpret or relate to the meaning of them.

Her fifth visit was a fortnight later, and it was found that she had slept poorly almost every night because of dreams which were becoming progressively more frightening and unreal. She had not rung the clinic before the appointment was due because she did not wish to "cause trouble, or worry the therapist". Although she looked a little 'washed-out' in appearance, the breast enlargement exercises were preceding well, and she was continuing to cope better with everyday life. Under hypnosis, she was unable to enter the dream state on direct command, not was she able to locate the emotions associated with the dreams. Imagery involving descending steps and entering a room with a curtained stage was consequently used, and the instruction given that as the curtains opened on the stage, they would also open on her dream. The subsequent enactment of the dream and the resolution of the associated fear consumed over an hour. Only brief details will be given here:

The curtains opened to reveal a "girl in swirling grey mist". The girl was unknown to the dreamer and great fear and anxiety was associated with the scene. On instruction to look deeper, the client remarked breathlessly: "girl has doll". She then began to shake, and her skin became clammy and pale. She was instructed to withdraw from the scene. The fear was dealt with by concentration without stimulus until it had faded significantly; she was then told to return to the stage/dream. The girl was still there with the doll. She began to "talk to" the dreamer, and to change, becoming "not a girl". The client became agitated, demanding that it "go away". The girl "died"; the doll became a "devil". The client at this stage was obviously extremely afraid; her skin again became pale and clammy. She was asking it to "go away" in an agitated fashion; she was then instructed to repeat this over and over. When she reported (with obvious relief) "he's going", she was

instructed to call him back. Much support and encouragement was given her in doing this (as described in Sanoi dream work) e.g. "He must come back . . . you must get from him the power you have given him . . . demand he come back . . . YOU are in control . . . it's YOUR dream . . . YOU KNOW you are in control. . . you sent him away, now bring him back . ." Eventually she faced him again. And again her agitation was obvious; she was "terrified to look at him" but finally able to do so. She was then instructed to demand a gift from him, which she did with much support and encouragement. He gave her a box, but on questioning, it was found that the fear of him had not diminished; therefore more gifts had to be demanded and given until all fear was eliminated. (Gifts symbolize power). She was instructed to "demand more gifts . . . demand all the power he has to give . . . Demand! YOU are in control now. Demand!" After some considerable time and encouragement — and obvious inward struggle — she suddenly relaxed and said "Life. He's given me his life!" She appeared a little stunned as she revealed that the "devil" was now transparent, no longer in the least frightening, and she felt strength and extreme relief. She was then allowed to leave the dream and instructed to relax deeper. Ego strength suggestions were given lightly, and she was left in the trance state for ten minutes to recuperate in silence. No breast-enlargement instructions were incorporated because of the client's obviously exhausted state.

On awakening, she said she felt mentally exhausted, but as if a weight had been lifted from her. She was puzzled and a little worried as to the meaning of what had occurred (no suggestions for amnesia had been given, and she recalled the events clearly). Reassurance was given not to concern herself about meanings. It was explained that she had worked through a problem in symbol on the subconscious level, and if necessary the conscious interpretation would present itself to her within a few days. She was also advised to ring the clinic immediately if any further problems with dreams or depression occurred.

This client attended the clinic twice more at fortnightly intervals to continue with the breast enlargement course. She reported no recurrence of nightmares, and at her final visit she said she was feeling much more secure in herself and sleeping better than she ever had. She remarked that she seemed to be gaining confidence in everything she did, and although a little nervous in the dark, she was no longer afraid to go out alone at night.

DISCUSSION

It appears that the first induction of hypnosis was enough to help this client gain sufficient ego-strength to allow her to sleep soundly, and the associated fear/anxieties of a teenage attack which she had repressed for so long were able to express themselves in her dreams. Perhaps the suggestion given on the fourth visit was somewhat premature on the part of the therapist — the client was not, at that stage, strong enough to assimilate and accept the deep-seated associated fear/anxiety on the conscious level. The patient should have also been instructed to contact the clinic if any problems occurred as a result of that post-hypnotic suggestion; it was unfortunate that the client felt she had to wait until her next appointment in the face of such obvious distress.

Although during the re-enactment of the dream, the client became actively afraid and anxious, only at the beginning was this anxiety judged to be so extreme as to necessitate removing her from the scene of the stimulus to resolve the associated fear. Continual encouragement and reassurance was administered throughout the dream in reminding her that she was "in control", and this was demonstrated to her when at her command, the apparition began to actually "go away".

This case was interesting in that the presentation of and the primary dream concerning a long-standing deep-seated fear/anxiety was completely unsolicited. Regardless of the client's obvious distress, the decision to persist in encouraging her to resolve the anxiety once and for all through dreamwork was taken in the light of: one, the observation that although she asked the "devil" to go away, she herself made no attempt to remove herself from the scene or lift out of the trance state, but stood her ground; and two, the therapist's interpretation of what had been occurring in the preceding two weeks, e.g. in response to suggestion given in the fourth visit regarding further

dreams, these dreams consequently unfolded persistently, in different symbols in a subconscious attempt to finally integrate and assimilate emotion which had been repressed, and so causing inhibition and anxiety for years.

REFERENCES

Ambrose, G. & Newbold, G. *A Handbook of Medical Hypnosis* **1968 London Bailliere, Tindall and Casseil Ltd.**

Cooke, C.E. & Van Vogt, A.E. *Hypnotism Handbook* **1965 California**. **Borden Publishing Company.**

Hartland J. *Medical and Dental Hypnosis* **1971 London Bailliere Tindall**

Kroger, W.S. & Fezler, W. *Hypnosis and Behaviour Modification: Imagery Conditioning* **1976 Phil. J. B. Lippincott Co.**

Lecron, L.M*.* *Self Hypnotism: The Technique and its Use in Daily Living* **1964 N.J. Prentice-Hall Inc.**

Meares, A. *A System of Medical Hypnosis.* **1960 Phil. W. B. Saunders**

Schuyler, J. & P.D. *Kingdom of Dreams* **1970 N.Y. Universal-Award House Inc**.

Wallis K. *Unpublished report from Workshop at Western Institute for Group and Family Therapy.* **Calif. (no date).** *Further information available from K. Wallis at Ryde Community Health Centre, Ryde, N.S.W.*

Willard, RD*.* *"Breast Enlargement Through Visual Imagery and Hypnosis"* **The American Journal of Clinical Hypnosis 19. 4. April 1977.**

Wolberg, L.R. *Hypnoanalysis* **1964. N.Y. Grune & Stratton Inc.**

HYPNO-BEHAVIOURAL THERAPY FOR THE TREATMENT OF STUTTERING
Z. Kelemen

ABSTRACT

The successful treatment of speech dysfunctions such as stuttering with Hypnosis: By the removal of the situational anxiety that usually precipitates the disruption of speech patterns and the increase of the stutterer's self-confidence, a positive reinforcing cycle begins that will gradually eliminate stuttering completely.

INTRODUCTION

Stuttering is a speech disorder characterised by spasmodic blocking and repetition of initial sounds of words. It is most likely to occur in situations that arouse tension and anxiety.

In its milder form, stuttering involves only a few important words that require the greatest effort for the articulation, particularly those beginning with b, d, s and t. In its more severe forms the blocking occurs on almost any sound, and the struggle to speak is accompanied by grimacing, head jerking and body contortions.

A great many renowned persons have been afflicted by stuttering, among them Aristotle, Charles Lamb, Winston Churchill and Somerset Maugham.

Stuttering is a puzzling disorder, and a wide variety of theories has been suggested. At one time it was attributed to anatomical defects of the tongue or palate, but this approach has been completely discredited. Forty years ago Coriat (1928) advanced the Freudian theory that the stutterer is fixated, or arrested, at the oral stage of psychosexual development and derives an unconscious satisfaction from the use of his mouth. Greene and Wells (1927) ascribed the disorder to a basic susceptibility to emotional tension and a tendency to excitability and uncontrolled reactions. Froeschels and Hellinck (1941) believed it is due to a disturbance in thought processes which makes it hard for the stutterer to find words and form sentences. They considered this disorder basically physiological but aggravated by psychological stress.

Neurological theories have not fared well in recent years. Some investigators have pointed out that many children have suffered from severe infectious diseases just before the onset of the disorder, and suggest that there may be residual brain damage in these cases. Yet there is no evidence of brain damage in the vast majority of cases, and stutterers do not differ from non-stutterers in their ability to co-ordinate their speech muscles.

Psychological theories are receiving the bulk of attention today. Barbara maintains that stuttering is a neurotic symptom which can usually be traced to faulty parent-child relationships. Children who are unwanted or ill-treated become basically anxious and cannot handle tense and threatening situations in an organised way. The speech situation is particularly difficult for them because they have trouble communicating with their parents. He believes the actual onset of the disorder, however, is often precipitated by a traumatic experience which puts the child under special stress: a bad fright, an operation, severe punishment, or in some cases forced conversion from left to right-handedness. This first stuttering reaction has a special effect on the anxious child. Even if it is slight, it makes him self-conscious and tense. His tension increases and so does his stuttering if his schoolmates ridicule him and his parents become apprehensive and try to force him to stop. As he grows older, he may try to avoid situations in which he is called upon to speak, and usually adopts bodily gestures and contortions to help him over the hurdle of speech. These solutions do not work well, and speaking becomes an ordeal which fills him with a sense of panic and disaster. In extreme cases he may become increasingly frustrated and unable to enjoy himself, and later in life he may even withdraw from society to live the life of a hermit.

Johnson (1961) believes that the critical period for the development of stuttering occurs during the third and fourth years when the child is first learning the delicate art of speaking smoothly. If the parents become concerned about his natural mistakes, and constantly correct him, they may communicate their worry and make him hesitant and fearful whenever he tries to express himself. As a result, the normal "primary stuttering" becomes transformed into "secondary" or "actual" stuttering. Schechan et al. (1962) believe that children who learn to fear speech situations for this or other reasons develop an "approach-avoidance" conflict — that is, they want to avoid speaking but at the same time feel that they must go through with it. They are then pulled in two directions at once and become momentarily blocked — that is, they stutter. This blocking is followed by actually succeeding in saying the word, and a consequent reduction of tension. The "reward" of reduced tension is believed to reinforce the pattern of stuttering.

In general, stuttering may be viewed as a disruption of speech patterns precipitated by situations that arouse acute tension. It is widely prevalent because the speech mechanism is so delicately balanced and communication is so important in life. In fact, most of us stutter at times, especially when we are subjected to special stresses that threaten our security, such as speaking in public, introducing important people to each other, or going through traumatic experiences such as near accidents. Such stuttering is only occasional and clears up soon after the stress situation has passed. Persistent stutterers, on the other hand, are afflicted with an intense state of "stage fright" when- ever they speak, and the self-consciousness created by the stuttering itself adds to the tension and prolongs the reaction. In other words, a vicious circle sets in and causes the stuttering to become chronic.

Today the approach to therapy is a comprehensive one in which stuttering is viewed as a function of the total personality rather than merely a speech disturbance. The objective is not only to re-educate speech patterns through training procedures, but to eliminate faulty emotional reactions through psycho-therapy and other psychological approaches.

It is important to begin treatment as early as possible, before the faulty speech patterns and emotional reactions become fixed. During the early stage of stuttering, between five and ten years of age, the therapist works primarily with the parents in attempting to ease their demands on the child and create a more relaxed home atmosphere.

Adolescent and older stutterers become acutely self-conscious and develop feelings of inadequacy and even self-hate. They are easily discouraged and constant reassurance is necessary. It is important to relieve tension in their lives as a whole. Most treatment is devoted to developing a feeling of adequacy in speech situations.

