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Editorial

In May of this year the 13th convention of Australian Hypnotherapists was held at Newport, Sydney. Over the next few issues of the journal a number of papers presented at the convention will be published.

This edition of the journal includes two such papers. Jeff Berger writes the first of these on the use of hypnosis and relaxation therapy in professional and life skills coaching. The paper overviews coaching, how and where it can be used, models it borrows from, its benefits and the differences between coaching and therapy. As coaching is becoming such a growth industry, Jeff has some interesting points for those wishing to extend their hypnotherapy skills and practice.

Debbi Holopainen and Gordon Emmerson, in their joint paper, review treating depression with hypnotically based ego state therapy. It discusses the use of hypnosis and ego state therapy's promise as an intervention without the time, cost or commitment to homework of cognitive-behaviour therapy.

Julie Phillips-Moore's paper, the second which was presented at the convention, outlines proposed research into the treatment of irritable bowel syndrome (IBS) with hypnotherapy, taking into account the mind-body connection and treating both the patient's physiological and emotional/psychological symptoms.

Professor Marty Sapp and Lynn Edwards write up their research on regression. Their study found that a regression hypnotic transcript produced a greater reduction in conflict responses than a relaxation hypnotic transcript, re-operationalising the concept of regression.

In a second contribution, Gordon Emmerson presents an interesting paper on the application of hypnosis and ego state therapy in couples counselling. It shows how both techniques can be applied to either improve a troubled relationship or to enhance to a new level of enjoyment in an existing one. Ego state therapy utilises hypnosis to access the different communicative parts of each person for improved awareness and problem resolution.

Finally, it is with some regret that this will be Mark Baddeley's last edition as Assistant Editor. Mark has been assisting me with the production of the journal for the past four and a half years and due to a number of other demands placed upon him, has decided to resign. I would just like to publicly thank Mark for his contribution and commitment in so many ways to the journal's life and production. I wish him well for the future.

MARTIN PEARCE
Editor

The Use of Hypnosis and Relaxation Therapy in Professional and Life Skills Coaching

JEFF BERGER
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This paper gives a brief overview of the nature of professional and life skills coaching and how and where it can be used. It examines the models the coaching concept borrows from in order to function, the nature of the coach-client relationship, the benefits of coaching for the client and the differences between coaching and therapy. In particular it discusses how the author uses hypnosis and relaxation therapy — along with the Choosing Continuum and Transitional Visualisation — as tools in the coaching process, to assist clients in positive coaching breakthroughs. Finally the benefits of coaching for the coach are discussed and the possibility of the clinical hypnotherapist adding coaching to their existing services after receiving the appropriate training.

WHAT IS PROFESSIONAL AND LIFE SKILLS COACHING?

Professional (or corporate) coaching aims to help people achieve more effectively in their work or professional environment. Life skills coaching aims to do the same at a personal level.

The aim of coaching is to improve and enhance performance and the acquisition of skills, to overcome the blockages that restrict performance in life or at work, to alter negative behaviour patterns and actions and to build confidence and self esteem.

WHERE COACHING CAN BE USED

As a psychologist I use coaching in a number of areas of my practice; in my work as a consulting psychologist within the private school system, in my

This paper was presented at the 13th National Conference of Australian Hypnotherapists, Newport Sydney, Australia 1–3 May, 2002.

corporate practice, in the Employee Assistance Programs I conduct for a number of organisations, in my role as consulting psychologist for a well-known wellness and lifestyle organisation, and in my work as consulting psychologist for a company providing psychological assessment services for various franchising organisations and in my private and community health practices.

This illustrates that coaching is a flexible modality and can be used — after appropriate training — in virtually every situation where significant work with others is required.

THE MODELS COACHING BORROWS FROM

Like most developing techniques coaching borrows from other operational models and then evolves what it has borrowed into something new. In Table 1 are some examples of areas coaching draws on and develops as reported by (Skiffington & Zeus, 1998, p. 19).

WHAT IS A PERSONAL COACH?

A personal coach is there for the client, is on the clients side, is open to what the client thinks the client wants or needs, wants what is best for the client, will be there for the client when life gets tough, will support the client all the way. A personal coach works with the client to achieve their goals and dreams. (Skiffington & Zeus, 1998)

WHAT CAN A PERSONAL COACH DO FOR A CLIENT?

Talk with the client about anything the client chooses in any area of the client's life, and keep it confidential. Really listen to the client about the client's work and life, their dreams, hopes, and goals. Respect the client's view of their pain, obstacles, and frustrations. Believe what the client says about him or her self, be honest with the client and always tell them the truth. Hold the client accountable for goals they set for themselves. Share ideas, wisdom, tips, experience, advice, and make practical suggestions. Only the client can make their dreams come true, but the coach is there to assist and mentor the client all the way. The aim of coaching is for the client to "seek and achieve success and satisfaction in their career and work life, balanced with harmony and joy in their relationships and personal life" (Skiffington & Zeus, 1998, p.14).

A further aim is to teach clients to dream. Like a championship athletic coach a personal coach teaches, trains, and guides the client to polish their

Table 1

Coaching Areas

Models Borrowed from	Coaching
Deficiency	Identifies skill deficits in the target population in terms of interpersonal communication, problem-solving, knowledge of resources and self-concept formation Focuses on the positive aspect of skill-building, the development of the creation of an increasing array of behavioural choices
Competency	Emphasises the performance of specific behavioural skills Provides a way of increasing the repertoire of skills available for use in a variety of situations
Information	Focuses on facts relevant to learners' life experiences, needs and interests taken into account in designing the content of the course Encourages learner tasks involving obtaining and collecting relevant information as an integral part of Life Skills process
Socialisation	Centres on activities for exploring values and attitudes congruent with societal norms Highlights observation, imitation and modelling as strategies for learning
Experiential	Accents an enquiry orientation that taps the experience of the learners and involves them in analysing their experience Emphasises action-learning techniques that use behaviour-modelling: imitation of effective behaviour; guided practice in the performance of new behaviour; recognition for learners' demonstration and application of new behaviour
Reflective	Focuses on training in reflection on each Life Skills experience, in order to develop interpersonal and intrapersonal insight Encourages the use of the written log to develop learners' recognition and recording or learning and feelings Provides opportunity to develop critical thinking skills through constructive criticism
Counselling	Attends to the affective domain Responds to need to express feeling reactions to the content of Life Skills lessons Gives opportunities for individuals to react and respond to their experiences

work and strengthen their personal and professional life. The personal coach cares about the client/ coach relationship, and journeys with the client as they become more and more extraordinary and accomplish more than they ever thought possible as they start to make their dreams a reality.

WHAT A COACH WON'T DO?

Take responsibility for what the client does or does not do for themselves. Impose values or make choices or decisions for the client. Try to manage how the client chooses to feel, about anything. Have dual relationships with the client (financial, romantic, legal, etc.) Put the client down or tell the client they are wrong in a negative way.

So then, in their work coaches are:

Professional. In that they are committed to the best interests of the client. The coach stands for the client as a person, without any conflict of interest or hidden agenda of what the client should be or do. Professional coaches remain objective and seek to elicit from clients their own understanding of the situation. The coach listens long and hard while exploring with the client his or her values, beliefs, and dreams; listening also for strengths and needs. Then they can both work from the client's position of strength.

Interdevelopmental. Counselling and traditional spiritual direction are usually one-way relationships in which one person gives and one person receives. Coaching is based on the belief that in every relationship both people can grow and learn. Coaches learn from every client, and find enjoyment in the synergy that develops, while also rejoicing in the growth and achievements of the client. The coach withholds nothing. Coaches make available to each client all of their education, training, experience, insight, tips, resources, and hard earned wisdom, and willingly share new insights, understanding, and language as they continue to learn and grow themselves.

Relational. Coaches are often available for short term strategising (perhaps three months). However, a coaching relationship can last as long as it is agreeable to both participants. Over time, trust grows and a mutual history emerges that provides a foundation for further growth. It is a relationship based on honesty and commitment. There is a level of sharing rarely found today, yet it stays on a professional basis. Unlike a friend, a coach never withholds an insight for fear of jeopardising the friendship. The coach always operates out of a reserve of income, time, energy, and personal support so that he or she can afford to share everything. More than friendship, there is a mutual

creativity and synergy that can lead to dramatic increases in personal and career stimulation, progress and enjoyment.

COACHING IS NOT THERAPY

This is an important point and needs to be made often, as the boundaries can often become blurred. The following statement may be helpful:

> *Coaching is about achievement; therapy is about healing. Coaching is about action; therapy is about understanding. Coaching is about transformation; therapy is about change. Coaching is about momentum; therapy is about safety. Coaching is about intuition; therapy is about feelings. Coaching is about joy; therapy is about happiness. Coaching is about performance; therapy is about progress. Coaching is about synchronicity; therapy is about timing. Coaching is about attraction; therapy is about protecting. Coaching is about creating; therapy is about resolving (Skiffington & Zeus, 1998, p.15).*

ESTABLISHING WHERE CLIENTS "ARE" IN THEIR LIVES

Most people want rewarding work, satisfying relationships, financial freedom, a life that honours their values, and more free time for fun and joy. A way of establishing where clients are with their lives is by using the "Choosing Continuum", the creation of US based therapist Ann Kramer and part of her innovative *Life Puzzle* program.

For Kramer (1998) The Choosing Continuum represents a way of assessing where a person is in their "life puzzle" — another way of saying where are they in realising their full human potential — as opposed to where they should be.

The continuum is represented by a scale ranging from 0–10, with 5 being the status quo. The status quo is simply doing enough to get by in life. So basically it is "Get up, do the day, go to bed, do it again tomorrow" The 0–4 end of the scale represents the reactive, passive, negative, victim centered personality, who will only act in life when it is absolutely essential to do so. Often they are totally aware of their life puzzle, and therefore of their potential. The 6–10 part of the scale describes people who are proactive, take responsibility for their lives and their actions, and who are positive and empowered in all they say, think and do (Kramer, 1998). The aim of coaching is to move clients from the 0–5 to the 6–10 side of the scale, or even to move closer to 10 than they currently are!

The position on the continuum is ascertained by asking a series of questions which can be modified according to the clients presenting coaching issues. In broad terms these questions centre on such things as self responsibility,

nutrition, exercise and physical care, work and professional life, feelings, thinking, relationships, parenting and family, communication, sexuality, financial responsibility, spirituality, play, special challenges, community and environment and finding meaning (Kramer, 1998, pp. 22–30). For Kramer, these are the components of the life puzzle, those things we need to achieve balance in, in order to move to the positive side of the choosing continuum.

While this appears a simple process and it is, the results when used in the coaching context are often quite profound. A number of my clients have made significant changes in their personal and professional lives as a result of engaging with me in the Choosing Continuum process. The other interesting — and surprising — thing that emerges is that some clients who to all appearances are at the top end of the continuum are really functioning at level 5 or lower! This realisation in itself is often enough for people to commit more wholeheartedly to the coaching process than may otherwise have been the case.

HYPNOSIS AND RELAXATION THERAPY IN THE COACHING PROCESS — TRANSITIONAL VISUALISATION

Having established a clients place on the choosing continuum it is then possible to begin to develop coaching strategies to encourage upward movement. From time to time this will include hypnosis and the use of another simple yet effective process I have developed over time called Transitional Visualisation (TV). The aim here is to get clients to look realistically and rationally at their situation in life. So, for example, if they are functioning at the 3–4 level on the Choosing Continuum, they need to realistically acknowledge this fact in order to be able to move on. This acknowledgement is necessary for coaching to be effective. Clients however often tend to overstate the negative or positive elements of their situation in life or the professional or personal issues confronting them, depending on their perspective. So a client who has some

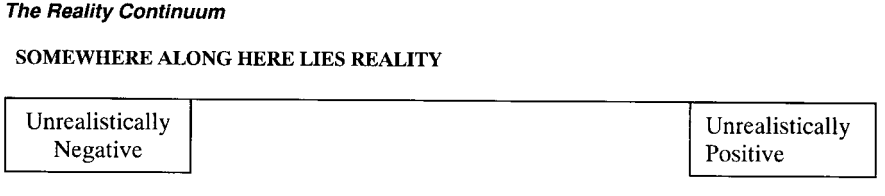

Figure 1
Transititional visualisation.

interesting possibilities for movement may refuse to acknowledge them; or another who really has limited options will act as if the world is his or her oyster! Transititional Visualisation seeks to replace these misperceptions with reality and anchor the client there. A simple diagram will assist (see Figure 1).

