

**Main Paper**

**EXPERIMENTAL EVALUATION OF A BRIEF 'IDEOYNAMIC'  
HYPNOTHERAPY APPLIED TO PHOBIAS**

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**Abstract**

This study used a test-retest design to investigate the effectiveness of a brief 'ideodynamic' hypnotherapy which notionally located and reformulated memories in the treatment of simple phobia disorder. Subjects were 19 phobics randomly assigned to treatment ( $n = 10$ ) and waiting control groups ( $n = 9$ ). Rapid, significant, and sustained relief from phobic fear and avoidance was reported by 50% of treatment subjects. A number of symptom and therapy process variables were correlated with treatment outcome. These included a negative association with hypnotizability and a positive association with hypnotic depth estimates. The ramifications of these and other associations are discussed and it is concluded that the 'ideodynamic' approach investigated may have contributed a therapeutic effect beyond the operation of treatment non-specific factors.

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In 'hypnoanalysis' of phobias autobiographical memories (Rubin, 1986) assumed to support symptoms have often been located using suggestions for age-regression and for their recovery. A reformulation of the memory is then typically attempted by encouraging emotional 'catharsis' and conscious 'insight' through a 'reliving' and 'working through' of the sensory and emotional aspects of the remembered event (see Gruenewald, 1971; Van Dyke & Harris, 1982; Brown & Fromm, 1986).

Baker and Boaz (1983), Domangue (1985) and Lamb (1985) have presented case studies in which phobias were very quickly and effectively relieved without stress by brief, hypnotic memory reformulating therapies which involved neither catharsis nor the acquisition of conscious 'insight'. Rather, suggestions for age-regression were used to locate apparently problematic memories which were then directly 'altered' so as to produce a more benign behavioural/emotional outcome. It was claimed that because age-regression was required to locate memories in these therapies they were suitable only for highly hypnotizable clients (e.g. Lamb, 1985).

However, Barnett (1981), Grinder and Bandler (1981), Rossi (1986) and Rossi and Cheek (1988) have described techniques, and presented both anecdotal and case study evidence which have indicated that brief memory reformulating therapy of the kind described above is possible with low hypnotizable phobic clients. Here the term 'ideodynamic', coined by Ernest Rossi (Rossi & Cheek, 1988), will be used to denote these forms of therapy.

Ideodynamic practitioners take it that 'right-hemisphere', primary process mentation in contrast with left-hemisphere, secondary process thinking, is essentially cooperative and health-minded, and uses sophisticated psychological systems capable of accessing, evaluating, manipulating and protecting the organism. Furthermore, they assume that these 'right-hemisphere' processes are centrally important in the formation, maintenance and relief of phobia. The theoretical underpinnings for these perspectives derive from Milton Erickson's model of hypnotherapy (see Erickson & Rossi, 1979); Freud's concepts of 'unconscious ego' (Freud, 1962, 1966), 'defence mechanisms' (Freud, 1960), and the 'censor' (Freud, 1912, 1915); Ernest Hilgard's (1977) neodissociation theory of consciousness; and recent theorizing about unconscious cognition (e.g. Shevrin & Dickman, 1980; Bowers & Meichenbaum, 1984; Kihlstrom, 1987).

Fundamental to 'ideodynamic' procedures is the use of 'ideomotor signalling'. This, it is assumed, allows interactive communication between the therapist and both the 'right-' and 'left-hemisphere' functioning of the client to enable the location of memories and to produce other 'hypnotic' behaviours (Lecron, 1954, 1963; Erickson, 1961; Cheek & Lecron, 1968; Hilgard, 1973, 1979; Hilgard, Morgan & McDonald, 1975; Erickson & Rossi, 1979). So ideodynamic therapists typically create a 'set' that encourages an interpretation of hypnotic occurrences in predominantly automatic and non-conscious terms also, as ideomotor signalling is apparently easy to achieve, ideodynamic therapists claim that memory location and reformulation techniques are potentially widely applicable (e.g. Barnett, 1981). Some ideodynamic therapists assume that memories of events can be located and reformulated without either the need for a 'reliving' of associated affect or the content of memories being made public (see Erickson & Rossi, 1979; Barnett, 1981). So non-cathartic imagery reformulation has been achieved using 'dissociated viewing' procedures (see Fromm, 1968; Mariner, 1969; Bandler & Grinder, 1979).