STUTTERING AND HYPNOSIS

It is a fairly common belief that speech dysfunctions are often caused by traumatic or emotional experience, usually between 4-6 years of age (le Cron and Bordeaux). It is also believed that stutterers are most commonly persons who are dependent and lack self confidence.

Stutterers dread situations where speech problems will become obvious to others and they will often remove themselves from social situations and will appear as being rather shy.

The cure rate for stuttering is fairly low and most therapies for stutterers of long standing have been ineffective. Even treatment with Hypnosis has had only limited success, usually with young children (Ambrose, Wolberg, Kroger all seem to agree on this point). Schneck, using symptom removal techniques, has achieved some limited positive results. It has been felt for some time that symptom-removal is the only possible way to treat stuttering with Hypnosis — Kroger (1963), Hallted (1972).

RATIONALE
It is suggested that the therapy should focus not on the symptom in the case of speech disorders but rather on the patient's anxiety and lack of self confidence. This approach firstly teaches the patient relaxation and calmness and then gradually a 'who cares if I stutter' attitude. The patient is convinced that stuttering is not a social disgrace and he is made to face the fact that he is a stutterer and to accept himself as he is. Suggestions under Hypnosis have been very effective in achieving this end.

As the patient begins to feel more independent and more confident, the stuttering decreases significantly. As the stutterer's anticipation of embarrassment and discomfort is removed the flow of speech becomes easier and less hesitant.

The second stage commences once the stutterer begins to feel confident and more independent, using visual imagery and Hypnosis he is placed into social situations, work situations and so forth so that the anxiety previously experienced in these situations diminishes. These imaginary situations (under Hypnosis) tend to reinforce the stutterer's ability to cope with any aspect of behaviour or situation they may encounter in everyday life. The stutterer is then encouraged to participate physically in these same situations and report on his activities at each session.

In the third stage of treatment, under Hypnosis actual words and letters that are problematic are either removed or rectified by direct suggestion. If an alternative word can be used without stuttering it is substituted and the problem word removed. If this is not possible then the suggestions are directed on the following basis — e.g. "You can say the letter 'M' easily, from now on the letter 'M' will be easy to say, you will say it as a sound not as a letter etc.".

HYPOTHESIS
The removal of the situational anxiety and the increase of a person's confidence using visual imagery and Hypnosis will reduce the amount of stuttering and begin a positive reinforcing cycle that will eliminate stuttering completely.

CASE HISTORY
John, an executive, aged 44 years, married with three children. Was referred for treatment for psychosomatic abdominal pains and stuttering. John was in the last stages of a sick leave from his place of employment. He had been suffering from acute abdominal pains which had no physiological cause, the referring practitioner felt that the pains may be psychosomatic and that possibly hypnosis may help in this area. Stuttering was not regarded as the primary problem.

John had been a stutterer since approximately four years of age. The stuttering was quite serious and prevented him from carrying out many of the duties that would be normally required in his position. He had been employed by the same organisation since leaving school at the age of 17. He often became depressed, extremely anxious and suffered numerous illnesses which resulted in frequent 'sick leaves' from work.

He had been on numerous medications and at the time of his first appointment was taking Librium (one per day) and Mogadon (one to two per night). After lengthy discussions it seemed that John's many symptoms over the years were an excuse whereby he could remove himself from his work situation where his stuttering caused a great deal of his anxieties. The 'secondary' symptoms were invariably the ones that were presented for treatment and not the 'primary' symptom of stuttering.

John had attended speech therapists, speech clinics and so forth over the past 25 years, but the treatment had been unsuccessful. His depression was largely due to his belief that his future at work was restricted and that any further chances of advancement were hindered. He had difficulties in speaking to people and using the telephone. The most significant absences from work were at times when a new employee had to be 'shown the ropes' or a situation involving

strangers was current. He had found himself a safe position where he was secluded from the public.

His social involvement was centred around his family and a cricket club that he had belonged to for many years. John, it seems, was efficient in his employment and regarded fairly highly by his peers and employers. He presented well and excepting his speech deficiency, spoke at an educational level. His IQ level was that of the top 6% of the population. On weekends he enjoyed playing cricket and coaching youngsters in cricket. He was highly regarded for his expertise as a bowler, a coach and a batsman.

Whenever he spoke to the people attending cricket sessions he could speak far better with less obvious speech deficiencies than he did at work. At cricket he felt as if he were an expert and often also a hero, (whenever he scored highly people gave him compliments and applause).

I decided that instead of treating the stuttering or even the abdominal pains I would concentrate on changing his self concept and increasing his confidence, thereby hopefully removing the anxiety producing situations. Over the next six sessions the only therapy given was relaxation[1] and discussions regarding his self confidence, and his self concept. He was made to realise that if he was able to remain relaxed, confident and have a fairly high degree of self concept at cricket there is no reason why this could not be repeated in his work situation.

John undertook to practise relaxation[2] at home daily. He was taught to use three deep breaths to relax himself instantly in any anxiety producing situation. After the sixth session I began to use hypnosis[3] as a conditioning process using his imagination to pre-live and pre-experience numerous situations wherein he was able to remain relaxed and anxiety free while still stuttering.

John was a good hypnotic subject, easily reaching the medium level of hypnosis on most occasions. The suggestions were effective. By his own report he felt less anxiety during his working days than ever before. His abdominal pains had disappeared and his need for Librium was completely removed. He occasionally still took mogadon in the evenings but far less frequently than previously.

I encouraged him to relive each of his daily experiences before going to sleep and to grade himself according to his performance during the day. If he had done something incorrectly he would have the advantage in the knowledge that the next time he would handle the situation differently. At work John still experienced difficulties in speaking on the telephone and meeting new people, but he felt less anxious than previously.

1. 5—Otype.

2. 5—Otype.

3. All techniques used for Hypnosis were either 'imagination' techniques or 'eye' fatigue type techniques.

At his twelfth visit I began using hypnosis and imagination techniques whereby he could see himself as a non-stutterer. The suggestions were centred on the concept that now that he is not "worrying" and is less anxious about stuttering he will stutter less. In a relaxed state, not giving a 'damn' about what people think, not feeling any degree of embarrassment or anxiety he would be able to allow the words to flow more easily than they had been flowing before.

Using this technique we were able to eliminate problems with words beginning with the letters f, s, w, and t. He still had a great deal of problems with the letters m and w. However, he wasn't anxious about it. He began making phone calls quite voluntarily, not trying to offload them to somebody else, even though as per his therapy this was allowed. I had suggested to him that if

he doesn't feel like making a phone call or talking to new people, he should order one of his subordinates to do this.

John reported that whenever he had a rather hectic day at work he was aware of having recurring nightmare type dreams wherein he was being attacked by German soldiers. He himself was an Australian soldier all alone in a trench and he always managed to fight the enemy off and win. By association the latent content of the dream was uncovered, the enemy were his colleagues and customers at work who he felt he was waging a war against. It was rather pleasing that in these dreams he was always the victor and I began to use much of this in his therapy. He became John the fighter, John the hero, a person who can beat all odds and win.

Gradually over the next few weeks I could see him changing. He was far more confident, had a high degree of self concept and became a lot more adventurous in his socialising, i.e. he actually attended two social functions at this time and enjoyed them immensely.

By the time John was on his twenty-seventh visit his stuttering problems were only slight, there was very little anxiety or embarrassment present in any situation and I suggested that his treatment should be terminated. Shortly after this John began stuttering again (on occasions only) and insisted that he needed more therapy. I realised he was using me as a crutch but I continued treatment.

The next two sessions involved a great deal of discussion about his future, about his ambitions and so forth. I realised that not only was John using me as a crutch but he had decided for the first time in his life that he could achieve virtually any goal that he wished to achieve. I was rather pleased that the therapy had been so effective. John had set his sights on becoming an auditor and he now wanted hypnotherapy to give him more confidence to pursue this end, in reality the hypnotherapy was limited and discussions accomplished rather more.

John achieved his goal and is now an auditor. His treatment took a total of eighteen months with an occasional break of two to three weeks but mostly involving weekly visits. His stuttering has ceased completely. He has had no further psychosomatic complaints, although occasionally he still sleeps rather poorly, but this he informs me is due mainly to work pressures and fatigue. His associates and family are constantly amazed at his change.

John last visited me in June 1979 (a social visit) just to let me know that his progress at work was still continuing and that he had been upgraded in the auditing department and he also recounted many of his hectic situations that he had weathered. He tells me that it still seems as if his previous years were a bad dream.

CONCLUSION
Although only one case history has been presented to demonstrate the effectiveness of this approach, a total of eight cases were available for study. One of the patients discontinued after four weeks of treatment because of a "job transfer" and one is still in stage (ii) of treatment.

Of the six remaining cases the therapy has been completed and it was found that the stuttering, or "the disruption of speech patterns precipitated by situations that arouse acute tension" have been eliminated successfully.

Whereas previous treatment was usually focused on symptom removal techniques (Schneck) or "cause" desensitisation (le Cron and Bordeaux) this technique disregards the "causation" and makes the patient feel more comfortable with his symptom by removing the anxiety that is usually experienced by stutterers. As this anxiety lessens so do the symptoms lessen to some degree? By the time any "symptom removal" is used, the symptoms have usually diminished greatly.

There may be some criticism levelled at the length of time this form of treatment required and whether or not the patient must be "motivated" sufficiently to become involved in such lengthy treatment. To this criticism I would suggest that it was observed that any patient suffering from a dysfunction such as stuttering, especially if "chronic", and has sought treatment himself, he is more than willing to proceed with lengthy treatment especially as the external situations begin to act as positive reinforcing agents virtually after the first session.

Overall, this method of treatment has been found to be most effective.

REFERENCES

Dempsey, G.L. & Granich, M. — *Hypno-Behavioural Therapy in a Case of a Traumatic Stutterer.* **The International Journal of ainical & Experimental Hypnosis. Vol. 26 No. 3 July 1978**.
Hahn, E. ***Stuttering,*** *Significant Theories and Therapies.* **Stanford University Press 1943.**
Hartland, J. *Medical and Dental Hypnosis.* **Bailliere, Tindell, London 1973.**
Kroger, W.S. & Fezler, W.D. *Hypnosis and Behaviour Modification: Imagery Conditioning.* **Lippincott, Phil. 1976.**
Peilman, C. *Overcoming Stammering***.** **Beechhurst Press NY 1947.**
Spithill, A.C. *Treatment of a Monosymptomatic Tic by Hypnosis*, ***American Journal of Clinical Hypnosis**.* **Vol. 17, No. 2 Oct. 74**

THE "VITAMIN PILL" FROM A CLINICAL HYPNOTHERAPIST

W. J. Stewart

ABSTRACT

Clients come to a therapist from a background of misinformation. The therapist needs to provide educational information on how the presenting problem came about, what is presently maintaining it and how it can be 'unlearnt' or changed; on relaxation training, hypnosis and on that related to the presenting problem. This can best be done by educational information sheets. Therapy effectiveness is thereby enhanced by this vitamizing effect. An example of such a sheet on hypnosis is given.

THE "VITAMIN PILL" FROM A **CLINICAL HYPNOTHERAPIST**

Many clients arrive at a therapist's office with strange ideas about what hypnosis is like, how hypnotherapy has its effects and are also quite uncertain about many other points. Of particular concern is the apparent common belief by some that hypnosis always enables miracles to be performed. Occasionally a person will arrive with no appointment from some distant town and expect to be cured of some problem in less than an hour. Worse, is the quite common belief that once you have a problem, no-one will be able to understand why you have it and no-one will be able to cause you to change, to be cured? Thus, many, many people are left stranded, hooked on drugs, living a life of symptom suppression, others live hoping for miracles while many live in misery with no hopes.