So the aim of Transitional Visualisation is to get the client to visualise the true reality of their situation and accept it; and then to develop the motivation to move from it to something better. In other words to initiate a process of transition. A series of questions is asked, based on those used in the Choosing Continuum, in order to facilitate the reality check and begin the transition. Hypnosis is extremely helpful in the Transitional Visualisation process for those clients who are willing to use it. There is no doubt that the suspension of the critical faculty allows clients to be more honest with themselves and in their assessments of their situation; and to more earnestly desire to do something about it. While I have not formally researched the issue, I believe that the improvement process is significantly enhanced using hypnosis for coaching, and the time needed for progress significantly reduced.

COACHING FOR THE COACH.

Finally, professional and life skills' coaching is rewarding, fulfilling and lucrative. Good coaches can and do earn up to $300.00 an hour or up to $3000 a day (but what an individual coach charges is totally up to the coach). However the rewards are not only financial. It is the sense of achievement that is felt when a client commits to the coaching program and significant achievements happen in their lives and that is the real reward. Relaxation therapy and hypnosis are important ancillary skills in the suitably trained coach's bag of tricks. To the best of my knowledge there are few, if any, coaches using hypnosis or relaxation therapy in coaching. Further, clinical hypnotherapists can also train as coaches and so add value to the services they provide. Good therapists can be good coaches. Most already have the right personality, temperament and skills. All that is required is the appropriate training and that is becoming more readily available from a number of sources. For anyone looking to expand their practice and the range of services they offer, coaching is a satisfying and rewarding possibility.

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Ego State Therapy and the Treatment of Depression

DEBBI HOLOPAINEN AND GORDON J. EMMERSON
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This paper reviews treating depression with the hypnotically based ego-state therapy. Depression is a common, costly (both personally and socially) disorder, and often does not respond well to traditional psychological or pharmacological treatment. Ego-state therapy is able to "provide significant psychological help to more people with modest expenditures of time and cost" in comparison to more traditional forms of psychotherapy (Watkins, & Watkins, 1993, p.9). Ego state therapy shows clinical promise as an intervention for depression (Emmerson & Farmer, 1996), and it does not require the time, cost, or commitment to homework of Cognitive Behavioural Therapy. An ego state intervention for depression (Emmerson, 2002) is introduced, and a case example is presented.

EGO STATE THERAPY AND THE TREATMENT OF DEPRESSION

Major depressive episodes are experienced by 10 to 20% of the population at some point in their lifetime (Robinson, Berman & Neimeyer, 1990). Depression has previously been referred to as 'melancholia' or 'hysteria' (Becker, 1985). The word 'depression' is used diversely in popular and professional literature to refer to a mood, a symptom, a syndrome and a disease. It covers a broad range of moods and behaviours, linked with the sadness of normal life to the despair associated with suicide. The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; APA, 1994) describes depressed mood affect as occurring independently, or as a part of a number of disorders.

Generally, a depressive syndrome is characterised by a cluster of symptoms that include disturbances in appetite, sleep and psychomotor activity; lack of energy/physical exhaustion; loss of interest; lowered libido; concentration difficulties; feelings of guilt, shame and sadness; and suicidal ideation (Kaelber, Moul & Farmer, 1995). As a symptom, depression is an 'abnormal mood' where the borderline between the normal and the pathological is indistinct (Scott, 1988). Symptoms associated with depression are normal so long as they are not extreme, intense and prolonged. Thus "clinical depression is distinguished from normal

reactions of grief and sadness in terms of its severity, duration or persistence, and effects on the individual's day to day functioning" (Affonso, 1984, p.150).

The Experience of Depression

Depression is a chemical imbalance that affects mood and emotions, over which the person has no control. The cause or trigger often remains unknown but the psychic pain of deep depression is real. Bernhardt (1998) likens it to having a root canal without anaesthetic as the pain builds, always present and without ending. The depressed person seeks negative feedback by remembering and rationalising the negative and discounting the positive. They can feel their pain is unique and can feel that they are all alone, even in the midst of a supportive and loving family. Depression can affect the person with distortions of self-image and self-worth profoundly, to the point that death seems the only escape. Often, the need for relief can be so overwhelming that some people use physical pain such as self-mutilation, mind numbing obsessive compulsiveness, over eating and substance abuse to gain some respite from the psychic pain (Bernhardt, 1998).

Treating Depression

Depression has been treated with many methods that include 'trephining' (holes were drilled in the skull to release the spirit thought to cause the depression), exorcising devils with prayer and ritual, alienation from the community and incarceration in a mental asylum (Read, 1993). Since the 1950s, theory and management of depressive illness has virtually been revolutionised with the introduction of psychopharmacology. Presently, depression treatments are dominated by medication, traditional insight-orientated therapy, or a combination of the two (Robinson, Berman, & Neimeyer, 1990). Although electro convulsive therapy remains a controversial option (Oltmanns & Emery, 1995), it has secured a place in the treatment of severe and acute mood disorders such as life-threatening forms of depression.

Research into the efficacy of various interventions for depression is inconclusive and fails to identify a specific treatment modality that is most effective in treating depression. The results of efficacy testing of cognitive-behavioural therapy (CBT), interpersonal psychotherapy (IP), drug plus clinical management (DCM) and placebo plus clinical management (PCM) in the treatment of depression have resulted in inconsistent findings. In some cases, no significant differences were found between the modalities (Elkin et al., 1989; Watkins et al., 1993); other results found CBT to be less effective than pharmacotherapy (Elkin et al., 1995); DCM was found to be more efficacious than CBT, and subsequent research has shown CBT to be more effective than behaviour therapy (Hollon, Shelton, &

Davis, 1993) and superior to interpersonal therapy at three months and one year follow ups (Shapiro, Rees, Barkham, & Hardy, 1995). In many of these cases (Elkin et al., 1989, 1995; Hollon et al., 1993), regardless of the treatment modality used, the quality of the alliance in the therapeutic relationship was found to be the "best overall predictor of therapy outcome" (Horvath, 2001, p.173).

Ego State Therapy

Ego State Therapy is relatively new therapy introduced in the mid-1970s by John Watkins, based on Federn (1952) and Weiss's (1960) concepts of segmentation of personality (Watkins & Watkins, 1993). Ego state therapy is "the use of individual, group, and family therapy techniques for the resolution of conflicts between the various ego states that constitute a family of self" (Watkins & Watkins, 1997, p.96). Many ego states have conflict between them created by anxiety, depression, or many other neurotic or somatic symptoms and maladaptive behaviours (Watkins, 1993). An example of conflicting ego states is evidenced by the statements, "Sometimes I hate myself," or "I don't like myself when I am like that." However, because these conflicting ego states do not present spontaneously and openly, they must be activated through hypnosis, a process utilised in 'ego state therapy.'

Watkins and Watkins (1993) promote hypnosis in ego state therapy as a flexible modality where direct interventions such as suggestion are used to potential; transferences are activated more quickly, time lines are crossed, the relationship of the therapist-client is intensified, experiential time is increased and treatment procedures are focused more specifically.

Ego States

When a person is undecided about something, for example, whether or not he or she should buy an expensive item, there may be an internal disagreement, where one voice may argue that it deserves to be spoiled so the item should be bought. However, another more frugal voice may argue that the item is too expensive or that the money would be better spent elsewhere. These voices are just two parts of the personality that make up the person (the family of self). These parts are called 'ego states' and Emmerson (1999) defines an ego state as "one of a group of similar states, each distinguished by a particular role, mood and mental function, which when conscious assumes first person identity" (p.13). When the person is angry the feeling may be, "I really don't like that person. He makes me so mad." The first person identity assumes the emotion. Later, in a different ego state the person may say, "He is one of my best friends. I don't know how I could ever say I did not like him."

An ego state is formed through the repeated use of some coping skill, or through the single experience of a trauma, establishing a key neural pathway that becomes part of the personality. The following describes ego state formation by use of metaphor:

> *Imagine the young brain as smooth, loose soil on a gentle slope. It has no channels for water to run. A number of small rains combined, or a single major rainstorm, will make channels that become permanent in this soil. The channelled hillside will naturally direct any water that falls near a channel into it. As the small child repeatedly uses a working coping mechanism a neural pathway is established in the brain and events that are reminders of that coping mechanism will be channelled down that pathway to the associated ego state. A trauma can be seen as the major rainstorm that can create a channel in a single incident. Reminders of that trauma will bring to consciousness (the executive) the associated ego state. (Emmerson, 2002, p. 17)*

Treating Depression with Ego State Therapy

Few empirical studies have to date been conducted into the clinical efficacy of ego state therapy. Watkins and Watkins (1997) outline the results of questionnaires given out to previous clients of ego state therapy to evaluate validity, effectiveness and efficiency, especially as compared to other therapies experienced by these clients. The results strongly suggest that clients regarded ego state therapy to be more effective and efficient than their previous therapies. Emmerson and Farmer (1996) investigated the effect of ego state therapy on 10 women suffering from 'menstrual migraine.' Women were administered the MMPI-2 and the Beck Depression Inventory (BDI) both pre and post treatment. The women were treated with four sessions of ego state therapy, and significant positive changes were reported on the BDI and on 'depression, anger and extroversion' on the MMPI-2. These findings are suggestive of the therapeutic potential of treating depression with ego state therapy.

Bernhardt (1998) contends that the reason depression is so widespread and difficult to cure is due to the cause it is not evident from observing the depressed person. Even the depressed person who is experiencing the symptoms and mood change is often unaware of the cause. Bernhardt claims that this is because the conscious mind and the biological unconscious mind do not communicate directly. Thus, the conscious mind can only assume the cause. This account makes sense in light of the explanation given from an ego state therapy prospective on the aetiology of depression. Emmerson (2002) claims that depression arises from covert (hidden or unconscious) ego states that feel misunderstood, hopeless and isolated, and often do not communicate well with each other. These states have energy they will not use, hording it due to negative feelings such as unconscious fears (Newey, 1986). An ego state that has controlled a sig-

nificant portion of energy with the main goal of becoming successful in business may hoard that energy when the client has financial bankruptcy.

Newey (1986) contends that hidden fears are a central problem in all depression because they disturb and inhibit behaviour and thus, creating blockages in the capacity to actively strengthen positive self-regard and gain a sufficient sense of satisfaction from life. These fears need to be located and removed but as they are largely unconscious (covert), they are often difficult to access, and this is the main reason why most therapies are time consuming and inefficient. According to Newey (1986), these fears are a component of low self-esteem evident in depression.

Ego state therapy uses hypnosis to increase internal focus and awareness so that residual trauma and fears can be more easily identified and resolved. Internal communication between ego states then improves and allows the person to feel more integrated, positive and more self-accepting (Emmerson, 2002). The goals of ego state therapy when working with a client suffering from depression, as outlined by Emmerson (2002) are to firstly locate the ego states that are hanging on to energy, rather than releasing it to states that are wanting and ready to use it. (An example of this is the flirty state of a person who feels they are no longer appealing. This state may feel, 'poor me' and hoard the energy it has controlled in the past.) The second step is to locate states that would like to have the energy, that are ready to use it. (An example is a state that would like to write poetry, or do volunteer work.) The third step is to facilitate negotiation between the states so the state that is hoarding the energy will release the energy to the state that wants to use it. Using hypnosis, this negotiation process is often not difficult.

Example of an Ego State Therapy Session to Treat Depression

Ego state therapy facilitates the identification of the ego states that are holding on to energy and helps to resolve the original trauma that created the fears. Treatment starts with assessment of reported or observed overt behaviour, uses hypnosis to explore and intervene at the unconscious level, and then returns to the conscious level to note results (Newey, 1986). This approach is an ongoing process used throughout therapy where buried fears are identified and removed systematically. There are many components in the intervention of depression as outlined by Emmerson (2002, p.130):

1. Interview the client to discover the exact symptoms of the problem.
2. Introduce ego state theory.
3. Introduce hypnosis.