The present study aimed to test the clinical efficacy of ideodynamic hypnotherapy in a first controlled investigation. The therapy used features from both Barnett's (1981) analytical hypnotherapy and Bandler and Grinder's (1979) dissociated viewing model of phobia treatment combined into an integrated ideodynamic procedure. It was assumed, given clinical evidence, that this would provide a potentially thorough, rapid and non-cathartic memory reformulating therapy applicable to simple phobia disorder (see the *Diagnostic and Statistical Manual of Mental Disorders, DSM-III-R*, of the American Psychiatric Association, 1987).

In the therapy procedure, ideomotor signals were used to monitor the location of and then review the alteration of a series of symptom-related memories. So if subjects signalled that a memory they had located was personally appropriate for processing 'visually' then this was done using an adaptation of the dissociated viewing procedure of Bandler and Grinder (1979). If a subject signalled a preference for non-visual processing then a form of Barnett's (1981) 'unconscious ego-state' therapy was employed. Thus control of abreaction and intense affect was attempted. Cognitive insight, talking through, and awareness of memory content were not encouraged.

It was predicted that, compared to controls, a treatment group would indicate significant improvements on indices of phobic fear, avoidance, interference and symptoms. A test-intervention-re-test-follow-up design was employed.

## METHOD

*Subjects*

Subjects of the study were 19 phobic individuals, four men and 15 women, with a mean age of 38.4 (s.d. = 11.50) years in the range 20 to 61 years. They were from an initial sample of 62 applicants who responded to media items offering possible treatment for phobias and who from their responses on the Anxiety Disorders Interview Schedule (ADIS-R) (DiNardo & Barlow, 1988) and the Symptom Distress Checklist-90 (SCL-90) (Derogatis, Lipman & Covi, 1973) met the DSM-III-R criteria for an axis 1 diagnosis of simple phobia disorder. They were also individuals from the initial larger sample who were without signs of major depression and who had not experienced mania, bipolar disorder or psychotic disorders. Individuals not selected for the study were referred elsewhere. The majority of the sample (14 - 73%) was employed full-time, three (16%) were employed part-time and the other two (11%) were tertiary university students. Most subjects (84%) were educated beyond High School Certificate level. Subjects were responsive to a range of phobic stimuli: insects, dogs, enclosed spaces, deep water, heights, storms, loud noises, and blood/injury. Only one subject had a single simple phobia, the majority (95%) had at least one discrete phobia other than a primary phobia. Primary phobias had persisted for a mean of 24.70 (s.d. = 16.57) years in the range 2-56 years. The mean duration of secondaries was 27.60 (s.d. = 15.30) years in the range 14-56 years. Over half of the sample (58%) had sought previous treatment for their fears. None of the sample reported freedom from phobia symptoms since these had been first noticed.

Fifteen subjects were tested on the Stanford Hypnotic Clinical Scale for Adults (SHCS-A) (Morgan & Hilgard, 1978-79). Of these subjects three (20%) scored in the low (0-1), nine (60%) scored in the medium (2-3), and three (20%) scored in the high (4-5) ranges of hypnotic responsiveness.

*Treatment\**

A therapy session comprised a recycling standardized sequence of steps leading to two possible memory reformulating treatment strategies. Progress throughout was monitored via ideomotor signalling. The steps were:

1. Hypnotic induction.
2. Establishment of ideomotor signals described to clients as a means of communicating with the 'inner unconscious mind'.
3. Beyond the first therapy session, a review of work done in previous sessions.
4. Gaining signalled permission from clients to work on their problem and for the 'inner mind' to review relevant memories.
5. Location of the 'earliest critical event' by the 'inner mind'.
6. Review of the located memory by the 'inner mind'.
7. Establishing age at the occurrence of the 'critical' event.
8. Ideomotor signalling indicating suitability of a visual imagoic processing of the event.

If visual processing was chosen, the dissociated viewing procedure (step 9A) was used next, otherwise the ego-state procedure (step 9B) was employed.

\*A copy of the actual therapy script may be obtained from Wayne Somerville (address at end of paper).

The dissociated viewing procedure (9A) involved the delivery of hypnotic suggestions to: (a) obtain a stationary dissociated image of the event located and reviewed at (5), (6) and (7) above; (b) have a 'moving' dissociated viewing of the event; (c) be comfortable and to calm the self-image; (d) ratify the comfort of the dissociated image; and (e) re-associate the self-images.