The general problem then is a lack of information, a lack of understanding about how problem behaviour may be learnt, arises from past experiences how it can be unlearnt, that the mind can be conditioned to change and so on. This is certainly the problem any good clinical hypnotherapist and also any psychologist must be aware of. The therapist needs to play a key role in the establishment of correct educational information in the area of his practice. Certainly all the rules of professionalism need to be followed in doing this.

Clients come from this 'backdrop' of the 'flux' of misinformation and when they present themselves at his office they may well carry many incorrect beliefs. Of crucial importance to the therapist is his establishing of correct information, to correct these large 'chunks' of misinformation.

Certainly the initial interview should be used to establish the information the client does have. Typically the initial part of the interview is concerned with establishing relevant history of the client. Some clients want to tell all about their problems, for others it is more difficult. In this time the client and therapist get used to each other; a relationship starts to form. Then usually the time comes when client or therapist can turn from the past and present to the future, a plan to change the behaviour problem.

The therapist needs to know past attempts, including failures to change the behaviour. Certainly of relevance are attempts of other behaviourists, including clinical Hypnotherapists. An explanation of why past attempts may have failed is important and how this new attempt will be different and how it will succeed.

In explaining the proposed program of change one needs to establish very clearly with the person that:

1. The present problem behaviour came about by learning experiences, or whatever, that there are meaningful reasons for its establishment even if both client and therapist are still unaware of them.
2. The present behaviour is being maintained by present feelings and internal biological functions, behavioural responses of the client and the environment the client lives in, that there are good reasons why the problem behaviour is being maintained at present.

3. What unlearning the behaviour involves and what new behaviours will be learnt in its place that the client may need to learn relaxation training, or whatever.
4. Exactly what the nature of hypnotherapy involves, in particular how conditioning of the mind works, the necessary requirements for hypnotherapy to be of maximum effectiveness.
5. How other parts of the therapy work, e.g. that proper relaxation, leads to one experiencing feelings of heaviness, tingling sensations, numbness — that everyone's feelings may be different and so on.
6. It is important for the client to do exactly as the therapist instructs, particularly in the order instructed, since the therapist has worked this out on the basis of his careful assessment of the client's history, what research evidence shows and the therapist's own clinical experience.
7. The client is completely committed to changing his own behaviour, and in return the therapist will do everything within his power to further motivate the client.

The therapist will then detail the tasks or activities that the client should undertake in the first week before session two. A client spends a large part of the time in the first session getting the problem off his chest or for others, trying to establish what the problem is. When he walks away he may still wonder about what the therapist said, particularly in relation to the seven points above.

If the client isn't clear, a therapist occasionally finds the client may not turn up for the second appointment; he may get a letter from the client expressing uncertainties about the possibility of change. This is particularly so if the client has had unsuccessful therapy from another hypnotherapist in the past. Also a therapist can often see how the client has failed to understand the information given in the first session by what he says in the second session. For therapy to be successful a client needs to know important things, like, for example, that heaviness, numbness, or tingling sensations are all positive signs of relaxation. They are desirable feelings and they should *not* be signs that a person is losing control of themselves. If the person does interpret them this way and holds on, he will be acting against any hypnosis.

Obviously a therapist needs to repeat the information, in the seven points on the previous page, in the second session. One of the main aims of the therapist should be to re-educate the client.

Re-education needs to be continued throughout the therapy sessions. Let us take some specific examples, and outline briefly the extra re-educational aspects of therapy, in addition to those in the seven points.

Sexual Dysfunctions:
A first crucial aspect of therapy is to discuss the beliefs about sex that the two partners have and to correct these. Before one can communicate effectively to the partners and the two partners between themselves, they need to learn the names of the sexual parts and their functions. They need to know the four phases of the sexual response cycle. I am surprised how many people are so lacking in information. Essential is the information about the learning of sexual dysfunctions, the role of anxiety, how one becomes a spectator to one's own sexual performance and the therapy procedure, the reasons for abstinence of intercourse in the early stages of the type of therapy of Masters and Johnson.

Weight control:
It is essential that clients wishing to lose weight know what types of food are, e.g. protein, vitamins, minerals, etc. what foods are rich in these and what a balanced diet should consist of. They need to know what weight loss only comes about by reduced food intake and/or more exercise. There are also many other points to communicate, such as how processing of food destroys its nutritional value. A critical point is the client has often learnt to feel guilty over eating, that he is not to feel guilty any longer.

All these points should be built into the hypnotic suggestions, that the behaviour was learnt by . . . that it can be and will be unlearnt . . . that the client knows that this is so very true and he is looking forward to carrying out the therapist's instructions so very carefully; and so on. Obviously having correct information will enable the client to think more clearly about his problem. His expectation of a successful behavioural change will be so much higher, since he knows there are reasons why he is the way he is, and more importantly, he knows that he can change because there are proven methods to enable him to. By knowing what hypnosis is about, and other aspects of therapy, the client can feel more relaxed with the therapist and his own problems.

As mentioned earlier, a client may be told relevant information, but still not be clear about it when he leaves the office. The best way to enhance the effectiveness of providing educational information is to give information pamphlets on topics related to therapy, to the seven points, and to the behaviour problem itself. After session one, the therapist can give out a sheet that tells the client about, say, relaxation training and feelings when one relaxes; on hypnosis, its benefits, what it feels like and so on. The therapist should *instruct* the client to read these. In later sessions the therapist should assign reading material, e.g. for sexual problems — on the parts of the sexual organs, etc. for overweight — on types of food, etc.

This educational information then, are the "vitamin pills", that the therapist needs to hand out to his clients. My own experience shows much improved awareness of the clients as to how they got the way they are. They gain insight into their past experiences and feel less anxious about it. Guilt feelings seem to fade away. Clients have said that it helps to give them a better way of approaching life. They become aware of the importance of knowledge to their living. Often clients say that when they start feeling uneasy about their problem they turn to the information sheet and read it. One lady said whenever she felt like smoking she would automatically pick up the booklet I had given her on smoking, and read it. As she did the urge to smoke disappeared. A very general comment on relaxation is that, after reading about the feelings of relaxation, and also training in it, clients report monitoring their own relaxation states throughout the day. This is even before I instruct them on differential relaxation training, if needed. Many clients I have given information to report finding more articles on the subject, or ask me to lend them more myself. Such are the vitamizing effects of giving educational information.

Such educational information sheets should only contain the essential points that need to be made. They should be simply written and not be too long. An example is the following on Hypnosis.

A SENSATIONAL EXPERIENCE — HYPNOSIS

Laying in a comfortable reclined chair with a feeling of sinking into its softness. Hearing things around you but not letting them bother you. Feeling limp, safe and so very, very relaxed. No thoughts are racing through your mind. You feel so very, very calm, so very, very good. Other pleasurable feelings will also be experienced. This is what it is like when you under hypnosis. What then is this, commonly called sensational experience all about? How can hypnosis help people change their behaviour?

Hypnosis is not the mysterious phenomenon, as some people believe it is, but it is really a very deepened relaxed body state. While in this very relaxed state you are still fully aware of what is going on around you. You do not pass out and lose control of yourself. It is like sleep but is not quite the same.

The most important point about hypnosis is that while in the hypnotized state we can condition our mind to do what we really want to do, by making suggestions to the subconscious mind. Suggestions are made to us every day. An example of this, somewhat close to the situation in hypnosis, is watching TV after a hard day. You settle into a soft chair to relax while watching TV. Soft music adds to the relaxed atmosphere, when adverts tell you of a desirable product. Before

you build up a resistance to the suggestion about that product, the program continues. The chances are that you and others will end up buying that product. People are susceptible for adverts since if they weren't many products wouldn't still be on the market.

The essential point then is that under hypnosis suggestions made lead to conditioning of the mind and to subsequent changes in your behaviour.

In using hypnosis we use our imagination. Many people turn to hypnosis after they've tried to change their behaviour using their willpower. They consciously try and try to, say, stop smoking. Many conscious thoughts, from say, adverts, what others say, body feelings and so on always act against your willpower to change. Hypnosis enables one to condition the mind to be more highly motivated to change, to achieve some goal, so that any conscious thoughts that would normally act against change are 'overpowered' and simply fade away and have no effect.

Conscious thoughts act to block the acceptance of suggestion to change your normal behaviour. Under hypnosis however these conscious thoughts don't block the acceptance of suggestions to change. The mind will accept suggestions and be conditioned in the very deeply relaxed state of hypnosis.

The subconscious mind however, won't accept suggestions it doesn't want to. Any hypnotist cannot therefore make any suggestions to you that are not acceptable. If he did then you would wake up.

Some people who ought to know better cannot escape the feeling that hypnosis is a sort of black magic having no scientific basis.

It is because many people don't understand the functioning of the mind and how it can be conditioned using hypnosis that they are suspicious of the values of hypnosis. This opinion also develops from misconceptions arising from stage hypnotists and what is seen in the movies. Unfortunately some writers of these scripts are not very well informed about the nature of hypnosis. I guess that, a part of this is due also to the fact that, in many ways, hypnosis is a fairly new applied science. Correct information therefore hasn't been readily available to the public from researchers and practitioners. This is particularly so in New Zealand where we perhaps have lagged behind other countries. This is certainly not the case in Australia. Sydney has a special school that teaches clinical hypnosis methods and research on hypnosis is also carried out at Macquarie University.

Public information on hypnosis is better and there are probably as many well qualified clinical Hypnotherapists in Sydney as there are physiotherapists. There are also a number of scientific journals especially devoted to research findings on hypnosis and its clinical applications. Conditioning of the mind then is really no different from learning mathematics.

Another view about hypnosis is that only the feeble-minded, the neurotic and weak-willed can be hypnotised. Clinical practice and research have shown that it tends to be the opposite. The more intelligent one is, the easier they find to respond to hypnosis. In fact being able to be hypnotized depends on the subject's ability to relax, concentrate and co-operate. Almost everyone can be hypnotized to some extent.

Some people believe that there are dangers involved with hypnosis. It is very true that only those qualified to practice hypnosis should be allowed to. With a qualified hypnotist there are no dangers. If you were hypnotized and lost communication with your therapist then you would simply awaken. You are, remember, conscious and not unconscious. No therapist can get you to do anything that you don't wish to do.

You can, and many, many people are, learning self-hypnosis or use in conjunction with their therapist's work, prepared cassettes to change their own behaviour. Self-hypnosis also has the values of hypnosis and, in my view; everyone should learn and practice it.

The benefits of hypnosis are very widespread and are still being discovered. Such problems as acute anxiety, nervous tensions, excessive smoking, insomnia, obesity, reactive depression, concentration difficulties, poor retentive memory, sexual dysfunctions, asthma, tension headaches, feelings of inferiority, unresolved fears, child behaviour problems, speech difficulties, drinking problems, marital communication problems, enuresis, phobias, student learning difficulties, constipation, personality difficulties, and lack of assertiveness are all able to be modified using clinical hypnotherapy. Quite often this may be combined with other psychological treatment procedures. People's lives can be transformed.

Smokers once living in misery with continual coughing, shortness of breath, lack of energy and other worrying complaints can now look forward to feelings of confidence, renewed energy and vigour, to smelling almost forgotten pleasant odours and tasting with increased sensitivity.

People suffering from severe tension headaches can now look forward to relief and consequently better performance in their daily activities from the use of hypnosis. Insomniacs will not now suffer nights of tossing and turning, pacing up and down, feeling worn out all day and depending on sleeping pills but can look forward to the ease of going into a deep, refreshing sleep.