4. Ask if there are any questions about ego state theory, therapy, and hypnosis.
5. Use a hypnotic induction.
6. Near the end of the induction have the client focus on the symptomatic feelings of the depression.
7. Enhance the negative feelings until significant affect is demonstrated.
8. Restate the feelings and ask the client to give a name to the state they are experiencing with those feelings.
9. Talk with the state to determine if a resolution can be made that will allow it to use the energy it has previously used. If so, work with the state to again interact with the outside world using the energy, and if not, continue below.
10. Ask to speak with a state that would like to have more energy, to do things it has always wanted to do.
11. Talk with the state that wants more energy and make sure it will use it with the outside world if the energy is forthcoming.
12. Negotiate between the states for the state that has been hoarding the energy to allow the other state to have more energy.
13. Express gratitude, by name, to all the states that have spoken.
14. Ask client to imagine being in a situation where the depressed affect would normally be experienced.
15. Check affect, to make sure the unwanted symptoms are not present.
16. If the unwanted symptoms are present go to 7 above and proceed.
17. Make sure no state is left with needs that cannot wait until the next session.
18. If the unwanted symptoms are not present, bring the client out of hypnosis.
19. Facilitate expression concerning the client's experience of the session.
20. End the session.

Example of a Ego State Therapy Session for Treating Depression

The following is an example (Emmerson, 2002) of a work with a depressed client using ego state therapy. The client, John, has exhibited the symptoms of depression starting with the severe facial scaring from a burn accident. (This example is provided from a compilation of work with various clients.) The example starts with step 6 above.

Therapist: I want you to imagine being at home on your couch, where you have told me you often feel very depressed. It is just has you have described it when you feel depressed. You have tried to watch TV but there is nothing that interests you and there is nothing you can think to do. You can feel the texture of the couch as you sit there, experiencing that feeling. Tell me exactly what that feels like in your body.

Client: I don't know. I just don't want to do anything. I don't even want to get up.

Therapist: What do you feel like physically?

Client: It's like my head has walls around it and it is uncomfortable inside.

Therapist: Have the courage to really go into and experience that discomfort inside those walls. What can you tell me?

Client: It's too much.

Therapist: What is too much. What is wrong?

Client: I can't let anyone see me. I can't go out. My life is ruined!

Therapist: What can I call that part of you talking with me now, that feels your life is ruined?

Client: Scared.

Therapist: Thank you for talking with me, 'Scared.' I realise you do not feel very good and I appreciate your talking with me. 'Scared,' what did you like to do before the accident?

Client: Go out with my friends and have a good time.

Therapist: And now you don't feel you can do that?

Client: No. They don't want me to slow them down.

Therapist: That must feel bad, feeling rejected like that?

Client: Yes, but there is nothing I can do about it. My life is over.

Therapist: 'Scared,' there are two things I would like to help with. I want to help you feel better and I want to make sure that the energy you have gets up to a really good use. Would you like that to happen?

Client: I don't know. I guess.

Therapist: Thank you. I want to now talk with a different state, at state that has things it would like to do, a state that would like more time and energy. Just say I'm here when you are ready to speak?

Client: I'm here.

Therapist: What can I call you?

Client: You can call me helper?

Therapist: Thanks for talking with me, 'Helper.' What would you like to do with more time and energy?

Client: There were a lot of kids in the burn unit. I would like to help then get through their hospital stay.

Therapist: If 'Scared' will release some of his energy to you will you make good use of it?

Client: Yes. I really think I could make a difference. I just have not been able to make myself move.

Therapist: Let's ask 'Scared' and see what he says. 'Scared,' have you heard what 'Helper' has said? He would really like to have some more energy.

Client: I heard.

Therapist: Would you be willing to give helper some of the energy you are not using so he can help the kids at the burn unit? It sounds like a really good thing to do.

Client: Sure, I'm not using it.

Therapist: Thanks 'Scared.' I want you and helper to talk together, internally now. I don't need to hear, and see if you can work out a deal and exchange some energy.

Client: Pause: Yeah, we have it worked out. Helper is taking some of my energy.

Therapist: Thank you 'Scared,' that is a great thing you have done, and I also want to thank 'Helper'. I'm sure you will make really good use of the time and energy? Now, 'Scared,' how do you feel? What do you need, right now?

Client: I feel tired and lonely.

Therapist: I want to speak with a nurturing part of John, a part that might like to make others feel better, a part that would like to come to 'Scared' and help him to feel better. Just say, I'm here when you are ready to speak.

Client: I'm here.

Therapist: What can I call you?

Client: You can call me John.

Therapist: OK. Thanks, 'John.' Would you like to go to 'Scared' and put your arm around him and let him know that you will be there for him so he will never have to feel lonely?

Client: Yes.

Therapist: Good. Go ahead and do that now. Pause: What is happening?

Client: I have my arm around him.

Therapist: That's great! 'Scared,' can you feel that?

Client: Yes.

Therapist: How does that feel?

Client: Really good.

Therapist: Ask John if he will always be there for you. Pause: What did he say?

Client: He said he will be.

Therapist: How do you feel now?

Client: Much better.

Therapist: Is it all right with you to continue to allow 'Helper' to put the energy to good use, and for you to continue to have the help of John?

Client: Yes.

Therapist: Thank you. Do you still want to be called 'Scared,' or do you want to be called something else? (Often the state chooses a new name, but it is not problematic if it wants to continue to be called by the original name.)

Client: I want to be called Loved.

Therapist: That sounds great. Is there any state that has a need to say anything about what we have done? Pause: I want to thank 'Helper' for accepting and using the new time and energy, and I also want to thank 'John' and 'Loved' for the arrangement they have worked out.

The therapist would then continue with step 14 above. The example provided is a guide and will vary with every client. Clients are all extremely individual, although this example is generally typical of work with a depressed client. Once a resolution has been achieved in this way rapid improvement in the depression is most often evidenced.

CONCLUSION

Ego state therapy is a relatively new therapy that has evolved since the 1970s. Ego state theory embraces the assumption that personality is comprised of a group of separate states each its own individual identity, memory and traits. These ego states together define the individual's personality structure. Ego states arise according to need and they remain active or available to varying degrees. Ego state theory holds that depression results from unresolved trauma or unconscious emotions that produce states that hang on to energy, causing blockages and interrupt normal functioning.

Depression is a major problem affecting up to 20% of the population. It covers a broad range of moods and behaviour, and it is can be manifested in a range from a continued sadness to the despair associated with acts of suicide.

Research has not clearly identified a treatment modality that is most efficacious in treating depression, but to date, no research has tested the therapeutic techniques of ego state therapy. Ego state therapy shows promise in treating depression, as it is a fast and powerful treatment that provides "a causal solution, not a coping strategy" (Emmerson, 2002, p. 257). Unlike other therapies, it provides direct access to the problem by using hypnosis to identify and access the ego states involved that carry trauma, pain, fear, frustration, misunderstanding or anger. Ego state therapy then facilitates communication between ego states to allow them to feel relieved, empowered and appreciated.

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Psychoneuroimmunological Background to a Controlled Trial of Hypnotherapy as a Treatment for Irritable Bowel Syndrome

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Nineteenth century philosophy and anatomy regarded the nervous system as the only pathway of communication between the brain and body. Research has now shown that the communication between the nervous and immune systems is *bi-directional* and that the immune system, the autonomic nervous system, the endocrine system and the neuropeptide systems all communicate with each other by means of chemicals called messenger molecules or ligands. This paper outlines proposed research into the treatment of Irritable Bowel Syndrome (IBS) with hypnotherapy, taking into account the mind-body connection and treating both the patient's physiological and emotional/psychological symptoms. In other words, using a more holistic approach to the treatment of IBS.

PSYCHONEUROIMMUNOLOGY

Psychoneuroimmunology (PNI) is a fascinating, relatively new area of research and is best described as a scientific investigation of how the mind (or mental states) affects the immune system and how the immune system can be affected by behaviour. According to Goleman and Gurin (1995), scientific evidence for the mind's influence on the body now comes from three diverging areas of research:

- *physiological research,* which investigates the biological and biochemical connections between the brain and the body's systems;
- *epidemiological research,* which shows correlations between certain psychological factors and certain illnesses in the population at large; and
- *clinical research,* which tests the effectiveness of mind-body approaches in preventing, alleviating, or treating specific diseases.

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The area that interested me most was clinical research because, rather than focusing on the *cause* of disease, most clinical research focuses on the more positive aspect of testing the effectiveness of mind-body approaches on illnesses.

Interest in PNI has grown because research from studies on brain-immune system interactions and clinical results from both health professionals and researchers have substantiated not only the psychological effects on health and disease but also the effect of diseases on the psyche. As Achterberg so aptly states:

> *There is little argument about the negative power of the imagination on health … Since nature creates few one-way passages, if we can become ill through our misbehaviours, even die from hexes and broken hearts, then we must also be able to make ourselves well. (Achterberg, 1985).*

The evidence for a link between the mind, the emotions, and the body has accelerated remarkably in the past few years yet the field is not without controversy. The concept that emotions can influence body processes and affect health is not new and also the attitude, held by many in the medical profession, that this notion is folklore has not always prevailed.

A HISTORY OF THE MIND-BODY CONNECTION

More than 4,000 years ago, Chinese physicians were aware of the fact that periods of emotional upset were often followed by physical illness and Egyptian physicians of the same period noted that by having an optimistic attitude, one could avoid poor health. Hippocrates taught his students to consider their patients' life circumstances and emotions as part of the treatment. Aristotle believed that the soul was inseparable from the body and that all bodily systems worked together to serve the whole organism. This concept of a mind-body connection is also seen in the writings of the 2nd century Greek physician, Galen, who noted that melancholic women were more prone to malignancies of the breast than cheerful women.

During the Middle Ages, there was no serious practice of medicine in most of the Western world except for that carried out by members of religious orders or folk medicine which was mainly practised by women and which included the use of imagination.

In the 17th century, however, the holistic ancient medical beliefs — or mind-body connections — were discarded because of changes in the philosophy and technology of medicine — the most powerful influences of this period being Francis Bacon (who asserted that science should be used to gain mastery over nature) and the French philosopher-scientist, Rene Descartes. Descarte's view (which came to be known as the *reductionist method*) was that there were

two separate substances in the world — *matter* (which behaved according to physical laws) and *spirit*: the body was matter, and the mind, spiritual. This split between the body and the spirit (or mind) came to dominate not only medical philosophy but religious philosophy as well.

Another theory, the *theory of specific aetiology*, came into being in France around the same time. This theory was strongly supported by research carried out by Robert Koch, whose experiments showed that only anthrax germs caused anthrax and no other disease and so he theorised that germs were the specific cause of every disease. Interestingly, Rudolf Virchow (a respected medical authority of the time), although agreeing that germs played a role in disease, disagreed with the simplicity of Koch's theory, arguing that there were other factors involved in disease such as heredity, pre-existing health, nutrition, environmental factors, stress, and the person's psychological state. His views, unfortunately, went unheeded and evidence for the theory that pathogens alone caused disease continued to grow (Graham, 1995; Hafen et al., 1996; Locke, 1986).

However, even though this biomedical approach had been dominant for this period of medical history (and still is to a great extent, to this day), other forces were at work which would once again arouse interest in the mind and its influence on the body. At around the same time as the theory of specific aetiology was evolving out of the research of Pasteur and Koch, Sir William Osler, a Canadian physician who practised in Britain is quoted as saying: *"It is much more important to know what sort of patient has the disease than what sort of disease the patient has"* (Dreher, 1995, p. 17) and the French physiologist, Claude Bernard, talked of the *milieu interieur* or balance of the body which, when disturbed, resulted in sickness or death. Bernard believed that a person did not have a disease because germs managed to gain access to the body, but instead, that the person became ill because the germs had found a hospitable home in a weakened terrain. During the 1930s and 1940s, another physiologist, Walter Cannon, built on Bernard's concept and coined the term *homoeostasis* to describe the body's self-maintenance of health — the built-in mechanism that helps sustain a vital balance. Cannon also showed how stress can alter bodily functions via the nervous system and coined the term "fight or flight" response to explain the reaction of the sympathetic nervous system to threatening situations.

Sigmund Freud also brought the mind-body connection back to the fore with his concept of conversion neurosis, which he believed to be a result of repressed emotions resulting in physical problems. This concept was elaborated on in the 1940s by his student Franz Alexander, a Chicago psychiatrist whose ideas were to evolve into the discipline of psychosomatic medicine. Alexander believed that "many chronic disturbances are not caused by external, mechanical, chemical factors or by micro-organisms, but by the continuous functional stress arising

during the everyday life of the organism in its struggle for existence" (Dreher, 1995, p. 36). Others such as Jung and Adler took up, and added to, this particular concept of a mind-body connection which was to become known as the theory of psychoanalysis.

Hans Selye followed on Walter Cannon's concept of "fight or flight" with more investigations on the physical effects of psychological stress and how it is tranduced into psychosomatic problems by the hormones of the hypothalamic-pituitary-adrenal axis of the endocrine system.

It appears then that the reductionist method which began with Rene Descartes, and the theory of specific aetiology which resulted from the research of Pasteur and Koch, were beginning to lose ground as more research started to come up with evidence suggesting (as the ancient medical practitioners and philosophers had stated thousands of years before) that there was indeed some connection between the mind and the body.

Researchers such as Bernard, Cannon and Selye had come up with *physiological* evidence for this connection and Freud and his followers had demonstrated a *psychological* connection. However, there was still a missing link and that missing link was the *immune system*. No-one as yet sufficiently understood the workings of the immune system enough (nor had the scientific instruments) to prove how the fight and flight response, stress, or emotions could have reactions at a cellular level.

THE IMMUNE SYSTEM

According to Ader (1991), the first sustained programme of research in this area was on the classical conditioning of immune responses carried out by Russian researchers Metal'nikoff and Chorine, who were working at the Pasteur Institute in the 1920s. Over time, scientists made other discoveries about the immune system. They learnt that immune cells could attack microbes with the same efficiency in a test tube as in the body (giving rise to the belief that the immune system functioned independently), that the immune system could distinguish between cells belonging to its own body and those which were foreign, and that it had a biochemical memory that helped it recognise and destroy foreign cells. But it wasn't until the late 1950s that finer details about the immune system were discovered. Research by a British biochemist, Rodney Porter and American immunologist, Gerald Edelman resulted in the finding of the precise molecular structure of an antibody and in 1957 Aaron Frederick Rasmussen, a microbiologist, and Norman Brill, a behavioural scientist, and an associate J.T. Marsh carried out various animal studies which demonstrated the pathogenic effect of emotional stress (Locke, 1986; Ader, 1991).

George Solomon, a Stanford psychiatrist, is considered the first to seriously consider the influence of mental states and traits on the immune system and began research on the mind-body connection in the 1960s in collaboration with his colleague Rudolf Moos. They were particularly interested in rheumatoid arthritis and the apparent association between environmental factors and psychological factors (such as emotional states) with the onset or exacerbation of the disease. Their research involved critical observations of the life histories and personality characteristics of the patients. Solomon became convinced that a connection between the brain and the immune system existed and, if this were so, it would conflict with the long-standing belief that the immune system network functioned independently of any other body system. Because his stress experiments indicated a link between the mind and the immune system, Solomon suggested the new science be called *psychoimmunology*.

Even though the results of his research were published in reputable scientific journals, few in mainstream medicine took notice and Solomon withdrew from the field after about ten years' work. However, when more evidence began to appear to support his claims, he returned to his area of research and was active up until his death last year (Locke, 1986; Ader, 1991; Dreher, 1995).

Other evidence showing the effects of the mind on the body began accumulating in the 1960s. Psychologist Neal Miller, while working at the Rockefeller University in New York, conducted a series of trials where he used conditioned learning techniques to try and direct functions that were considered involuntary. He managed to train rats to relax or contract specific muscles of their intestines and even control the flow of blood to one or both ears (Locke, 1986). Lawrence LeShan suggested that mental states could have definite, physical repercussions on other diseases and, after interviews with a vast number of cancer patients, came to the conclusion that there was a "cancer personality." Also at this time Herbert Benson, a cardiologist at Harvard Medical School was carrying out research on the relationship between stress and hypertension and reasoned that if stress could turn on hypertension, some other factor might be able to turn it off. Later, in the 1970s, he studied practitioners of Transcendental Meditation and found that during meditation some were able to bring about physiological changes, such as lowering breathing rate, pulse and blood pressure, at will.

In 1969, radiation oncologist, Carl Simonton and Stephanie Matthews-Simonton (whose background was in motivational counselling), began looking at the possibilities of the influence of the mind to induce and enhance the "will to live" in cancer patients. They explored a number of psychological techniques and claimed to have achieved quite dramatic results through the use of visual imagery techniques which, to them, indicated that patients had a much larger influence over the course of their disease than they were given credit for. These findings

were considered to be anecdotal evidence and were not published in mainstream journals (Simonton, Matthews-Simonton & Creighton, 1978; Kidman, 1983).

However, even though experiments and research were suggesting there was a link between the mind and the body, the way to control or direct this influence had not as yet been discovered. A serendipitous observation on mortality in a conditioning study being carried out by Robert Ader in 1974 finally resulted in the hypothesis that classical conditioning could modify the immune system.

Ader and his colleague, Nicholas Cohen, had been conducting standard Pavlovian conditioning experiments with rats, instilling in the animals an aversion to saccharin-flavoured water by injecting them with cyclophosphamide after they had drunk the water. As was expected, the rats continued to experience the nausea caused by this drug even when the sweetened water alone was given to them. It was only after many of the animals had died during the experimental process, that Ader and Cohen realised that as well as causing nausea, cyclophosphamide was also a powerful immunosuppressant and that they had inadvertently taught the rats to suppress their immune system whenever they drank the sweetened water (Locke, 1986; Ader, 1991). Ader and Cohen then designed a study to directly examine this discovery. According to Ader, this study demonstrated that "like other physiological processes the immune system was subject to classical (Pavlovian) conditioning providing dramatic evidence of an inextricable relationship between the brain and the immune system." (Ader, 1991). However, these findings did not make an impact on the biomedical community of that time because the belief still existed that there were no connections between the brain and the immune system.

Because Ader believed that the nervous system was also involved in the relationship between the brain and the immune system, he changed Solomon's original name for this new science from *psychoimmunology* to *psychoneuroimmunology*.

Still more findings of a connection between the brain and the immune system began to appear in the 1970s. Edwin Blalock discovered that lymphocytes were a source of brain peptide neurotransmitters and pituitary hormones. Further studies revealed that supernatant fluids from human lymphocytes contained ACTH and endorphins, a result which, for the researchers at that time, was surprising since peptides were thought to exist in the brain and pituitary gland only. This discovery suggested that a relationship could exist between the brain and the immune system as they apparently spoke the same chemical language (Ader, 1991).

Karen Bulloch discovered that the thymus gland in the rat contained fibres of the vagus nerve which descends directly from the brain, and David Felten expanded on this finding by using fluorescent dyes to trace the pathways of these same nerve fibres. As well as finding connections to the thymus, he also found

connections to the spleen, lymph nodes and bone marrow and networks of nerves near blood vessels through which the immune cells passed. This latter finding suggesting that nerve impulses could directly influence the behaviour of cells (Ader, 1991; Dreher, 1995).

However, even though researchers had found an anatomical connection between the lower brain and the immune system, they had not fully explained how the immune cells in the blood and lymph nodes could be influenced by the central nervous system. This breakthrough occurred in the early 1980s when Candace Pert and colleague, Michael Ruff, discovered that neuropeptides acted as messengers between the mind/brain and the immune system by way of receptors on the molecular surface of monocytes. These receptors are designed to receive substances which can change the growth patterns or activities of cells. Therefore, this discovery by Pert and Ruff indicated that brain chemicals present in the bloodstream could alter the behaviour of immune cells and, because these neuropeptides are believed to be the chemical carriers of emotions, it follows that changes in one's emotions could result in changes in one's immune system. Thus Pert's view that neuropeptides and their receptors are part of a psychosomatic network has brought about a new understanding of mind-body integration and psychoneuroimmunology has successfully challenged the commonly held assumption of an autonomous immune system (Pert et al., 1985; Dreher; 1995; Pert, 1997).

Research conducted over the past several years has substantiated these findings of a connection and interaction between the behavioural, neural, endocrine and immune systems and there appears to be an attempt by more scientists to understand the workings of the immunoregulatory function.

THE MIND-BODY CONNECTION IN IRRITABLE BOWEL SYNDROME

Following on this, then, one can understand how emotions can affect the gastrointestinal system. One of the divisions of the peripheral nervous system is the *enteric nervous system* — also known as the "brain of the gut" — which consists of approximately 100 million neurons (or nerve cells) and extends the entire length of the gastrointestinal tract (GI). It functions independently of the autonomic and central nervous systems to some extent, although it also communicates with the central nervous system via sympathetic and parasympathetic neurons.

Sensory neurons of the enteric nervous system monitor chemical changes within the GI tract and the stretching of its walls. Enteric motor neurons govern contraction of GI tract smooth muscle, secretions of the GI tract organs such as acid secretion by the stomach, and activity of GI tract endocrine cells.

IRRITABLE BOWEL SYNDROME

Irritable Bowel Syndrome (IBS) is frequently observed in the general population and has been shown to affect up to one in four people. It has been estimated that between 10–25% of people in Australia, Great Britain and the United States have symptoms consistent with IBS at some time in their lives and 5% of all GP consultations are taken up with this disorder (Jones & Lydeard, 1992; Houghton et al., 1996; Camilleri & Choi, 1997; Talley, 1999). There is also the cost of millions of dollars a year to our economy through time off work, doctors' fees and the numerous medical tests that are needed to rule out the possibility of more serious complaints.

There are many different patterns or combinations of symptoms for IBS and most specialists follow a set of guidelines (either the Manning or Rome criteria) which consists of four main symptoms which are very common in IBS:

1. Pain in the abdomen relieved by passage of a bowel movement.
2. More frequent bowel motions when the person is in pain.
3. Looser bowel motions when the person is in pain.
4. A feeling of abdominal distension — clothes feel too tight and the abdomen feels bloated.

Other symptoms include: constipation, diarrhoea, variation in bowel habit from constipation to diarrhoea, excessive flatulence, bloating and ineffectual urging.

IBS can be extremely debilitating for some patients yet tests to investigate the cause of these symptoms are always normal with the unfortunate result that some doctors regard this complaint as an unimportant medical condition. To make matters worse, patients become extremely anxious and depressed because they are obviously suffering and yet there appears to be nothing wrong with them – perhaps they really have some serious illness that the tests have failed to pick up? Moreover, because the diagnosis is never assured and symptomatic treatments are not always successful, these patients are susceptible to receiving unnecessary, costly, treatments.

Even though the incidence of IBS accounts for a high percentage of the gastroenterologists' workload, its aetiology and pathogenesis are still unknown. Most literature suggests that the cause of IBS is a result of a hypersensitive GI system which is exacerbated by stress or emotional states (Prior et al., 1990; Whitehead et al., 1990; Bouchoucha et al., 1999; Camilleri et al, 2001; or a result of a previous bacterial infection (Neal et al., 1997; Gui, 1998; Rodriguez & Ruigomez, 1999; Talley, 2000).

TREATMENTS

There are a number of different treatments for IBS, most of which appear to fall into two distinct categories: those that deal with the mind and those that deal with the body (see Table 1). It appears, then, that once again the mind-body connection has become detached to some extent.

In my view, as *both abdominal and psychological symptoms* are associated with impaired health-related quality of life in patients with IBS, the optimal treatment should be a holistic one in which *all symptoms* are taken into account — psychological as well as physiological. Hence the need for the following clinical trial.

RESEARCH PROJECT

In a number of overseas studies, hypnotherapy has been shown to be a valuable treatment both in the alleviation of the symptoms of IBS and in the reduction of the need for symptomatic medication (Whorwell, 1987, 1991; Whorwell et al., 1987; Francis & Houghton, 1996; Houghton et al., 1996). Evidence exists in Australia of widespread acceptance of hypnosis by GPs and there is a suggestion of a need for evidence of this therapy's effectiveness (Pirotta et al., 2000).