Many others will now also be able to look forward to better living, happier and healthier, with the advantages that hypnosis can bring. Hypnosis, it is a sensational experience.

HYPNOSIS AND LEARNING THEORY

A. V. Wood

INTRODUCTION

When dealing with theory researchers and clinical experimenters of hypnosis confine their research — as much research should be to controlled laboratory conditions. However, any research that involves the human beings cannot, as researchers do, ignore all variables and set up controlled experimenters.

The results of such findings must by necessity be at variance with the findings of the hypnotherapist or behaviour modification practitioner who deliberately makes allowances for human differences.

Consequently the findings of controlled experimenters must not be accepted as unqualifiablely correct as the author attempts to show in his own personal clinical practice. To hold such controlled findings as indisputable is to ignore the worth of the practitioner.

Various studies over the years, into hypnosis and learning procedures, have yielded contradictory results. Many such studies have considered either the acquisition of certain material by a patient whilst under a state of hypnosis or the recall of material learnt at an earlier time, either whilst the patient was in or out of a state of hypnosis.

Huse (1930), using material learned in the waking state 24 hours before testing found no evidence of any improved recall in hypnosis. Similarly, Young (1925), in an extensive study in this area, testing memory for many types of material, found no evidence for increase in memory in the hypnotic state. Eysenck (1941), like Young, conducted an extensive study involving many performance tests as well as memory for learned material. He found that there was a marked difference in the ability to recall so called "useful" material as opposed to nonsense material.

Whilst the foregoing studies do not indicate that hypnosis facilitates memory or learning, several other studies do lend some support to this notion. White, Fox and Harris (1944), found a significant gain of about *50%* for meaningful material learned in the hypnotic state but they confirmed Eysenck's findings of no significant gain for "useless" or nonsense material. Also in 1944, Rosenthal confirmed these results.

A more recent study by Sears (1955) compared a group of subjects learning the Morse code under hypnosis with matched group learning in the waking state. Testing was carried out in the waking state for all subjects. The difference in the number of errors in the two groups continued to increase with more practice, until after 30 hours the group learning under hypnosis was making significantly fewer errors.

Many of the early studies and even the more recent ones do not allow definite conclusions about the effect of hypnosis because of the number of different variables introduced by different researchers. One such variable that of the intelligence of the patient has been demonstrated to correlate with hypnotic suggestibility. (Curtis, 1943). Anxiety has been reported (Spence, 1956) to influence a wide range of learning tasks.

In his extensive review concerned with learning and hypnosis, Uhr (1958) indicated that none of the experiments he reviewed had examined the effect of the trance state on learning without the confounding effect of motivation, intelligence and other extraneous variables. Some other studies which have controlled one or more of these variables have indicated that hypnosis in itself affects the degree of performance less than that of suggestibility or susceptibility. (Fiedler, London and Nemo, 1961; London and Fuhrer, 1961).

Robert L. Schulman, in his Ph.D. dissertation for the University of Illinois, in 1962 hypothesised that:

1. Hypnosis enhances learning, so that subjects learn significantly more efficiently when hypnotised than when not.
2. Learning ability is positively related to hypnotic susceptibility, so that relatively susceptible subjects perform better than relatively unsusceptible subjects under all conditions.
3. The effect of hypnosis upon learning efficiency will be more manifest in the case of individuals who are relatively susceptible than upon those relatively unsusceptible to the hypnotic state.

Without considering in detail the methods employed by Schulman in carrying out his research, and the type of subjects involved in the programme, it was interesting to note some of his conclusions.

First, he found that there was no significant differences in recall of learned material from subjects who were hypnotised and those where the subjects were not hypnotised. What he did find, or rather verify, was that there were relative differences in the subjects' degree of hypnotic susceptibility and this played some part in the degree or response. However, he did not find such a correlation as did earlier researchers.

Nor did he find that the subjects' degree of anxiety contributed significantly to performance scores.

Indeed, his dissertation seems to have come up with some strange conclusions because he concluded that "the treatment of hypnosis did not significantly influence performance on any task relative to performance in the unhypnotised subject."

It must be remembered, however, that this study considered only one aspect of the use of hypnosis — and perhaps to consider one aspect only may lessen the validity of any experiment.

This study dealt only with acquisition, rather than recall or memory and it employed a fairly rigid experimental procedure rather than a more flexible approach as would be used in everyday usage.

In most of the studies which have claimed that hypnosis facilitates learning (Rosenthal, 1944; Sears 1955; White et al., 1940), the test for the effect of hypnosis was carried out when the subjects were in a condition other than one in which the learning took place. In other words, the subjects would learn in the waking state and then be tested in the hypnotic state or vice versa. When conditions are changed in this way, it is difficult to evaluate what effect the state of hypnosis had on the performance in question. It should also be noted that even some of the studies (Huse, 1930; Mitchell, 1932; Young, 1925) which have *not* found hypnosis to have an effect on learning have followed the same general type of experimental procedure.

The author's criticism on Schulman's findings is that the hypnosis was induced in every case from standardised procedures — which a practising hypnotherapist would regard as invalid. In Schulman's experiments hypnosis was induced by being read from cards and the hypnotist did not use idiosyncratic cues for deepening the trance state.

Further, all subjects, regardless of their degree of susceptibility, were induced with the same technique. Whilst this may seem sound methodologically, it is quite likely that many affects of hypnosis may be obscured by the minimal treatment of hypnosis or unsusceptible patients or subjects. As in other areas of psychological research controls and standardisation are the prime prerequisites for obtaining results which hold true on cross-validation but rigidly controlled techniques with all patients, regardless of susceptibility, is not the way in which the hypnotherapist aids his patient. Thus there is a significant difference between the approach of the research experimenter and the practising psychologist or hypnotherapist.

With all this confusion from existing experimental research in controlled "antiseptic" conditions, the author decided to conduct his own research under everyday clinic conditions, more applicable to the practising hypnotherapist than the conditions existing in a controlled laboratory experiment.'

Between 1967 and 1971 the author kept records specifically for those patients who came for assistance with learning and memory recall. It is to be noted that unlike the majority of research work which concentrates mainly on the ability to recall work learnt whilst under hypnosis, the patients in this "practical research" were neither memorising or recalling information whilst in a state of hypnosis. It is this significant difference which the author feels is the cause of such different results.

The following variables were considered for the 253 patients who were part of this programme:
1. Rapport
2. Degree of susceptibility
3. Depth of hypnosis
4. Use of posthypnotic suggestion
5. Age of patient
6. Intelligence of the patient (I.Q.)
7. Conscious motivation

Rapport, the harmonious relationship between therapist and patient produces a close interpersonal relationship where "the space between" is filled by the closeness of the concentration existing between therapist and patient. As a result of this special relationship, suggestions from the therapist (heterosuggestion) are more readily followed.

In addition, greater attention is paid to the therapist when this attention exists. When a subject is in good rapport with a therapist then, under hypnosis, he usually responds with more precision to suggestions, particularly if these are in accord with his wishes and other emotional needs. As an important variable, rapport during hypnosis is more intense and provides therapist and patient with an emotional satisfaction seldom achieved by other forms of psychotherapy.

Rapport is a specific prerequisite for hypnotic induction, utilisation of the hypnotic process and for the production of subsequent behavioural changes. (Kroger and Fezler, 1976). Yet, rapport was ignored as a variable in the controlled experiments of the researchers surveyed above.

Susceptibility has a direct relationship to the success of the therapy and here several of the controlled researchers agree with the practising therapist, although some researchers could not even agree on this relationship. In the author's practice it has been found that the higher the degree of susceptibility the higher the rate of success of the suggestions given.

The use of posthypnotic suggestion is where the author's own practice differs widely to research into learning theory. The author firmly believes that a higher degree of success can be achieved if both the learning and recall is carried out in a state of conscious awareness rather than in a state of hypnosis. The role of the hypnotherapist in giving suggestion prior to the acquisition of learned material is to heighten the awareness of the patient to facilitate the learning process. This involves the use of hyperesthesia or increased use of the senses, particularly in learning theory, the increased use of perception.

It is also essential that four elements of post-hypnotic suggestion be present, namely that the posthypnotic suggestion is positive, repetitive, ego strengthening and motivational. The writer does not intend to explore in detail the necessity for these elements to be present in posthypnotic suggestion in either learning theory or any type of behaviour modification as it is already widely recognised by practising therapists, as opposed to controlled experimenters. Sufficient to state

that a conducive learning situation is to be created by the therapist in a state of hypnosis and then such an atmosphere will aid the acquisition of material by the patient in a posthypnotic state.

Controlled experimenters have ignored the relationship between depth of hypnosis and the "success" of suggestion. It is generally accepted by therapists that posthypnotic suggestions should be given in a light state of hypnosis only, for the deeper the state of hypnosis, the less likely the patient is to react to the posthypnotic suggestion as such suggestions were implanted too deep into the subconscious for conscious effect.

Specifically in the case of memory training and recall, the age of the patient is an important variable. It has been shown in the author's own practice that school students of secondary school age are not only better subjects as far as susceptibility is concerned but that they can better acquire and recall learned material than tertiary students — particularly older tertiary students. The capacity of the brain to absorb and recall knowledge and information has been shown by researchers to be at a peak at the pre-tertiary level. Yet this factor was ignored also in much of the controlled "research" referred to above.

Again ignored by many researchers is the intelligence level of the patient or subject used for testing purposes. It is an established fact that hypnosis cannot increase ability; it can only increase performance range within the existing ability range of the subject so hypnotised. Each of us in the conscious, unhypnotised state performs to a certain level or percentage of our existing ability. The use of hypnosis can only aid an increase in that level of performance. The therapist is a behaviour modifier — not a person that can increase intelligence in the patient. Whereas the author found that in his own practice, persons of lower intelligence did not achieve such a high degree of success with hypnosis, the controlled experimenters gave no consideration at all to intelligence as a factor influencing their results.

Nor did they give any consideration to motivation — conscious motivation of the patient. The patient who comes to a therapist with a desire to increase his performance in both memory and recall of given information is much more likely to receive positive benefits and results than is the subject in Schulman's research where he/she had no idea as to the purpose of the hypnosis — as stated by the researcher. And motivation is affected by anxiety — something which the therapist deals with but researchers do not, yet they admit it is a variable. The anxious patient is again less likely to attain positive benefits from the hypnosis than is the patient who lacks anxiety. The therapist treats anxiety, the researchers did not.

In the author's own practice then, suggestions for increased awareness are given as a posthypnotic suggestion and the patient acquires the learned material in the unhypnotised state. Similarly he is able to recall the information more readily in the unhypnotised state as this is also stressed as part of the post hypnotic suggestion.

The overall findings of the 253 patients treated by the author (and it is here stated that all were of either school age or tertiary students) is that there was a 67% improvement in the ability to acquire knowledge and to recall pertinent information by persons of school age and a *58%* improvement by persons of post school age — or tertiary students.

It should be noted, however, that this "improvement" is in the ability to recall learned material, not to interpret learned material. Significant results can be obtained from hypnosis involving the use of hypermnesia — but controlled experimenters who have little place in the practical surgery may well debate the validity of hypnosis for some decades to come.