Perhaps the most successful research in the area of hypnotherapy and IBS has been done by Peter Whorwell (and associates) in England. However, in his hypnotherapy sessions, he uses imagery which he calls "gut-directed" imagery that relates solely to the patients' *physiological symptoms* and does not take into account their *psychological/emotional symptoms.*

The following research project aims to compare the "gut-directed" imagery with a more holistic approach, the hypothesis being that those participants

Table 1

Mind-Body Categories for Treatment of IBS

MIND	BODY
Some practitioners support a psychological aetiology	Some practitioners favour a physiological mechanism
psychotherapy	diet (fibre/carbohydrate)
cognitive behavioural therapy	lactose intolerance
biofeedback	food intolerance/allergy
hypnotherapy	previous bacterial infection
antidepressant drugs	laxatives/anti-diarrhoeal drugs

whose *total symptomatology* is taken into account will achieve a more rapid and longer-lasting (if not, permanent) relief from the symptoms of IBS compared to those participants whose physiological symptoms alone are addressed. (A second hypothesis under consideration is that participants who are instructed in self-hypnosis will feel that they have more control over their illness and thereby will achieve a better success rate in the improvement of their symptoms).

AIMS AND OBJECTIVES

This research proposes to:

- Evaluate the use of hypnosis and imagery in the treatment of IBS in Australia.
- Compare imagery that reflects all of the patients' individual symptoms (psychological/emotional/physiological) with the standard "gut-directed" (purely physiological) imagery often given to patients in previous clinical trials (Whorwell, 1989, 1991; Drossman, 1995; Galovski, & Blanchard,1998).

METHOD

Setting and Participants

Participants for this study will be 90 patients who have been diagnosed with IBS by their medical practitioners/gastroenterologists and who will be recruited from private medical and naturopathic clinics and from the general public.

Patients will be screened by means of:

- the *Irritable Bowel Syndrome — Symptom Scale* (a modified version of the Bowel Symptom Questionnaire) to establish diagnosis and exclude other alternate diagnoses;
- the *SCL-90-R* — a standardised questionnaire to measure psychological symptoms; and
- the *Fantasy Absorption Scale* (FAS) — a new scale to measure fantasy proneness. A third hypothesis being considered for this trial is that those participants who rate high in fantasy proneness (which is strongly related to imagery) will show a more obvious and rapid improvement in their symptomatology.

Control Group. One third of participants who will undergo sessions in progressive relaxation (without imagery) and will take home a tape of the script to practise daily.

Experimental Group 1. Another one third of participants who will undergo sessions in hypnotherapy using the *"gut-directed" imagery* script similar to that used in previous clinical trials. They will also be given a tape of the script to take home and practise daily.

Experimental Group 2. The final one third of participants who will undergo hypnotherapy using an *individualised imagery* script that consists of both the *"gut-directed"* imagery script (as in Group 1) plus imagery relating to the patients' particular psychological/emotional symptoms that were evident on completion of the SCL-90-R. They will also be given a tape of their individual script to take home and practise daily.

Exclusions. Participants will only be considered for the study if they have remained continuously symptomatic despite conventional therapy given to them by their medical practitioner or specialist.

Participants will be seen for initial screening and testing procedures and then fortnightly for 3 months. At the beginning of every session they will be given a questionnaire to check on any changes in symptoms that may have occurred over the past fortnight. The questionnaire is then handed to the clinic receptionist who will hand it on to an independent researcher who will carry out statistical analysis.

SUMMARY

IBS is, in its most severe form, is an extremely debilitating illness that not only causes pain and suffering on the physiological level but on the emotional/psychological level as well. A range of psychological factors, such as emotional distress, anxiety, anger and depression have been associated with IBS as well as an impairment of health-related quality of life and high health care costs. Hypnotherapy has been shown to be effective in the treatment of IBS but so far, has failed to take into account both physiological and psychological symptoms. This research project hopes to rectify this situation by treating the patient in a more holistic way and bringing about a more lasting (if not, permanent) relief in *all* of the patient's symptoms thereby improving his or her quality of life.

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Reoperationalising Adaptive Regression During Hypnosis

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Employing a non-randomised two-group pretest post-test design, this study found that a regression hypnotic transcript produced a greater reduction in conflict responses than a relaxation hypnotic transcript. Finally, this study re-operationalised the concept of regression.

Proponents of psychoanalytic theory have long held that hypnosis elicits a regressive shift from secondary to primary process thinking. Produced by relaxation of ego control, this shift toward the unconscious gives rise to nonverbal imagery, symbolism, and nonsequential thinking while diminishing primary control of ratiocinative, ordered, language based and reality oriented thought (Fromm & Nash, 1997). Central to this construct is the idea that increased accessibility to primary process mentation promotes alterations toward constructive problem solving, coping and mastery. Coined as adaptive regression (Hartmann, 1939), this alteration uses the more archaic portion of the mind to integrate and adapt to conflict. This temporary adaptation combines conscious and unconscious processes in logical and intuitive interplay by reducing conscious effort toward threat, harm and conflict and heightening focus on instincts and drives (Fromm & Shor, 1979).

Adaptive regression is one component of the topographic model of regression, which has been the psychoanalytic groundwork for understanding mental changes during hypnosis. Currently, this model is considered the distinctive and most plausible explanation and characterisation of hypnosis.

Freud (1900/1961) described topographic regression as a shift from higher to lower mental functions based on a response to stress and conflict. This regressive shift enables the emergence of primary process thinking evident in mental productions during the sleep state, dreaming, psychopathology, and the hypnotic state. Freud also contended that primary process thinking occurs during wakefulness, and is evident in art, slips of the tongue, humour, and inebriated states. This cognitive alteration reduces the efforts of secondary process thinking

and shares with sleep and dreaming a withdrawal of the cathexis of attention and an underlying neurological reorganisation (Freud, 1916–1917/1963).

Unlike temporal regression, topographic regression is described as a reversal of thinking in space and not in time. Freud described this shift as the reverse of the reflex arc in neurology and physiology and therefore a reverse movement from thought-structures to sensory perceptions or images. Temporal regression is defined as a return to an earlier point in development and is considered a retracing of maturation. According to this model, hypnosis can return to and reanimate an earlier mode of relating (Freud, 1915/1961).

Debates continue as to whether Freud's contention of this return and reanimation is actually possible. Some psychoanalytic and cognitive-developmental psychologists continue to support the stance that earlier stages are retrievable and necessary in the treatment of individuals with serious impairment. Supporters of this view contend that psychopathology in general is a temporal regression to one or more earlier modes of development. In addition, relation to self and others in the individual with serious disturbance is a function of one or more of these developmental steps.

Proponents of the topographic regression theory argue that the psychic structure of an adult is permanently altered over time and the ability to return to a pure form of a particular stage is impossible. Research generated in this area provides conflicting results. Various studies have been unable to rule out the influence of demand characteristics on the behavior of subjects when undergoing a regressive hypnotic script and have found no evidence that cognitive functioning changes from adult to child-like characteristics (Spanos, Ansari, & Stamm, 1979). Barber (1962), Roberts (1984), Sarbin and Farberow (1952) found that intellectual functioning of hypnotically age regressed subjects remains adult-like when measured by standardised intelligence tests. Lynn and Rhue (1991) stated that research evidence of a temporal regression through changes in physiology, perception, and personality processes remains unconvincing. The overall view of regressive shifts, whether temporal or topographic has been challenged by socio-cognitive theorists. Kirsch and Lynn (1999) argued that motivation and expectancy determine suggestibility rather than actual mental shifts, and that behavior in general, is nonconscious.

Freud theorised that via the sexual instinct, the individual under hypnosis transfers or fixates libidinal impulses onto the hypnotist. Sapp (2000) maintaining Freud's libidinal regression theory emphasised that only a portion of the ego maintains involvement in the libidinal regression, as a large portion of the personality continues to participate in relation to reality or the external world. This transference process was considered at the time to be the essential mechanism of the hypnotic experience. Libidinal theory has undergone scrutiny and

has been revised by ego, object relations, and self-psychologists (Sapp, 1997; Sapp, 2000). According to Lynn and Rhue (1991), transference onto the hypnotist occurs not by means of libidinal regression based in drive theory, but rather follows the lines of a topographic regression. Within this framework, transference is a function of reductions in defense and increases in expression, the shift from secondary to primary process thinking, and a decrease in control and a greater allowance of gratification. The individual displaces archaic interpersonal schema onto the hypnotist and condenses this material into several ideas represented by single images.

The view that hypnosis elicits a topographic regression includes not only the shift from secondary to primary process thinking and transference, but increases in access to affect, changes in the experience of the body, alterations in volition, increases in ego receptivity and regression in service of the ego or adaptive regression.

Reduction or loosening of defenses increases availability of affect. This increase in affect is personally relevant to the hypnotised subject, because during hypnosis it is spontaneous, and heightened in intensity. Bryant and McConkey (1989) Damaser, Shor, and Orne (1963) Hepps and Brady (1967) and Sheehan (1969) found that emotional responses from hypnotised subjects and those simulating emotional responses had similar heart rates, muscle activity, skin conductance, and anxiety responses. All four studies were unable to rule out the possibility of the effect of demand characteristics. Lynn and Rhue (1991) asserted that age regression may increase access to emotional material but suggested that obtaining an overall accurate picture of a particular childhood event may not be possible. In several recent studies, hypnotically age-regressed subjects while not appearing more child-like, exhibited more spontaneous, emotionally intense, and specific reactions toward a transitional object (e.g., blanket) than nonhypnotised controls (Nash, Johnson, & Tipton, 1979; Nash, Lynn, Stanley, Frauman, & Rhue, 1985).

Alterations of the executive ego during regression elicit changes in how the body is experienced. Freud asserted that the ego originated from reactions to surface bodily sensations and is therefore, fundamentally a bodily ego (Freud, 1923/1961). Currently, no research has been generated in this area. Lynn and Rhue (1991) described that in some subject's alterations such as sensations of shrinking, swelling, and loss of equilibrium have been reported. Subjects depicted these sensations without prompting. Sapp (2000) reported experiences of depersonalisation and body distortions from some subjects related to hypnotic susceptibility.

While a change in volition during hypnosis is expected, it is not to the exclusion of will and control. Some subjects can and do refuse to comply with hypnotic

conditions without permission from the hypnotist. However, a feeling or sensation that a portion of the experience occurred without effort or purposeful behavior has also been shown. While the executive function reduces defenses and shifts its focus of attention, an experience of effortless responding may occur. During a hypnotic session, for example, subjects engage in purposeful and goal directed activities such as arm lowering when the suggestion has been given that a heavy weight is resting on top of their arm. The separation of intent to comply and awareness of the intention is evidenced when the subject complies by lowering the arm under the weight, but consciously reports that the arm remained in a raised position. The sensation of involuntary responding has been well documented across the hypnosis literature, however, debate remains concerning whether shifts in mental function actually occur (Lynn & Rhue, 1991;Sapp, 2000; Sapp & Hitchcock, 2001).

Ego receptivity is the ability of the ego to allow greater interplay between external forces and the instincts and drives. In the healthy individual under hypnosis, the ego permits primary process material to surface while orientation to reality is in part suspended. This suspension maintains the relationship with the hypnotist as its single exception. This solitary tie to reality relies upon a trusting therapeutic relationship. Intrusions of preconscious and unconscious material are not perceived as a threat to the individual's stability and control and can be woven graciously and advantageously to enhance and facilitate cognition, affect, and memory. In the case of the poorly integrated and developed ego, primary process material is accessed passively and subsequently experienced as intrusions that are not under the control of the individual's ego. Coined as ego passivity, access to intrapsychic material produces feelings of helplessness and panic. Ego passivity may also occur if the hypnotist attempts to pressure an individual into experiencing thoughts, emotions, or memories that they are unwilling or unable to handle (Fromm & Nash, 1997).