REFERENCES:

Curtis, J. W. *A study of the relationship between susceptibility and intelligence,* **Journal of Experimental Psychology**, **1943, 33, 337-339.**

Eysenck, H.J. *An experimental study of the improvement of mental and physical functions in the hypnotic state,* **British Journal of Medical Psychology, 1941, 18, 304-3 16.**

Fiedler, F.E. London, P. & Nemo, R.S. *Hypnotically induced leader attitudes and group creativity.* **Technical Report No. 11***,* **1961, University of Illinois, United States Public Health Service Grant, M1774.**

Hull, C.L. *Hypnosis and Suggestibility,* **New York: Appleton-Century**, **1933.**

Huse, B. *Does the hypnotic trance favour the recall of faint memories?* **Journal of Experimental Psychology, 1930, 13, 519-529.**

Kroger, W.S. & Fezler, W.D. *Hypnosis and Behaviour Modification,* **J.B. Lippincott, Philadelphia**, **1976.**

London, P. & Fuhrer,M. *Hypnosis, motivation and performance****, International*** **Journal of Clinical and Experimental Hypnosis, 1961, 29, 321-333.**

Rosenthal, B.G. *Hypnotic recall of material learned under anxiety and non-anxiety producing conditions.* **Journal of Experimental Psychology, 1944, 34, 369-389.**

Salzberg, C.H. *The effect of hypnotic, posthypnotic and waking suggestion on performance using tasks varied in complexity.* **International Journal of ainical and Experimental Hypnosis, 1960, 8, 25 1-258.**

Sears, A.B. *A comparison of hypnotic and waking learning of the International Morse Code.* **Journal Clinical and Experimental Hypnosis. 1955, 3, 215-221.**

Schulman, R.E. *Hypnosis and Verbal Learning, Unpublished doctoral dissertation*, **University of Illinois**, **1962.**

Spence, K.W. *Behaviour Theory and Conditioning,* **New Haven: Yale University Press**, **1956.**

Uhr, L. *Learning under Hypnosis: What Do we Know, What Should we Know*? **Journal of Clinical and Experimental Hypnosis, 1958, 6, 121-131.**

Weitzenhoffer, A.M. *Hypnotism: An objective study in Suggestibility.* **New York: Wiley**, **1953**.

White, R.W., Fox, G.F. & Harris, W.W. *Hypnotic hypermnesia for recently learned material.* **Journal Abnormal Social Psychology, 1940, 35, 88-1 03.**

Young, P.C. *An experimental study of mental and physical functions in the normal and hypnotic state.* **American Journal of Psychology, 1925, 36, 214-232.**

A RAPID INDUCTION TECHNIQUE: MY APPROACH

J. Hariman

INTRODUCTION

Historically, the first users of rapid induction techniques are probably stage hypnotists. With so little time available, trance induction has to be done quickly.

During the 1940's, when clinicians became interested in the clinical applications of hypnosis, many of them turned to stage hypnotists for tuition. But, since patients were by definition mentally unstable, a more permissive and less frightening (and aggressive) technique became a necessity. Also, in comparison with stage hypnotists, clinicians did not have a choice of subjects. Techniques had to be developed which were applicable to all of them, despite their trance capabilities.

Most of the techniques which were subsequently developed were relatively slow, taking from 15 minutes up to an hour or more to induce a trance.

Not much reference is made to rapid methods of induction in the current literature. Cheek & Le Cron (1968 p. 32) describe a method using a mild startle effect which they claim is not objectionable and is both rapid and effective. The Carotid Artery Technique is described by Hartland (1972 p. 73) and Furst (1973 p. 207). This involves pressure being applied upon the vagus nerve and carotid artery on each side of the Adam's apple at about the level of the cricoid cartilage till the person relaxes. This and another shock technique is condemned by Kroger (1963 p. 74). A rapid induction technique which is suitable for a patient in a reclining position is described by Werbel (1965).

An intriguing report in which adequate dental analgesia was produced rapidly by a posthypnotic suggestion (successful in virtually 100% of 100 dental patients) is given by Barber (1977). The standardised induction, which took up to a maximum of 20 minutes consists basically of 'going down the stair' procedure. Barber conjectured: "Perhaps increased use of rapid induction analgesia would provide information on the wider applicability in a variety of clinical contexts".

Recently, Matheson and Grehan (1979) present a rapid induction technique which is a modification of M.H. Erickson's arm catalepsy induction technique. There are, however, two major disadvantages. Firstly, it "is not suitable for beginners". Secondly, "such problems as painful bursitis of the elbow or shoulder, or the presence of active arthritis which may be bilateral, must be ruled out before proceeding". (p. 298)

The technique to be described shortly is suitable for beginners with reasonable experience since all possibilities are covered. (In Matheson & Grehan's technique, *rigid horizontal arm catalepsy* is the only possibility). Also, since in the most likely possibility (floating in the air) the arm is not rigid but remains relatively relaxed, there is no need to worry about painful bursitis, arthritis and the like. To the author's knowledge, this technique has never been described elsewhere before.

THE TECHNIQUE:

1. "Before we proceed, there are two points I would like to make. Firstly — the most important thing here is what you do, not what I do. (This suggestion implies that hypnosis is an active psychic process. It is neither a passive nor an unconscious state. This suggestion implicitly urges the patient to co-operate fully). Secondly: during trance your unconscious is prominent. Various things will happen automatically, quite independently of your conscious effort and deliberation. (With this remark, the experimental nature of trance is defined. Consequently, any spontaneous occurrence should produce trance — and if this has been accomplished, to deepen it). Just let them happen. (This remark says in effect, 'If you wish to resist, you can'. It is intended to discharge 'resistance' by giving the patient freedom.)"

2. "Settle back comfortably. Close your eyes. Now take three nice, comfortable breaths with me all the way. In — out and relax. In — out and relax. Next time you breath out, feel as vividly as possible — all your body tension and energy — drifting away, fading away with your breath. In — out — completely and totally relaxed now. Fine. (Many susceptible patients can be expected to start to enter trance at this point)".
3. "All I want to do is to take your arm like this. (Lift the patient's arm by the wrist to his eye level, in the end level of 'arm levitation'. Then, let it go quickly. There are two possibilities. Possibility one: It is most likely that the patient's arm will sort of float in the air. Possibility two: It will drop to his lap. Whatever happens is fine)".
4. "As you have noticed, you have slipped very easily into hypnotic trance. I think you will agree that your arm has reached this position by itself, independently of your conscious effort and deliberation. (This remark ratifies trance and says in effect that the patient is highly hypnotisable. This entails a further admission — that therapy will be a great success)."
5. "*You* can stay in this state as long as you find necessary, and you can go even deeper. (This is a truism, since the patient unconsciously knows that it is necessary for him to be in trance before therapeutic suggestions can be implanted. And that the deeper the trance, the better the result will be. Thus, this remark is an indirect deepening procedure)".

NOTE:
From point *5,* the therapist can either deepen the trance or proceed directly to treatment.
Note that only the *commentaries to the remarks* are put in brackets.

DISCUSSION:
I have found that most of my patients' arms 'float' in the air. (If, on the other hand, the arm drops to the lap, this usually indicates that the patient is at least in a light trance). This phenomenon has a strong 'surprise' element, since it suggests that trance is already developed. This procedure tends to circumvent 'resistance' before it can develop. When used with resistant subjects, it shortens the induction period and allows more time for therapy.

Apart from circumventing resistance and shortening the induction period, the surprise element also tends to increase the level of expectation of the patient. In this context, it is worthwhile noting that an ever increasing number of reports (Bednar, 1970: Frank, 1968), subscribe to the viewpoint that it is the patient's belief in the therapist and in the technique used by the therapist that may well be the most important factor in his or her improvement. Torrey (1972) has very effectively made the same point by reducing all successful psychotherapy to four elements and stressing the importance of one of them — patient expectancy of getting well. The patient, as Gindes ***(1951)*** has pointed out, will get well when he is convinced that he can be well.

Also, it (surprise element) serves as a 'confusion' technique, since it blurs the outer reality and focuses the patient's attention inward. The same trick has been used by stage hypnotists for centuries. They behave aggressively so that the subject is confused and self conscious. This, in turn, make the subject's mind receptive for clarifying suggestions which finally paves the way to trance work proper. (Erickson et al, 1976).

And finally, most of the remarks proceed by way of *implication.* The advantage of this approach is twofold. Firstly, its subtlety tends to facilitate the change from within. It affects the patient unbeknown to him. This has the further advantage of (as above) circumventing resistance, since implications are extremely difficult to resist. (Erickson, et al, 1976; 1979).

REFERENCES:
Barber, J. Rapid induction analgesia: A clinical report. ***The American Journal of ainical Hypnosis, 1977, 19, 138.47.***
Bednar, R.L. Persuasability and the power of belief. ***Personnel guid J,*** 1970, 48, ***647-52.***
Cheek, D.B. & Le Cron, L.M. *Clinical Hypnotherapy.* N.Y.: Grune & Stratton, 1968.

Erickson, N.H.; Rossi, E.L. & Rossi, SI. *Hypnotic realities: The induction of ainical hypnosis and forms of indirect suggestion.* N.Y.: **Irvington,** 1976.
Erickson, M.H. & Rossi, EL. *Hypnotherapy: An exploratory casebook.* N.Y.: Irvington, 1979.
Frank, J.D. The influence of patient's and therapists' expectations on the outcome of psychotherapy. ***Brit. J. Med. Psychol.,*** 1968, 41, 349-56.
Furst, A. *Posthypnotic Instructions.* **Wilshire Book Company**, 1973.
Gindes, B.C. *New concepts of hypnosis: As an adjunct to psychotherapy and medicine. NY:* ***Julian Press**,* 1951.
Hartland, J. *Medical and Dental Hypnosis.* 2nd ed. London: **Bailliere Tindall**, 1972.
Kroger, W.S. *Clinical & Experimental Hypnosis.* Philadelphia: **J. B. Unpincott Company**, 1963.
Matheson, G. and Grehan, J.F. A rapid induction technique. ***The American Journal of Clinical Hypnosis**,* 1979 (April).
Torrey, E.F. *The mind game: Witchdoctors and Psychiatrists.* N.Y.: **Emerson Hall**, 1972.
Werbel, E,W. *One surgeon's experience with hypnosis.* N.Y.: **Pageant Press Inc**., 1965.

POSITIVE MENTAL BULLDUST
G. Turner

The secret of success is that there is no secret.
Positive Mental Attitude along with hard work and Time Organisation is a by-product of an awareness that comes to people who allow themselves to experience life.
Belief is only a belief, it is not reality.
You get what you resist.
The title is polite, you know what I mean.
It is hard for anybody to grow up these days without hearing about, reading about, being exposed to, or having crammed down their throats, the virtues, nay, the absolute necessity of having a Positive Mental Attitude.

Many claim Napoleon Hill started it all with "Think and Grow Rich", which must have been close to forty years ago. I found a book with identical philosophies, printed in 1910 called "Right Thinking". Of course if you really want someone to blame, then how about the way the Apostles related the stories of Jesus and the role, having faith has in achieving success, wealth, health, happiness and Heaven. I contend that over the last nearly 2000 years we've been subjected to some gross misinterpretations of the words of the Master.

I've heard all the contempories. I've read them all, taught their philosophies, made money by it, lost money by it. I've spoken with some of the greats in this business of "Motivation". In my own dung heap I have had moments of greatness myself. (I've also had the dung thrown at me). I have letters from many people, rags to riches people, 'show biz' starts, and business people, all grateful for my 'help'. I've been hailed as Guru, Mentor, Teacher, Philosopher and Motivator. I want to tell you it's all BULL!!!

If you are one of the disciples, one of the converted, a believer, then you are now saying: "Aha! It hasn't worked for G.T, he's disillusioned, he hasn't followed the rules properly, he should read "XYZ Factor, The Secret Source of Positive Motion by Richard Wit Cranium, who discovered enlightenment whilst overdosing on Andrews Liver Salts and Agio lax".

Why, you may ask, this tirade against this institution of PMA, against the 'religion', the path to success, the sacred cow of Insurance Salesmen, the Holy Grail for Motivators Sales Managers and some Hypnotherapists?

"Hypnotherapists, Heaven forbid!"
Yes, even Hypnotherapists. The reason my friends, is that while soever this myth is perpetuated, real growth is stifled. I have been guilty and I suspect so have you, of attempting to replace one habit for another in your patients, a Positive attitude for a Negative one, feeding people this tripe of evaluation, "Good is Good, Bad is bad."

In my work I have encountered many people ploughing through life waving their Positive Mental Attitude in front of them like a Crucifix to drive off the devil. "I am Positive" they scream as they go down for the third time, business collapsed, health collapsed, marriage collapsed. I've been there — that may account for some of my cynicism. Perhaps you've been there too? There are millions of sick people out there being fed this PMA pill. I have prescribed it to many. For some it works, for most, not. I have come to some conclusions which I would like to share with you.

All therapists tend to forget that people are individuals and so fall for the trap of prescribing the same thing for the same complaint. You (see the accusing finger?) tend to have a favourite way of 'curing' smoking, overweight, etc.

There are some complaints which respond to a specific treatment that seems to work for everybody. There is little doubt that the most successful cure for Asthma is a Parentectomy and the best cure for a frigid woman is a frigid man.

But what about the negative person (see how we evaluate?) whose attitude is that of the 'Born Loser'? Someone suggested an operation to sever the Anovular nerve. (The nerve that connects the anus to the eye? it gives a shitty outlook on life. If you doubt its existence, just pull a hair out of their backside and watch their eyes water).

The person we are trying to make Positive in our clinics, in our classes, courses or 'T' groups is just an ordinary human being with more than his share of programs or 'conditionings' (or whatever your favourite 'buzzword' is for a lifetime of acquired survival thinking). He or she has probably tried to be positive and even succeeded for a short time but typically has succumbed to something stronger lurking around in their 'personality package'.

A Positive Mental Attitude doesn't work because it is not the major ingredient for success; it is a by-product of Awareness. The only thing that we need do is assist people in succeeding, overcoming misfortune, improve health, sex life or anything else, is to open up the channels of awareness.

People will have ups and downs, highs and lows. Don't kid yourself, you have them too. The best way to cope with these things is to let them be there; if you resist them they will simply push back.

I used to think life was a Roller Coaster with exhilarating highs followed by plunging into deep low gullies. Up and down, never knowing what is just around the next bend or over the next hill. Now I am enlightened, life is still a Roller Coaster with its highs and lows. There is one difference; however, I am now riding in the car instead of lying on the track."

I have interviewed many successful people. Successful, not necessarily rich (even the ones who live modestly don't seem to worry about money). I can hear some of you saying; 'Who determines success?'

Just pick 20 friends, relatives or acquaintances and in that group there will be one who is 'successful'. You will know which one it is without definition.

The successes I have spoken with admittedly all have a Positive Mental Attitude but it is not the reason they are winners. They all claim to work hard yet that is not the reason either. These things as I mentioned earlier are by products. At this point I must say that they never appear to be working hard to make their successes. Their work is a joy and a pleasure and they don't seem to know about time or even day or night. They find time for charity work, service clubs, church or community activities and sport, all of which has given rise to another myth or 'secret' of success and that is Time Organisation.

Millions have been spent by big businesses and corporations on installing Time Organisation programs. There are systems to teach people to control their time and almost as many books and films on the subject as there are on Positive Mental Attitude. Time Organisation as a secret or sole method of success is as much bulldust as the other.

If it isn't PMA, Hard Work or Time Organisation, what is it?
One can become involved in words like Self Esteem, Ego Drive Awareness etc., etc. The actual 'thing' defies words but because this article relies only on words we will settle for "Awareness" and books have been written on that subject alone. This can be very Subjective so here are some *my* feelings on the subject.

People who are aware:
Experience the moment
Live here and now
Learn from experience
Don't let yesterday or tomorrow destroy their NOW
Are true to their own feelings, thoughts and values
Behave authentically at all times
Avoid 'game playing'
Are not governed by feelings or emotions but are aware of their existence
Go with the flow, they don't push against it.

These are but some of the things people who are aware utilise in successful living. They don't look too difficult? Let's take a couple of examples and see how you 'measure up'.

'Experience the moment'. How often do we do this compared to the amount of time we spend reminiscing, stewing over things we "should a done", thinking, worrying or planning the future. Experiencing what you are doing right now is a good way to begin becoming aware.

'Learn from Experience' is another thing we humans find it difficult to do. The "Analogy of the Cheese" is something you may have heard before but it is worth repeating.

A psychologist puts a rat in a maze containing four channels and places some cheese at the end of channel A. The rat goes down and finds the cheese. Next time the psychologist places the cheese at the end of channel B. The rat goes down A, doesn't find the cheese, it may rip down A again for a recheck and then goes down channel B and of course gets the cheese. Then the cheese is placed at channel C. The rat checks B where it was last time, then moves into C etc., etc.

By putting a human being in a maze and telling him, "I want you to *believe* that the cheese is in channel A", we will discover the human going down channel A and getting the cheese for the first time, but when it is moved, he will go down channel A and finding no cheese, he will go down channel A again, and again, and again because he believes it is there.

The lesson or moral is this; the rats learn from their experiences, humans would rather be right then get the cheese.

We don't seem to learn from experience. We have this incredible belief system that other animals don't seem to have. We are handed a constant stream of things to 'believe in' from the moment we are born and we just build up this huge account of beliefs which we think are real and so we live by them.

"I believe in God", "I'm not very smart", "I'm very intelligent", "Blood is thicker than water", "Whites are superior", "Black is beautiful", "Children should be seen and not heard", "Breeding is important", "Democracy is best", "Socialism is the answer", and so we go. Not one original thought, probably not one *real* experience. All this garbage was given to us by others who also only believe it and pass it on to other innocent minds.

Why do we do this? Because we are programmed to be *right!* Man would rather be right than get the cheese.

It doesn't help if a -man (or woman) is *positive* he is right. The cheese is still not in channel A. We Hypnotherapists are guilty of perpetuating this gigantic myth of the necessity of a Positive Mental Attitude. I am guilty of value judging, of replacing one program for another. In fact you can't replace programs, all you do is add new ones, as if we don't have enough already.

This article will upset the belief system of a lot of people 'programmed' to be right, especially some academics that have spent the bulk of their life taking on and accepting blindly their teachers beliefs about things they have never experienced.

Experience is the only thing that is authentic; anything else is just bought and accepted. We 'buy' the story of Positive Mental Attitude, we want to believe it. What is incredible is that literally millions of people bought it, tried it and found it doesn't work yet still believe it.

"It worked for him, (Conrad Hilton, Tracy Wickham, Neil Armstrong, Dick Smith, etc., etc.) I must be doing something wrong".

That's us, always ready to live by the program, "Poor me, I'm not as smart as they are". All you're doing 'wrong' buster, is believing that bulldust fed to you by the 'Motivators'. It's a good living for them. I know, I'm one.

Once you let that belief go, once you stop looking outside yourself, once you stop trying to 'improve' yourself, once you stop resisting failure, poverty sickness or whatever you need your positive mental attitude for, then that is when you will start succeeding in this game of life.
A Universal Law has manifested some time or another for all of us, it is this; *"You* Get What You Resist".

Some resist failure so vigorously they are constantly failing. The harder one resists poverty the poorer he gets. Your patients experience difficulty with smoking, overweight, nail biting, impotence, frigidity and so on *because* they fight it.

Maybe your belief system is resisting the truth of what I am saying. I admit this is *my* truth but I want you to know it as my experience, my awareness, *not* my belief. Just go with your experience, drop all your beliefs, all the things you were taught at school, at college, hypnosis school, psychology classes, University or whatever. Don't disbelieve them, just don't believe them.

Allow yourself to experience things, become aware, aware of feelings thoughts and images. Don't fight them, don't resist them, just experience what you are experiencing.

The secret is that there is no secret, there is nobody out there. I am all I have, you are all you have. All feelings, emotions, conditionings, programs, or beliefs are not the person they are the personality. They are the things; a person *has* as part of the survival kit. These programs or survival habits are formed from the moment we are born. One learns survival techniques until they become second nature. Unfortunately they become redundant and inappropriate as we mature but we still respond out of them.

These automatic responses, if they bring about failure are called 'negative' mental attitudes. If they happen to bring about successes they are called 'positive'. However, what works one time may not work the next. This is how habits are born, they work for a time and so we buy the program.

The people who are successful have risen above the automatic responses. They act appropriately — now, they behave authentically, not playing roles they hope will get them the results they want. They don't play games.

With this awareness, I believe you can be an even more effective practitioner than you are now. You can teach patients to 'go with the flow'. When they stop resisting failure they will succeed.

HYPNOTIC SUSCEPTIBILITY AND AGE REGRESSION
G. Haimer

In a large number of experimental papers on a variety of hypnotic phenomena, T.X. Barber (Barber, 1969; Barber, Spanos and Chaves, 1974) has consistently shown that when unselected subjects are randomly allocated to conditions which differ solely in the presence of absence of a standard hypnotic induction procedure, then no significant differences are found between the conditions.

Barber's work has been the subject of much criticism from researchers adhering to the traditional theory (Hilgard, 1970; Reyher, 1975). Their chief criticism is that Barber's methodology contains one fundamental error, which is, that it fails to acknowledge the importance of the large and reliable differences between people in their hypnotic aptitude or susceptibility. Since unselected subjects are randomly allocated to hypnotic and non-hypnotic conditions each condition is likely to contain a large number of subjects who are relatively low in the kind of aptitude that defines the hypnotic domain. So, despite the administration of a hypnotic induction procedure, few subjects in the so-called "hypnotic" condition are likely to become "hypnotised" in the traditional sense. Therefore, Barber's findings can be said to be, at best, only marginally relevant to the role of the hypnotic state in the production of hypnotic phenomena.

In response to criticisms of the methodology of Barber's experiments, Fellows and Creamer, 1978 studied the role of hypnosis in the production of age regression by suggestion. Twenty subjects of high hypnotic susceptibility and twenty subjects of low hypnotic susceptibility were randomly allocated to one or more treatment conditions: hypnotic induction procedure or motivational instructions. Both treatments were followed by suggestions to regress to the age of seven years. Two measures of age regression were taken in the survey: the Draw-A-Man Test and a subjective rating of the reality of the experience.

The results showed significant effects of both variables, with high susceptibility and induction treatment producing better regression on both measures than low susceptibility and motivation treatment. Hypnotic susceptibility was the stronger of the two variables. The ranking of the four conditions correspond with predictions of hypnotic depth from the theory state of hypnosis. The drawings of all regressed groups were more mature than the norms for the age of seven and the drawings of a group of seven year old children.

In age regression the subject was instructed to return to an earlier period of seven years of age. If the procedure is successful the subject will appear to talk, think and generally behave in a manner appropriate to the suggested age: he will seem to remember a great deal of what happened at the time and fail to acknowledge subsequent events; and on returning to the waking state, he will usually affirm the subjective reality of the experience. Hypnotic age regression has been the subject of a great deal of research (for reviews of the field see Reiff and Scheerer, 1959; Gebhard, 1961; Yates, 1961; Barber, 1962).

Barber's (1962, 1969) reviews stress the following points: (1) that though regressed subjects appear to behave in a childlike manner their performance on standardised tests tends to be superior to the norms for the suggested age; and (2) that age regression can be produced equally well in non-hypnotised subjects either by giving them motivational instructions to do their best to imagine that they are going back in time etc. or by instructing them to act as if they were regressed (O'Connell, Shor and Orne, 1970). Though the first of these points may be accepted, the implication of the second point, that is the state of hypnosis playing little part in the production of age regression, is open to question.