ADAPTIVE REGRESSION

Kris (1936/1952) originally identified adaptation during a topographic regression as a regression in service of the ego. He regarded this improved mastery as the ego's ability to begin and end libidinal and structural regression. Kris asserted that the ego's ability to diminish control or regress was a voluntary and temporary withdrawal of cathexis. "The ego enrolls the primary process in its service and makes use of it for its purposes." This regression is viewed overall as nonpathological, healthy and of short duration. Kris' view of regression in service of the ego centered around his studies on creativity. He believed that evidence of adaptive responding was clearly identifiable through art, humor,

and other creative acts by loosening of ego control and access to earlier modes of perception and cognition. This reduction of defenses realises greater affect, memories, and more primitive components of experience.

Fromm and Shor (1979) viewed adaptive regression as a temporary and voluntary letting go of day-to-day control. She theorises that adaptive regression is a movement backward on the developmental ladder, which elicits a more free form, less defensive and rigid style of perceiving, sensing and thinking. With hypnotic relaxation, productive changes can be maintained and utilised during the waking state. Fromm posited that hypnotic regression is both temporal and topographic, arguing that the two types cannot be separated. From a case study (the case of Don), Fromm cites evidence of a return of an unused, affect-laden language, which she identifies as a temporary reinstatement of an earlier portion of development.

Wallas (1926) described creativity as an example of a psychological regression. According to Wallas, the creative process includes four phases: preparation, incubation, illumination, and verification or evaluation. Verification or evaluation is the final phase in which secondary process thinking may determine the value or the logic of the outcome. Fromm and Nash (1997) viewed Wallas' incubation phase, as a relaxation period while the illumination phase is the regression component of adaptive responding. According to Sapp (2000), relaxation is the mechanism of hypnosis or any other state in which increases in feelings of unreality, dissociation of cognitive, sensory, and motor activities, decreases in ego control, periods of amnesia, and increases in response to suggestion are experienced.

Adaptive regression differs from pathological regression by the ability to maintain some ego control. As long as the regulating ego can maintain a watchful eye, the use of primary process material is selective and voluntary. Pathological regression occurs when the ego becomes paralysed by an involuntary breakthrough of primary process material (Kris, 1934). Autonomy between the primary and secondary ego, ensured by growth and independence through developmental stages, is necessary for an adaptive regression to occur. Hartmann (1939) defined this non-pathological regression as a "progressive adaptation" (Fromm & Shor, 1979). Involuntary breakthrough of primary process material is evidenced in alcohol and marijuana intoxication, neurophysiological disorder, hemispheric asymmetry, thought disorder, schizophrenia, paranoid schizophrenia, process schizophrenia, sociopathy, borderline personality disorder, and childhood anxiety. It has been through the understanding of psychopathology with intrusions of primary process as a topographic regression that has led researchers to characterise hypnosis in essentially the same way.

The adaptive quality of the ego's ability to surrender itself in part to other mental faculties has generated much discussion among many fields and has been described or defined in a variety of ways. Considerable attention has been paid to our greatest thinkers, philosophers, scientists, and artists in an attempt to capture how the mind creates, imagines, and produces complex ideas and elaborate displays of the depth of the human mind. Certainly, this shift or ability to use other portions of the mind can be attributed to Freud's tripartite theory, and is a phenomenon that has been recognised across cultures and throughout time through ancient, Hindu practices to Transcendental Meditation.

The proclivity that secondary process mentation defines higher order thinking undercuts and dismisses portions of the brain that have been directly attributed to the greatest and most profound human discoveries.

Claxton (1997) defined primary process thinking as sensorimotor intelligence and believed that this unconscious intellect or ability had exceptional importance for the first two years of life. However, he theorised that the senses and essentially therefore, primary process, took a back seat during development and was eventually replaced by secondary process thinking, a more intellectual and abstract means of knowing.

It seems apparent that our reliance on reality oriented knowledge, deemed as an indicator of intelligence, is not in isolation, responsible for expanding our thinking not only as discoverers but also even in attempting to solve injury to the psyche and day-to-day conflicts.

Primary process thinking has been described as essential during the creative process. Albert Einstein, for example, described his creative process in this way:

> *The words of the language as they are written or spoken do not seem to play any role in my mechanism of thought. The psychical entities, which seem to serve, as elements of thought are certain signs and more or less clear images that are in my case of visual and some of muscular type. These elements take part in a rather vague play…in which they can be voluntarily reproduced and combined…This combinatory play seems to be the essential feature in productive thought, before there is any connection with logical construction in words or other kinds of signs which can be communicated to others…In a stage where words intervene at all, they are, in my case, purely additive, but they interfere only in a secondary stage (Claxton, 1997 p. 56).*

Here, Einstein aptly and perhaps unknowingly described primary process thinking by explaining that his mechanism of thought was visual in nature, independent of language, vague, and non-logical. Much like Wallas' theory of creativity, he added that words intervene only secondarily.

It is possible that regression in service of the ego may not only be the "respite" from external forces and the tapping of drives and instincts that Fromm describes, but perhaps an illumination of a great library. Psychological

research has shown that reductions in pressure and anxiety during tasks and therefore reliance on "intuition" promote far greater accuracy in problem solving. When the store of knowledge or secondary process thinking is utilised, performance tends to be poor when compared to the use of intuition or unconscious automatic processing (Claxton, 1997).

If adaptive regression is a function of the hypnotic trance, therapeutic implications necessitate a more thorough investigation of this construct. Currently, the only measure designed to identify adaptive regression is Holt's Rorschach Measure of Adaptive Regression. The Holt system was designed to measure the degree of primary process material expressed (Defense Demand) and the ability to integrate it effectively (Defense Efficiency). Previous studies using the Holt system have been unable to identify evidence of adaptive regression.

Fromm et al. (1970) conducted a study using Holt's system to identify the presence of primary process mentation and adaptive regression during hypnosis. Results indicated increases in primary process mentation. Increases were greater in well-adjusted females than in well-adjusted males. No evidence of adaptive regression was found.

Using Holt's system, Wiseman and Reyher (1973) measured primary process material by hypnotically inducing dreams. More primary process material was identified for hypnotised subjects than those in a waking state. However, no elevation of adaptive response was found. Levin and Harrison (1976) also found increases in primary process during hypnosis but no evidence of a shift in control and defense (adaptive regression).

This study reoperationalised adaptive regression during hypnosis using the Rotter Incomplete Sentences Blank (ISB) along with several other indices. The ISB attains a single adjustment score for each subject based on responses to each sentence stem. All sentence stems are scored as positive, neutral, or conflict responses. If hypnosis induces regression in service of the ego, the number of conflicted responses reported by hypnotised subjects should decrease. We theorised that a decrease in conflict response from the waking state to the hypnotised state may be at least one indicator of adaptive responding by way of increased ability to problem solve.

METHOD

Participants

Participants included 51 undergraduate and graduate students from a mid-western university. Participants were recruited from educational psychology and psychology classes. Each subject received extra credit for fulfilling a class requirement.

Following a screening for dissociative pathology and hypnotisability, 38 moderately to highly hypnotisable subjects were selected for two conditions. Age range for subjects was 19–39 with 8 males and 30 females.

Materials

General Dissociation Scale: is a 15-item scale used to identify dissociative pathology. The GDS is a Likert scale with a range of 1–4, with a reliability of .85 (Sapp, 2000).

Waterloo-Stanford Group C Scale (WSGC): is a group adaptation of the Stanford Hypnotic Susceptibility Scale: Form (SHSS: C). The WSGC is a 12-item objective experience scale of hypnotisability with an induction. Bowers (1993) found internal reliability as .80 in one sample and .81 in another for the WSGC.

Inner Subjective Experience Scale (INSUB): is a 12-item subjective hypnotic experience scale. The INSUB uses a Likert scale ranging from 1–6 and is used in conjunction with the objective questions of the WSGC. Kirsch, Milling, and Burgess (1998) found internal reliability of .89 for the INSUB. This scales measures the automaticity of hypnotic responding (Sapp & Hitchcock, 2001).

Hypnotic Depth Scale (HYPDEP): is a Likert scale ranging from 0–10, with 10 depicting the deepest hypnotic experience.

Vividness of Imagination (VIVIM): is a Likert scale ranging from 0–10, with 10 depicting the most vividness of imagery.

Description of Hypnotic Experience: is a 7-item self-report scale corresponding to hypnotic experience during the Waterloo-Stanford Group Scale. It was adapted for this study for the regression and relaxation conditions.

Sapp (1997, 2000) designed regression and relaxation hypnotic transcripts. Participants received one of the two scripts. Each script was about the same length of time, and they were played on a tape recorder to standardise the experimental process.

Rotter Incomplete Sentences Blank (ISB): is a projective measure yielding an overall adjustment score. The ISB contains 40 sentence stems that upon completion are rated as positive, neutral, or conflict responses. Rotter, Rafferty, and Schachtitz (1965) found interrater reliability of .83 for women and .84 for men and split-half reliability coefficients of .96 for women and .91 for men. Material obtained from the ISB is considered similar to that obtained from the Thematic Apperception Test (TAT). Sentence completions may be interpreted

symbolically by a psychoanalytic framework or by a common sense or face value approach.

Flesch-Kincaid Grade Level score: is a computerised method that rates text on a U.S. grade school level. Grade level attained suggests that an individual at that grade level can understand the text.

Flesch Reading Ease score: is a computerised method that rates text on a 100-point scale by measuring word difficulty and sentence difficulty. It is calculated by averaging the number of syllables per word and number of words per sentence.

The higher the score, the easier the document is to understand. Word count: is a computerised method of obtaining total number of words used in a document.

Procedures

Students diagnosed with a mental disorder, undergoing psychotherapy, or reporting a history of physical or sexual abuse were excluded from the study.

After completion of informed consent, participants were screened for dissociative pathology using the GDS. Those obtaining a moderate to high score on the GDS were excluded.

Students were given a brief explanation of hypnosis and administered the WSGC, INSUB, HypDep, and VIVIM. Those identified in the moderate to high range of hypnotisability were selected for the study.

A repeated measures (within-subjects) design was used. Subjects were selected for the control (relaxation) (n = 16) or experimental (regression) (n = 22) groups based upon student attendance at two sessions. Prior to hypnotic induction, both groups were administered the ISB. Following completion of the tasks, each group was administered either the regression or relaxation hypnotic script. During a pause in the script, subjects again completed the ISB but in inverse order. Following completion of the ISB, the remainder of the hypnotic script was administered to end the hypnotic experience. Both groups completed the Description of Hypnotic Experience scale. The experimental group was given a 10–15 minute period following the hypnotic script to ensure that each of the subjects were no longer hypnotised or continuing to have a regressive experience.

Pre-test ISB and post-test ISB were scored by rating sentence stem response as positive, neutral, or conflicted and omitted items were adjusted as described in the ISB scoring manual. Word Count, Flesch-Kincaid Grade Level scores, and Flesch Reading Ease scores were computer generated for pretest and posttest ISB. ISB responses were entered as one continuous paragraph for purposes of calculating the above scores. Spelling errors and punctuation were entered as the subject

responded. Each subject was credited with all stems regardless of omissions for Word Count. Two researchers scored all ISB forms independently.

RESULTS

Using a nonrandomised pretest-posttest design, we found that for the four covariates (pre-tests) ISB, Flesch-Kincaid Grade Level score, Word Count, and Flesch Reading Ease score, and the covariates used as post-tests, homogeneity of regression hyperplanes assumption was tenable for MANOVA, Wilk's lambda = .59, $F(16, 77) = .594$, $p > .05$.

Results of hypnotisability scales for screening revealed no significant differences for level of hypnotisability between groups, Wilk's lambda = .84, $F(4, 33) = .210$, $p > .05$. Screening measures included the WSGC, INSUB, VIVIM, and HypDep. Out of 38 subjects, the WSGC was missing for three subjects in the experimental group, however, each WSGC was scored and level of hypnotisability was obtained before admittance to the experiment.

MANOVA was performed to analyse the four covariates (pre-tests) and four dependent variables (post-tests); ISB, Flesch-Kincaid Grade Level, Word Count, Flesch Reading Ease to determine effects of the independent variable hypnosis. Adjusted population mean vectors for the experimental (regression) group and the control (relaxation) group were significantly different, Wilk's lambda = .14, $F(16, 89)$, $p < .001$. Inter-rater reliability for the ISB was .95, performed by two independent scorers.