First, the independent group design employed by Barber does not enable one to come to firm conclusions on this point. In the Barber and Calverley (1966) study the small differences between the hypnotic and non-hypnotic groups in the recall of previously learned material during

regression could be due to the fact that there were relatively few subjects in either condition capable of becoming hypnotised to a depth necessary for *the production of* age regression. Secondly, the simulation design used by O'Connell et al (1970) in their study of age regression is open to question (a) for confounding subject susceptibility and instructional variables (Barber, 1969) and (b) for using simulators as a comparison group which appear to show special treatment effects.

The interaction design employed in the work of Fellows and Creamer (1978) overcame both these problems: there was a clear "hypnosis" condition and susceptibility and treatment variables varied independently. Two indices of age regression were used in the study: (1) an objective measure of drawing ability from the Goodenough-Harris Drawing Test (Harris, 1963) and, (2) a subjective measure of the reality of the experience for the subject on a five point scale. Drawing has often been used as a measure of age regression (see Gebhard, 1961, for a full review), but much of this research is difficult to interpret owing to the variety of procedures and measures used. However, the standardisation of the Draw-A-Man Test by Harris (1963) has now made this a convenient, quick and reliable method of assessing age regression.

The subject measure was taken since the reality of the regression experience for the subject has long been regarded as an essential feature of hypnotic age regression. The subjective state is seen by traditional theorists as being a major distinguishing feature of hypnosis. Its importance was confirmed by O'Connell et al (1970) who found the subjective report of really feeling the suggested age to be the only reliable factor differentiating hypnotically regressed subjects from simulating subjects. However, this finding is open to question since the simulators received fairly explicit instructions that they were only to behave as if regressed and not feel regressed.

Many researchers tend to see the difference between the hypnotically regressed subject and the simulating subject as the difference between remembering the situating and reliving the situation. The hypnotically regressed subject is completely reliving the experience and whilst interpretation and fantasy formation is still present, interpretations of phenomena at the regressed age are less likely to be coloured by the interpretive bias of later age experiences.

In the research conducted by Fellows and Creamer subjects were selected as being either high or low in hypnotic susceptibility.

They were either given a hypnotic induction procedure or given motivational instructions to try hard to imagine being regressed. They were then instructed to return to the age of seven years and to draw a man. They were subsequently asked to give a subjective rating. A group of seven year old children were also asked to draw a man. The researchers were looking for the following: (1) any base-rate differences in drawing ability between high and low susceptible subjects; (2) any effects of either variable or their interaction on the regression measures; (3) any differences between the "hypnotic state" condition (high susceptibility with induction) and other conditions; and (4) to the extent to which the regressed drawings matched the test norms and those of seven year old children.

Results included the fact that the scores of the subjects on the Barber Suggestibility Scale strongly confirmed the initial group selection of high and low susceptibility subjects.

All drawings were independently scored using the 73 scoring criteria in the Goodenough-Harris Drawing Test Manual (Harris, 1963). The following was revealed: (1) there were no significant differences between the groups in the base-rate scores though there was some tendency for the high susceptibility subjects to score higher than the low susceptibility subjects. (2) In the regression situation both factors and the interaction were found to exert significant effects on the drawing scores. Subsequent tests showed that the high susceptibility with the induction group scored significantly lower than either of the two low susceptibility groups. (3) The analysis revealed significant effects for both hypnotic susceptibility and for the induction procedure but not

for the interaction. (4) Analysis of the subjective ratings showed highly significant effects of both factors and of the interaction.

Regarding the relationship between the regressed drawings and those expected from seven year old children, we may first compare the mean drawing scores with the published norms. (Harris, 1963). The overall mean base-rate score of 54.7 is equivalent to a standard score of approximately 114 for adults. This standard score is equivalent to a raw score of 29 at the seven year old level which is the sort of score one would expect from the present sample of subjects at the real age of seven years. The nearest "realistic results" were obtained by those of high susceptibility with a score of 37.6 whereas those of low susceptibility scored a mean of 50.9, the equivalent of a 13 year old. The high susceptibility without induction performed at the 11 year age level and the low susceptibility group without induction also performed at this level.

One of Barber's (1962, 1969) conclusions regarding hypnotic age regression is strongly supported by these findings. Though the drawings produced in the regression situation were less mature than those produced in the normal situation they were considerably more mature than (1) the published norms for the suggested age and (2) the drawings of seven year old children. This also confirms similar findings from other work on the drawings of regressed subjects (Taylor, 1950; Sarbin and Farberow, 1952).

There is, however, little support for Barber's second conclusion that age regression can be produced equally well in hypnotised and non-hypnotised subjects. Indeed the results of this research by Fellows and Creamer indicates that being hypnotised facilitates the production of age regression. The hypnotic induction variable was shown to have significant overall effects upon both the objective drawing scores and the subjective ratings in the regression situation.

If, on the other hand, we define "hypnotised" in terms of theory (Hilgard, 1965) then we must consider the interaction between the two variables. In the experiment referred to above the depth of the hypnotic state would vary according to the susceptibility of the subject and the quality of the induction procedure. So, the deepest state should occur in the high susceptibility with induction condition producing better age regressions than the low susceptibility group with motivational instructions.

Barber's (1969) interpretation of the findings of Fellows and Creamer would be along the following lines. Initially, subjects were selected who were either particularly adept or particularly poor at imagining certain unusual things that were suggested to them, such as going back in time and becoming a child again. The main effect of the induction procedure was to prepare them for the imaginative task by defining the situation as one involving hypnosis with all the expectations and demands that this brings with it, by establishing positive attitudes towards the forthcoming task and by setting up an effective rapport between subject and experimenter.

The motivational instructions also did some of these things though less effectively than a control condition without such instructions. Hence, Barber feels it is unnecessary to employ the concept of a hypnotic state to explain hypnotic phenomena and prefers to interpret them in terms of cognitive, motivational, attitudinal and social variables operating in the traditional hypnotic situation, a view also supported by Sarbin and Coe (1972).

It seems to confirm to the practising clinician that an age regression can be achieved with more reliability when the subject is one who is highly susceptible, for such a patient will attain a deeper level of hypnosis than a subject with a low susceptibility rating. There is little doubt that age regression is facilitated by the induction of hypnosis as compared to motivational instructions in the wakening state. The secret of success then seems to be to create such a rapport and general state with the patient that one can raise the level of susceptibility thus invoking a deeper state of hypnosis after the induction procedure — but that is surely the topic of a whole new piece of research.

REFERENCES:
Barber, T.X. (1962) Hypnotic Age Regression: A Critical Review, ***Psychosomatic Medicine*** **Vol. 24**, pp. 286-299.
Barber, T.X., Spanos, N.P. and Chaves, J.F. (1974). *Hypnotism: Imagination and Human Potentialities.* New York**: Permagon Press.**
Fellows, B.J. and Creamer, M. (1978) An Investigation of the Role of 'Hypnosis', hypnotic susceptibility and hypnotic induction in the production of age regression, ***British Journal of Social and Clinical Psychology**,* Vol. 17, Part 2, pp. 165-170.
Gebhard, J.W. (1961) Hypnotic Age Regression: A Review, ***American Journal of Clinical Hypnosis**,* Vol. 3 pp. 139-168.
Harris, D.B. (1963) *Children's Drawings as Measurement of Intellectual Maturity: A Revision and Extension of the Goodenough Draw.A -Man Test,* New York: **Harcourt Brace and World.**
Hilgard, E.R. (1970) A Review of T.X. Barber's 'Hypnosis: A Scientific Approach', *American* ***Journal of Clinical Hypnosis**,* Vol. 12, pp. 272-274.
O'Connell, D.N., Shor, R.E. and Orne, M.T. (1970) Hypnotic Age Regression, An Empirical and Methodological Analysis. ***Journal of Abnormal Psychology*** 76 (3) Part 2.
Reiff, R. and Scheerer, M. (1959) *Memory and Hypnotic Age Regression: Development Aspects of Cognitive Function Explored through Hypnosis,* New York: **International Universities Press**.
Sarbin, T.R. and Coe, W.C. (1972) *Hypnosis: A Social Psychological Analysis of Influence Communication,* New York: **Holt, Rinehart and Winston**.
Sheehan, P.W. (1971). A Methodological Analysis of the Simulating Technique, *International* ***Journal of Clinical and Experimental Hypnosis**,* Vol. 19, pp. 83-89
Taylor, A. (1950) *The differentiation between true and hypnotic regression by figure drawings.* Master's thesis, **The College of the City of New York**.
Yates, A.J. (1961) Hypnotic Age Regression, Psychol. ***Bull.**,* Vol. 58, pp.429-440.

CASE NOTES AND TECHNIQUES
CONDITIONING FOR HYPNOSIS VIA TELEPHONE IN A CASE OF DENTAL PHOBIA

J. Kingsbury

CASE HISTORY

The client was a thirty one year old married woman with one child. She had not attended a dentist in ten years, and was unable to even accompany her son to the dentist as the smell associated with the surgery caused an uncontrollable urge to "run away screaming" — in fact, she was unable to bring herself to enter the building wherein the dentist had his rooms. She had an aversion to the thought of being touched inside the mouth, especially on the teeth. Dental treatment had now become a matter of urgency because of the formation of abscesses in two of her teeth, plus numerous cavities. Several weeks before, her husband had made an appointment for her to see his dentist who sent her tranquillizers to prepare for the visit. She had taken the medication as directed but had nevertheless been not only unable to face the appointment, but could not bring herself to walk outside the door of her house on the morning of the scheduled visit. She had cancelled the dental appointment per phone five minutes before it was due.

The client presented as nervous and agitated. She had had an unhappy childhood, she said, and didn't wish to discuss it. She remembered being forcibly held down in a dentist's chair as a youngster, and she requested that we not use age regression as she did not "ever wish to look at her past again". In the past few years she had undergone several minor operations, and reported feelings of sadness and fits of crying immediately after recovery from the anaesthetic. She was at present taking no drugs except the occasional aspirin for toothache.

THE PROCEDURE

During the first visit, the client was taught a relaxing exercise to practice each day at home. A very light trance state was induced via arm levitation, and general ego-strengthening suggestions were given emphasising confidence and independence. It was noted that the client responded poorly to visual imagery tests.

The second consultation took place one week later. The client was much more at ease, and entered a medium trance state quickly. As she had shown poor visual imagery skills, and was not physically relaxed, a disguised attempt to achieve age regression was made in the hope of eliciting a mild abreaction and thus reducing tension. However, the hypnotised client immediately resisted (as no doubt was to be expected considering her remarks at the initial consultation) and no further effort in this area was made. She was then told to "just listen and go with it" as imagery of a pleasant and dissociative nature was presented (any scene could be used, and in this case we used that of a beach as it had been earlier ascertained that she found being near water pleasant and relaxing). In the midst of the imagery, she was informed: "you are now in a dentist's chair". The client reacted violently to this with trembling and agitation. The beach imagery was again introduced and she was told to "concentrate on those emotions, those tensions, those fears . . . really FEEL them ... FEEL it all …. really concentrate . . . feel ALL the tension. When you felt ALL the tension, you may relax, but not before..."

In my experience, this technique usually results in an escalation of the tension to a peak, and then a falling off gradually into relaxation and this case was no exception.

When relaxation had occurred, the client was again told "you are in a dentist's chair", and the above procedure repeated until relaxation "in the dentist's chair" was achieved (three repeats were necessary).

A "stiff arm" technique was then used to show the client that "the more you try to bend it, the stiffer it will become". This was then transferred as follows: "soon the dentist will ask you to open your mouth, and you will, you know you will because you know the more you try to resist, the wider your mouth will open …… ". This suggestion was repeated several times before finally: "now

open your mouth". The client opened her mouth slowly and kept it open as her teeth were tapped gently with a pen. The session was completed with ego-strengthening suggestion, and a brief suggestion: "in the future, whenever you sit in a dentist's chair, you will relax completely . . . "An appointment was made for one week later.

The third visit did not take place until three weeks later due to the client suffering a severe bout of influenza. She had been practicing the relaxation exercises daily, however, and was now able to induce a light trance state quite readily in herself. After deepening, simulation of the dental visit combined with imagery as described above was again carried out. This time abreaction was minimal and she remained quite relaxed and co-operative while her teeth were grasped and gently tugged. The suggestion was given that in the future, while in the dentist's chair, she would visualise a spinning ball which would take her through the colours of the spectrum and so deepen her state of relaxation. She was told that she would begin to feel rather anxious until she made an appointment with the dentist, that "you will be impatient to make the appointment as soon as you arrive home today . . . and as soon as you make the appointment, you will feel completely calm and relaxed and at ease."

The earlier described "*stiff* arm" technique was then used to relate to: "no matter how hard you try to feel fear of the dentist, no matter how hard you TRY to be afraid, the calmer you will feel, the more confident, the more relaxed . . . " The usual ego-strengthening suggestions were given, and in addition a suggestion was given to ring me on the morning of the dental appointment: "as soon as you hear my voice on the telephone, you will begin to feel a sense of calmness, well being . . . of relaxation, and you will easily be able to enter a state of deep hypnosis at the count of five."

RESULTS

Three weeks later: The client rang at 8.00 a.m. to say her appointment was at 9.30 that morning. She had been quite calm until the morning, but was now very nervous. Hypnosis was induced as suggested previously (with reassurance that she would hold the phone securely and remain seated) and a brief resume of the beach scene superimposed on the events leading up to dental treatment were given, e.g. "you are now walking into the dental surgery, feeling so calm, relaxed as if on the beach . . . walking along the beach, the waves lapping to and fro . . . notice the yacht in the distance . . . you are now in the dentist's chair, leaning back, restful . . . as if sitting on the beach, your back to a tree, gazing out across the water . . . " The spinning ball idea was briefly reinforced and the suggestion given that "the closer you get to the dentist, the calmer, the more relaxed, the more confident you will feel . . . " She was then woken. The entire sequence took little more than five minutes.

Two weeks later: The client telephoned at 7.00 a.m. to inform me that her second appointment was due at 9.00 a.m. that day. She was a little tense and felt she needed a "booster". She reported that the first visit to the dentist had been "great". She'd wanted to feel scared but couldn't. While driving to the surgery, the closer she got the better she'd felt. In the chair and during treatment she'd felt marvellous; the dentist was "beaut". and had told her there was a lot of work to be done on her teeth.

Similar technique and suggestions were given as previously plus a stress on independence, feelings of security and confidence.

One month later: The client rang to report that all was going well and she had had no further worries regarding the dentist, nor any recurrence of her phobia. Not only had her own teeth been attended to, but she had taken her son to his dentist and remained with him while dental treatment was carried out.

DISCUSSION
Although this client tested poorly in the initial consultation in the area of visual imagery, this was probably due to nervousness, as in subsequent visits in a deeper trance state her imagination was more than adequate for this combined imagery/flooding technique to be effective. Without a good trance depth and/or very good imagery ability the technique cannot be as effective because one needs to work with the tension involved with the phobia in order to resolve it. The method is much quicker than that of systematic desensitisation, and in my experience more permanent. Showing the client that the feelings associated with the phobia CAN be resolved builds confidence in the ability to cope in the future.

Because it is most important that encouragement and support be at hand at the crunch, the conditioning for hypnosis via telephone on the morning of the dental appointment was implemented. Without this extra boost, fear may well have again overwhelmed the client. If she had cancelled that dental appointment, there would have been no chance to prove the post-hypnotic suggestions which would then have lapsed and (in my experience) made it a little harder for future post-hypnotic suggestion of that type to be effective.

REFERENCES:
Hartland, J. *"Medical and Dental Hypnosis"* **1971 London Baililere Tindall.**
Kappas, J.G. *"Professional Hypnotism Manual"* **1978 Calif. Panorama Publishing Co**.
Kroger, W. and Fezier, W. *"Hypnosis and Behaviour Modification: imagery conditioning"* **1976 Phil. J. B. Lippincott Co.**

CASE NOTES AND TECHNIQUES
Senoi Dreamwork
K. Wallis

Senoi dreamwork developed from the study of the culture of the Senoi-Temiar tribe. The tribe lives in the highlands of Malaya. For over three hundred years dreamwork has been a dominant aspect of personal and tribal discussions. Every morning the children of the tribe relate their dreams to the adults, who work with the children helping them to understand and integrate the components of dreams. Later the adults adjourn to a tribal meeting where the dreams of the children and their own dreams are discussed. From the discussions, personal and tribal decisions are made.

The creativity of the dream is translated by the Senoi into songs, dances and new ideas. These are seen as gifts from the "dream universe". The Senoi regard the dream universe as being as equally as valid as their awake life. Also they are aware that the "spirits" of the dream are manifestations of their own personality. They believe that to live their life fully one must experience and learn from both the dream and awake worlds.

TECHNIQUE

The group leader asks the client to go back into the dream and relate what can be seen, and what is happening in the present tense.

There are six main stages of the dream, they are: the Key; the Embellishment; the Main Figure; the Gift; and the Artefact. The final stage of the Quest is more concerned with the reinforcing the lesson of the dream in the awake world.

THE KEY

Many people have difficulty in remembering dream content; for the most part all that is recalled is a small section of the dream. This fragment, no matter how brief or vague, is the Key. This is the basic point from which to develop the re-experience of the dream. The Key is an index point from which total dream recall may begin, If this concept is accepted, then the options for recall are opened, unlike the concept of a dream "fragment" which implies that only a small part of the dream still exists. This is not so, as all the dream still exists in the subconscious.

Dreamers may recall a dream that is not the same as the original dream. One hypothesis is that the message from the original has been attended to in the person's subconscious, and that the dreamer has now modified the dream symbolism. Note that if the dreamer notices a change in the dreams recall, then recall of the original dream is automatically acknowledged.

The change in dream recall may be due to new issues becoming more important, and these messages need to be dealt with more quickly than the messages in the original dream. Losing dream recall is the repression of a message from our inner self to our conscious self. A message in a dream may be repeated in exactly the same form, thus a dream recurs. Recurring dreams indicate that a message from the dream universe is being avoided; if the message is avoided and conscious awareness does not take place then the dreamer will have no more dream recall until the "stuck" position is resolved.

"To re-establish active communication with the dream universe, the dreamer consequently returns to the last (or most important feeling) dream Key that he/she remembers. By working that dream, recall returns — very often immediately". Another way of finding the Key is to ask the dreamer what feeling was experienced when they awoke. This feeling is the Key. That there is always a Key is a basic assumption; the problem is finding it and then making use of it.

The Embellishment
Once the dreamer is in the dream recall, it is essential that active re-experiencing the events using the present tense is undertaken. It is important to remain as concrete and tangible as possible when working with the dream. If the dreamer is asked what he/she is seeing the response to the question is encouraged to be a description of the events and objects in the dream. Embellishment is important because the description and the filling of the dream setting enable the dreamer to get deeper into the experience. Therapists may encourage the dreamer by using positive double binds and regarding the report of the dream as coming from another plane of consciousness, e.g. "Take all the time you need to get in touch with your dream universe and let me know when you are there. Remember you are the master of your dream universe".

The Embellishment phase is concluded when a Main Figure emerges. This may be a person, a monster, a spectre, an object, or even an amorphous entity like a haze, a fog, or just darkness.

The Main Figure
Usually the Main Figure presents readily, however, if the figure is an amorphous state some clarification work is necessary. For instance, if the state is a fog, the dreamer is directed to proceed to the centre of the fog and speak to the "spirit of the fog". The aim is to identify and isolate a Main Figure so that conversation may occur between it and the dreamer. If the figure is unclear the dreamer may move closer to it or further away from it, what feels more comfortable to the dreamer so that he/she might see and speak with the figure successfully.

The Main Figure may fade, disappear or run away. When this happens the dreamer is asked to keep it in vision by calling on his/her power or getting the assistance of "acquaintances or even friendly strangers". The figure may assume an ugly or unfriendly form to escape assimilation. All the dreamer need do is tell the figure to take off the mask. If the figure keeps presenting an unfriendly and menacing form, the therapist directs the dreamer to get the spirit to remove masks until a form or face is arrived at that the dreamer can deal with comfortably and successfully.

The therapist uses paradoxic suggestions, e.g. "Take all the time you need to approach the spirit and let me know when this is done". By accepting the direction, the dreamer acknowledges that the task will be difficult but he/she will be successful.

The object is to approach the Main Figure and to seek its source of power so that the energy may be taken back and used for the growth of self.

The Gift
The receiving of a gift from the spirit of the dream is the proof that the self and the power centre of the dream have communicated and accepted each other. A Gift should represent the "essence of a spirit's power". In asking for a gift the dreamer is encouraged to receive something tangible and that the gift is the best gift that the dreamer could receive from that particular spirit. Check after the Gift has been obtained that it does in fact represent the power of the spirit. Once the Gift is obtained then the energy of the dream has been accepted by the dreamer and the message of the dream is answered either consciously or in the subconscious. After this stage has passed the dreamer may awake or continue to get more gifts from the spirit until it is no longer menacing or unknown.

The Artefact
This and the final stage of dreamwork is completed in the awaken state. The Artefact is the translation of the essence of the dream into a concrete entity in the physical environment, linking the dreamer's internal experiences into an external creative drive. To span the gap between the dream and the awake worlds, the dreamer is asked to sketch the Gift arid retain the drawing in a prominent place. This reinforces the therapeutic gains from the dreamwork by acknowledging the power gained from the dream and exhibits the creative potential of the self.

The Quest
The aim of the Quest is the attainment of the gift from the immediate environment. If the gift is not readily available then the individual searches for it. Again reinforcement and time structuring towards finishing off the dream and full integration of the dream message is the object of the questing process.

Uses of Senoi Dreamwork
At present research is being conducted studying the use of the technique with psychotic hallucinations and somatic symptoms coming from the conflict in dreams. During the sessions of the dreamwork, the dreamer experiences the rapid eye movements of Paradoxic sleep, thus the self induced dream gains a deep level of authenticity for the dreamer. I have noticed that dreams may be finished in a therapy session and the client will have the finished dream that night. Also it seems that as a person develops greater self esteem that the deeper and often more traumatic memories will come from the subconscious, at a time when the client has more resources to deal with the repressed facts. It is possible for clients to change and control their dreams during the actual dreaming sleep.

Perhaps the most successful application of this type of dreamwork is in controlling nightmares, especially when the subject is a child. Children enjoy the dreamwork because of its terminology and its emphasis on stimulating creative expression.

I have used the Senoi technique in conjunction with other treatment approaches in dealing with dreams and projected fantasies. The technique may sound gimmickry, as it did to me at first, but I have found the technique a potent treatment easily adapted to suit a variety of presenting problems.

REFERENCES:
Johnson, Jack and Erikson, M. *"Senoi Dreamwork"* **Unpublished paper 1975 (South California).**