Univariate F-tests indicated that the dependent variable Reading Ease contributed to multivariate significance. Univariate Fs for ISB, Word Count, Flesch-Kincaid, and Reading Ease respectively were: $F(1, 32) = .750$, $p > .05$, $F(1, 32) = .842$, $p > .05$, $F(1, 32) = .514$, $p > .05$, $F(1, 32) = .013$, $p < .05$.

In terms of mean differences, there was not a significant difference between the regression group and relaxation group on the ISB. For example, on the ISB, the adjusted mean for the regression group was 120.69 and 122.47 for the relaxation group. Also for the ISB, with the regression group, the standard deviation was 16.27 and it was 15.49 for the relaxation group. With Word Count, the regression group had an adjusted mean of 231.48, and the relaxation group had an adjusted mean of 229.31. The standard deviation on Word Count was 43.58 for the regression group and 49.17 for the relaxation group; with the Flesch-Kincaid, the adjusted mean for the regression group was .09 and –.14 for the relaxation group; and the standard deviation was 1.00 for the regression group and .99 for the relaxation group. The regression group had an adjusted mean of 91.20 on Reading Ease, while the relaxation group had an adjusted

mean of 86.42. Finally, the standard deviation for Reading Ease for the regression group was 5.27 and 4.04 for the relaxation group.

Of the subjects in the regression group 64% reported either slight, moderate, or high levels of hypnotic experience, while 50% of subjects in the relaxation group reported slight to moderate levels of hypnotic experience. These scores were based upon responses to the Description of Hypnotic Experience scale after experimental conditions.

DISCUSSION

Using the ISB as a tool to identify changes in mental function during hypnosis, we hypothesised that adjustment scores would decrease for both hypnotic groups with greater reductions in the experimental (regression) group. Since the control group underwent a relaxation hypnotic script, we expected some decrease in adjustment scores based upon relaxation theories of hypnosis. Greater reductions were expected for the experimental group based upon direct suggestion to regress.

Evidence of increases in primary process mentation during hypnosis has been shown in previous studies, however no evidence of adaptive regression has been found. Assuming the presence of primary process during hypnosis, this study did not attempt to measure primary process and instead focused on decreases in conflicted responses as evidence of adaptive regression. We propose that shifts from conflicted to neutral or positive responses reflect an increase in adaptive and creative responding and, therefore, an increase in conflict resolution.

Improvement in adjustment scores or reduction of conflict responses was greater for the regression group than the relaxation group. While interrater and split-half reliability is consistently high in the literature for the ISB, re-test reliability comes into question. One of the few studies, which examined re-test reliability for the ISB, found a reliability coefficient of .70 for a group of mothers re-tested after a median interval of 20 months (Churchill & Crandall, 1955). Stephens (1960) found low re-test reliability coefficients among college students when re-tested at six-month, 12 month, and three-year intervals. Concluding that the scores of college students who were acclimating to the college experience would be expected to change more than the group of mothers, Stephens stated that the difference of test scores for the college group was found to be significantly related to instability of, or changes in, adjustment rather than reflective of low re-test reliability. Adjustment scores from pre-test to post-test should remain relatively unchanged; particularly in this study during which the time frame between pre-test and post-test was narrow. Based

upon this assumption, improvement in adjustment scores obtained in this study support the hypothesis. It is safe to conclude that measured changes indicate occurrence of adaptive regression and are not related to retest unreliability.

Theoretically, increases in primary process mentation decrease demand for ratiocinative, ordered, and reality based thought dependent upon language. Reduced critical evaluation of language-based skills during hypnosis may be an indication of this shift. Based upon this assumption, we expected hypnotised subjects to use fewer words and less sophisticated language to respond to sentence stems. Therefore, we expected decreases in Word Count and Flesch-Kincaid Grade Level scores, and increases in Flesch Reading Ease scores changed in both group, but with greater differences in the experimental group. Reductions in Word Count and Grade Level, and increases in Reading Ease, were noted for both groups. Increases in Reading Ease scores contributed more than Word Count and Grade Level to statistical changes for both groups overall.

Using a formula which calculates Reading Ease based essentially upon the number of syllables per word and the number of words per sentence, it is interesting to note that although Word Count and Grade Level decreased in both groups, Reading Ease increased only slightly in the control group as compared to the experimental group. This would seem to suggest that although the control group used fewer words to respond to the sentence stems, sophistication of language used remained essentially the same. Given the constraining structure of the test and the content of the sentence stems, small differences may be of interest. Based upon the theoretical basis of language differences during regression, this may be an area of interest for future research.

Replication of this study using the ISB or similar projective measures using only highly hypnotisable subjects may be warranted. High hypnotisables may produce a more powerful relationship between reductions of conflicted response on the ISB and hypnosis.

Obtaining ISB scores for only maladjusted subjects during hypnosis may also be of interest. Fromm et al. (1970) suggested that well-integrated individuals experience adaptive regression during hypnosis while poorly integrated individuals tend to have a pathological or near-pathological regression. Within this study, 11 subjects (5 control, 6 experimental) scored in the maladjusted range based on the suggested cutoff score in the scoring manual. Of those 11, seven subjects' (2 control, 5 experimental) scores dropped within the adjusted range during hypnosis, two subjects' (1 control, 1 experimental) scores decreased slightly but remained at a maladjusted level. One subject's (control) score increased and one subject's (control) remained one point above the cutoff for adjustment.

The major limitation of this study is the lack of randomisation, which leaves the selection threat to internal validity operative — that is did the groups differ on some variables before the study was conducted? (Sapp, 1997).

Clearly, one form of hypnosis is psychological regression, or as operationally defined within this study, a special case of adaptive regression. This view is similar to dissociations theory of hypnosis, in that participants produce an alteration in consciousness (Hilgard, 1994). Moreover, suggestions for relaxation are another form or type of hypnosis that can produce alterations in conscious experiences; therefore, in essence, there are many forms of hypnosis. And this notion suggests that hypnosis is a multivariate construct that has features of regression, relaxation, dissociation, and so on. In addition, this study supports the new three-dimensional theory of Barber (1999), who stated that there are a variety of forms of hypnosis. Barber stated that the debate between state and non-state hypnosis theorists is no longer pertinent to the area, because seldom do a researcher of clinician see the entire range of hypnotic types of clients. For example, some clients use fantasy to produce hypnosis, others use dissociation, and some clients use their positive attitudes toward hypnosis to produce hypnotic effects. In essence, there are clients who experience hypnosis as an altered state of consciousness, and there are clients who do not experience hypnosis as an altered state of consciousness. Finally, as Sapp (2000) Sapp and Hitchcock (2001) stated hypnosis is a complex phenomenon, and it will take the synthesis of many areas in order to continue to shed light on this elusive construct.

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Couples Counselling: An Ego State Therapy Approach

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The relationship with a partner can be one of the most rewarding and challenging aspects of living. Maintaining healthy partnered relationships has become more difficult with evolving gender roles, cultural pressures, and a reduced security of permanency. This is evidenced by an increased number of separations and divorce. Repairing, rather than enhancing, a relationship has become the only vision of many couples. Ego state therapy is uniquely equipped to both (1) assist a couple in communication and awareness in order to improve a troubled relationship, and to (2) assist a couple in learning to enhance to a new level the enjoyment of their relationship. Ego state therapy utilises hypnosis to access the different communicative parts of each partner for improved awareness and for problem resolution. An angry part of one person cannot be properly heard by a partner listening from a part that feels hurt and reactive. Using ego state techniques individuals learn about the distinctive parts of themselves and their partners, and they learn which parts can best communicate with each other to feel heard, to negotiate, and to enjoy the positive aspects of the relationship. Ego state couples counselling is appealing to clients and is easily understood by them.

COUPLES COUNSELLING: AN EGO STATE THERAPY APPROACH

When two people want to maintain a good relationship or have difficulty in just maintaining their relationship they sometimes seek help in couples counselling. Couples may want to heal a damaged relationship or enhance a relationship that is already generally positive. Ego state therapy (Emmerson & Farmer, 1996; Emmerson, 2000b; J. G. Watkins, 1976, 1977, 1978a, 1978b; H. H. Watkins, 1978; J. G. Watkins & H. H. Watkins, 1976, 1979a, 1979b, 1979c, 1981, 1982, 1986, 1990) helps couples by assisting them in communication and in awareness, both self-awareness and awareness of their partner. Ego state therapy can also help a relationship by individually helping partners in a relationship clear away their own traumas and their own internal ego state communication problems that might otherwise interfere in the relationship. Further reading will be required for the reader who is unaware of ego state therapy but the following quote may help enlighten those who are new to the therapy.

> *Ego state therapy is based on a theory that the psyche is not an homogenous whole, but is composed of a group of distinguishable parts particular to the individual. These parts, or ego states, allow the person to switch between states that have different roles and experiences of affect. While in a cognitive ego state the individual may be able to relate with acute intellectual awareness and with very little affect, and when in an emotional ego state the same person may be driven by affect. Ego state therapists attempt to facilitate desired change by working directly with the ego states that will benefit most from intervention. (Emmerson, 2000b, p. 1)*

Relationship problems can arise from various difficulties. Three major areas of difficulty in relationships are (1) differences in ideas, or philosophy, (2) problems in communication, and (3) individual problems a partner may experience that may impinge on the relationship. While ego state therapy is not an intervention that is aimed toward changing ideas, better communication and acceptance can reduce problems resulting from a conflict of ideas. It may therefore be useful to look at some differences in ideas that can cause problems in a relationship. Examples of differences in ideas include the following:

- Religious Beliefs — These can range from major differences in basic beliefs to differences in how or how often a belief should be practiced.
- Children — Do both partners want children? If so, how many? How should children be raised?
- Roles — How is the workload divided?
- Money — Where does the money come from? How much should be spent and on what? How are the decisions for spending or saving money made?
- Other Relationships — What kinds of other relationships are acceptable? How much time should be spent interacting as a couple?
- Holidays and Free Time — How should time be spent (e.g., mountains, cafe's, shopping, at home)?
- Extended Family — What is the role of the extended family in the relationship, and how much time is spent with them?
- Vocation — How important is the vocation of each partner? Whose vocation demands locating near?
- Sexual Issues — The frequency and nature of sexual activity, and what is acceptable within the relationship (provocative movies, shows, clothes, flirtations, other partners).
- Health and Fitness — Diet and exercise. What legal (e.g., caffeine, nicotine, alcohol) or non-legal drugs (e.g., marijuana, cocaine, heroin), if any, are acceptable? What foods should be eaten and what body fitness should be maintained.

- Disclosure — How much information is shared with the partner? How honest or trustworthy is the relationship?
- Step Families — Relationships with X-partners or stepchildren can generate difficult issues.

This is only a partial list of issues from which couples can have difficulty. Looking at the list a person can wonder how any two people are ever able to maintain a relationship. It is possible to maintain a good relationship, even with many differences in ideas, but to do so it is important for the couple to have effective communication. While the relationship between the therapist and the clients is important and should be a part of any therapy (Bachelor, 1988; Coady, 1999; Golden & Robbins, 1990; Kuehl, Newfield, & Joanning, 1990; Rennie, 1992; Wark, 1994) ego state couples counselling focuses on the communication between the partners. Good communication is imperative for a good relationship. Lazarus (2000, p. 224) stated, "If the issues fester and expand, the gunnysack of pent-up anger and resentment grows larger and additional troubles begin to brew."

A common problem couples have in communicating relates to the ego states from which each is communicating at a given time. Couples can easily understand that they respond differently in the relationship, depending on their mood state. Sometimes they are reactive and other times they feel strong and understanding. It is important for each person to be able to express fully, and to feel heard and understood. In order for this to happen the ego state that is executive (out, and in control) must be able to speak with a state of their partner that can hear and understand what needs to be said.

An angry ego state of one partner should not be executive at the same time as a defensive state of the other partner. This would result in the angry state feeling unheard and resented, and often feeling even more angry, and the defensive state of the other partner feeling attacked and abused. Both partners would most likely end the disagreement feeling worse. When one partner is speaking from an angry state the other partner needs to be in a more removed, intellectual, understanding state in order to hear what is being said, process it, and show understanding without getting upset. This intellectual state does not have to agree with the angry state, but it does need to be able to show an understanding of the other partner's perspective.

An ego state with pent-up feelings needs to be able to release those feelings, and if the pent-up feelings are held toward a partner, to resolve those feelings it is best if the feelings can be expressed directly to the partner. Expressing the feelings and feeling heard is like letting the steam out of a pressure cooker.

Couples counselling can be thought of as a six-step, four phase process:

1. information gathering
2. the individual phase,
3. the co-learning phase,
4. the negotiation phase,
5. the practice phase, and
6. the assessment.

It is not necessary for all six steps to reach completion in order for a relationship to improve, but until all steps have been completed the potential of the relationship cannot be realised. For example, merely resolving individual issues may allow a relationship to improve, but further improvement may result from the improve ability to communicate that completion of the later steps allow.

Prior to beginning, it is important to make sure that both partners want the relationship to continue. Unless both want to invest work on the relationship it may be that some form of separation counselling is most useful.

Ego state couples counseling normally takes a minimum of seven sessions. In the first session of counselling the two partners will meet together with the therapist to describe and define their problem. During this session the process of ego state couples counselling can be explained. It is important that a trusting relationship with the therapist (Christensen, Russell, Miller, & Peterson, 1998) is fostered during at this early stage, and maintained throughout therapy. The Individual Phase will take a minimum of two sessions (one for each client), and this phase may take a number of sessions depending on the needs of the clients. The remaining three phases may be completed with in a single session for each, or they may take multiple sessions, depending on the couple. A final session will follow the fourth phase in order to make sure that the couple are ready to continue to use their states together in a positive way. Couples counseling sessions generally follow the following timetable, although the depending on the couple the length of the phases (especially the individual phase) may vary.

- Week 1, Information gathering session: The partners come in together to define the problem and indicate a desire to invest time and effort into the relationship.
- Weeks 2–3 (or multiple sessions depending on need), Individual Phase: These are individual sessions and they may be scheduled into the same week. Hypnosis is normally used in these sessions.
- Week 4 (depending on length of Individual Phase), Co-learning Phase: The partners come in to attend the session together.
- Week 5 (depending of preceding phases), Negotiation Phase: The partners come in together.

- Week 6 (depending on preceding phases), Practice Phase: The partners come in together. It may be that one or both partners feel a need at one of these later phases to return for further individual work.
- Week 7 (depending on preceding phases), Follow-up Session: The partners come in together. This session is to make sure the couple is ready to continue on their own. It may best occur at least two weeks following the Practice Phase.

PHASE 1 — INDIVIDUAL PHASE

Each partner should resolve individual traumas, internal ego state communication problems, and have an ego state mapping. This is the only part of ego state couples therapy that utilises hypnosis. While surface states may be mapped without hypnosis, mapping underlying states require the use of hypnosis. Surface states are those states that commonly become executive, and underlying states are those states that commonly remain unconscious. It is important to access underlying states if personal problems are based in preconscious states.

An ego state mapping is one or more sessions to identify the client's main ego states, and their characteristics. Each client will have his or her individual array of states. Means of mapping ego states include the non-hypnotic technique of having the client to switch among a number of chairs each time a separate ego state is expressed. Each state gets a name that corresponds to its nature. Or, hypnotically, helping the client to move between states and name them, each time a separate mood/attitude state is expressed. States may be switched between by using the name that has been given a particular state, to call that state back to the executive ("I would like to speak with 'intellectual' please. 'Intellectual,' how do you respond to John when he says that?"). It is especially important to identify and name all states that are used to commonly interact in the couple's relationship.

Internal traumas can result in spurious or neurotic reactions within the relationship that cannot be resolved by focusing merely on the communication between partners. For example, if unresolved anger exists (Emmerson, 2000a) concerning a parental relationship when one of the partners was a child, reactions toward a partner may be more of a reflection of the unresolved anger toward a parent than a reflection of true feelings about the partner. If the internal communication within a partner ("I don't like myself when I do that.") does not allow an acceptance of self, that partner will not be able to respond as an equal in a relationship. The ego state mapping of each partner is a necessary step in couples counselling. Each partner needs to learn personal states in order to be able to call upon and use those states at various times in couples communication.

PHASE 2 — CO-LEARNING PHASE

Couples, with the help of the therapist, should learn each other's states, along with the talents and weaknesses of each state. It is not enough for each partner to know many of their own states. The partners also need to know and appreciate the states of their partners. They need to understand the importance that no state should be dismissed and left out of the communication process. When each partner learns their own states and the states of their partners they will begin to understand why it is important for some states to avoid each other, and others to prefer to talk together. It does not help a state with pent-up feelings to be confronted by a state feeling resentment when those feelings are expressed. The state that feels the resentment, likewise, does not like to feel abused by feeling the anger of the partner. By the end of this second phase partners will begin to understand the importance of one state asking to speak directly to a specific state of their partner (e.g., "My adolescent state would like to talk with your nurturing state."). Whenever partners communicate each is communicating from an ego state. By learning their personal states and the states of their partners, clients are able to have more control over the nature of the communication. This allows better expression, and deeper understanding.

PHASE 3 — NEGOTIATION PHASE

Negotiation with the couple should determine which states of each partner are best to communicate during problem resolution. During the negotiation phase the therapist should speak with each of the states (of each partner) that will likely be communicating during the steps of problem resolution. Agreement should be made with each state that will be playing a role in problem resolution. If a state is not willing to take up a role in this process, a different state should be sought that can and would like to participate in this process. For example, if when speaking Jill's 'Emotional' state may not want to talk with John's 'Assertive' state, so it is important to identify a state Jill has that is willing and able to communicate with John's 'Assertive' ego state.

Partners should learn during the negotiation phase that the four steps to problem resolution are releasing/listening, talking, bargaining, and resolving, and they should learn which of their states are best suited for each step.

- Releasing/Listening: This is just saying what is pent up and needs to be said. One partner is talking, while the other partner is either quietly listening or just asking clarifying question. No discussion takes place here.

- Talking: Only after expression has been allowed, this step allows discussion to further clarify the issue. No retorts or bargaining occurs here.
- Bargaining: Here each partner discusses their own point of view.
- Resolving: Agreement, compromise, or agreement to disagree occurs here.

Different ego states may be needed for each of these four steps, or the same state may be used in multiple steps. For example, John may need to release from an angry state while Jill listens from an intellectual understanding state (releasing/listening step). Jill may need to release from a frustrated state while John listens from a nurturing state (releasing/listening step). Both John and Jill may prefer to discuss the issue (talking step) from reflective states. Jill may want to use her assertiveness state in the bargaining step, while John may prefer to use his business state during this step. John or Jill may decide to use the same state they used in the 'talking step' in the resolution step, or one or both may wish to use a different state.

PHASE 4 — PRACTICE PHASE

Couples should bring out real life issues and practice switching and using the states that are most helpful in communication and resolution. During this process the therapist needs to help each partner make sure the preferred state is executive. If a reactive state jumps into the executive the therapist can assure that state that it is important for it to be heard, and that it will have an opportunity to speak when the pent-up feelings of that partner are being expressed. If the partners are able to follow though the problem resolution process in counselling, they will likely be able to follow though on their own, given the will to do so. They need to be clear that issues may arise after leaving therapy that will necessitate creativity on their part and they may need to call on states that were not a part of training in therapy.

The states that are chosen by each partner for problem resolution are only first examples. As their communication process evolves following couples therapy they will spontaneously refine which states can best talk with the states of their partner, and at which times. The increased self-awareness and awareness and respect of the partner will help the communication process to positively evolve. Prior to this type of therapy it is easy for a partner to believe that the most difficult state of a partner is that partner. Learning about how the personality is structured allows each partner to know of the other that while there are states there that may be having difficulty with aspects of the relationship, there are also states that have much love, acceptance and respect.

BRINGING RELATIONSHIPS TO A HIGHER LEVEL: THE ENHANCED RELATIONSHIP

Ego state techniques can bring a relationship to a higher level of enjoyment and fulfillment. It can help a relationship with normal levels of communication to higher levels of intimacy. Couples who have resolved communication problems may want to continue to achieve enhanced communication and enjoyment in their relationship. Couples who already have good communication may want to use ego state therapy to achieve this higher level of enjoyment in their relationship.

Above we learned that healing destructive communication patterns requires that certain ego states of one partner should not attempt to talk with specific ego states of the other partner. An angry state of one partner and a defensive state of the other partner should not attempt to communicate directly with each other. The manner to achieve an enhanced relationship is the bringing together ego states that can, not just communicate to resolve issues, but can fully enjoy each other.

One partner may have an ego state that feels fragile and in real need of love and hugs, while the other partner may have a state that truly enjoys nurturing. When these two states are executive at the same time both partners can enjoy deep emotional closeness. The fragile state may have learned to hide in the relationship in fear of a disapproving state of the partner that could bring pain. The fragile state will learn it is safe to come to the executive when the partners are able to learn the importance of respecting each of their states and using the states for a higher enjoyment of the relationship.

The phases to an enhanced relationship are the same as those to heal a destructive relationship, the individual phase, the co-learning phase, the negotiation phase, and the practice phase. A relationship can be improved without a completion of all four phases, but the potential of the relationship cannot be met. For example, a past trauma may inhibit a closeness in one aspect of the relationship, but partners may still be able to bring out states that enjoy each other.

Each partner will need to be ready for couples work by resolving any personal issues, improving his or her own internal communication problems, and by having an ego state mapping. The partners will need to learn not only their own states, but the states of their partners. This is often viewed as a gift of power and joy, to learn the parts of a partner. Partners are better able to understand and respect each other. They can be proud of the parts of their partner that they now can ask to come to the executive for special communication (e.g., "My child part would love a hug from your nurturing part." Or "This tastes fantastic. Can 'Hedonist' have a taste of this?").

The negotiation phase does not have to be inclusive of all the combinations of interactions the states of the partners will want to enjoy together. It could not achieve this level of depth and detail. What is important is that they learn as many ego states as practical, both their own and their partners, while in counselling. Partners will continue to learn what interactions work best. They will be able to be creative. It is difficult for most people to learn about underlying states outside of hypnotic therapy, and these states can greatly add to the richness of a relationship.

The practice phase of enhancement counselling can involve practice in the counselling office and at home. It is important that each partner learns to bring different ego states to the executive in the counselling office to ensure the technique has been learned. It is often quite easy for a client to bring an ego state to the executive once it has been talked with directly during counselling. The home practice can be private and need not be reported in detail to the therapist. It is only important for the therapist to be able to give assistance if the partners are having difficulty with the process selecting and bringing to the executive ego states that most want to enjoy each other.

It may be the case that a critical or pent-up state has a need to be heard before a nurturing or fragile state can enjoy the relationship. Partners should learn that each state must be respected, and that by fulfilling the needs of each state, every state can more fully enjoy the relationship.

SUMMARY

Ego state couples therapy maintains a focus on each partner being able to consistently express feelings and be heard by the other partner. Communication has been criticised as a primary focus in couples counselling (Lazarus, 2000) because the teaching of communication has most often been from an active listening paradigm. The focus has been on 'how it is said' to the near exclusion of 'how it is heard.' The focus in teaching communication to couples has also neglected the needs for the separate ego states of each partner to feel expressed. The therapy presented here focuses less on how it is said, than what part of the person needs expression, and what part of their partner can best hear that expression.

With ego state couples counselling there is no focus on blame (Friedlander & Heatherington, 2000) or gender (Guanipa & Woolley, 2000), as these issues are resolved when clients are empowered to bring forward ego states that can hear and understand difficult issues. Ego state couples therapy allows clients to understand their strengths, as well as their partner's strengths, and it empowers the clients with their own ability to use the best parts of themselves for each situation,

whether it is for conflict resolution, or for relationship enhancement. This therapeutic approach does not stop at understanding. It encompasses practice and review. This combination of understanding self and partner, negotiation, practice, and review provides a powerful tool for change.

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