The ego-state procedure (9B) involved the delivery of hypnotic suggestions about: (a) confirmation by the 'adult inner unconscious mind' of understandings obtained at (6) above; (b) transfer of adult 'wisdom and knowledge' to the younger ego-state; (c) assessment of 'younger ego-state's' need to maintain the old feelings; (d) encouraging the adult ego-states to develop means to enable the younger ego-state to 'let go of the old tensions'; (e) requesting the younger ego-state to 'let go of the tensions'; and (f) testing to confirm that there has been relief from the old feelings.

Before arousal from hypnosis there were two further steps in the standardized treatment; the first, step 10, involved suggestions for a further review by the inner mind to uncover critical events beyond those already uncovered at step 5. If more events were uncovered these were processed employing the techniques described in 5 through 9 above. The next step, number 11; involved an extra check of current 'comfort'. Finally, at step 12, which occurred immediately before arousal from hypnosis, subjects were given a suggestion 'permitting' posthypnotic amnesia.

#### *Procedure*

Before treatment, all subjects completed (1) the Fear Survey Schedule (Wolpe, 1973), to provide pre-treatment assessment of level of fear associated with phobias, and (2) the Bett's Questionnaire on Mental Imagery (QMI) (Sheehan, 1967) to assess individual differences in capacity for imagery.

Following the pre-test session there was an orientation session. Here there was discussion about the misconceptions and fears often associated with hypnosis: phobia was 'reframed' as a well-intentioned protective behaviour; subjects were told that they would not be required to discuss experiences during the therapy which would occur later; subjects were given an audio-recorded relaxation exercise for home practice; subjects were told that further treatment or referral would be available if needed; subjects completed the ADIS-R interview for comparison with post-treatment assessments of phobic fear, avoidance, symptom severity, and life interference exerted by phobia.

At this point the 19 subjects were randomly allocated to either a treatment ( $n = 10$ ) or a waiting control ( $n = 9$ ) group. Therapy for subjects of the treatment group commenced on the week following their orientation sessions. Following therapy sessions subjects completed an 11-point hypnotic depth scale (end points 0 = no hypnosis and 10 = extremely deep hypnosis) and an 11-point 'maximum discomfort during the session' scale (0 = completely relaxed and comfortable to 10 = extremely tense and uncomfortable). These instruments collected estimates of hypnotic depth and maximum discomfort during the session.

Each subject received at least two sessions of therapy, or a maximum of three sessions if signalling indicated the presence of further unresolved memories after two sessions.

Follow-up data for the treatment group were obtained at 2, 4, 10, 16 and 20 weeks following their last treatment session. Follow-up data were also obtained from the waiting control group at 2, 4 and 10 weeks following their orientation session. At weeks 2 and 4 for both groups, and at week 16 and 20 for the treatment group, subjects completed a mailed questionnaire version of the ADIS-R scales. At the 'in

person' week 10 follow-up, subjects completed the ADIS-R scales and the SHCS-A. At each follow-up subjects provided reports of the extent to which they had been exposed to phobic stimuli since the previous assessment.

Therapy for subjects in the waiting control group commenced immediately following the week 10 follow-up session. All treatment sessions were audio recorded.

RESULTS

With the exception of one subject from the control group, all other subjects reported encountering their phobic stimulus at least once during the data collection period. The majority (74%) of all subjects reported multiple encounters during the assessment period.

Variances in scores are substantially different between groups at assessment points beyond pre-test. Consequently, within-group one-sample *t*-tests were conducted to assess the significance of differences on the variables of primary and secondary phobic fear, avoidance of, and interference from primary phobic stimuli between: pre-test and post-test (2 weeks later); pre-test and follow-up (4 weeks later) and pre-test and follow-up (10 weeks later). Primary and secondary mean (s.d.) fear scores for the two groups of the study on the occasions mentioned above are shown in Table 1. Results from the test of significance of differences also described above are shown in the same table. As these results show, there is a steady significant decline from

Table 1. Mean scores on ADIS-R Scales of Primary Phobia Fear and Secondary Phobia Fear as a function of time and group.

Group	Primary Phobia Fear <sup>a</sup>				Secondary Phobia Fear			
	Pre-Post:	Time			Pre-Post:	Time		
		2 weeks	4 weeks	10 weeks		2 weeks	4 weeks	10 weeks
<i>Experimental</i>								
Mean	3.80	2.67	2.25	2.40	3.67	3.00	2.29	2.44
s.d.	0.42	1.12	1.04	1.17	0.50	0.58	0.76	0.88
<i>n</i> <sup>b</sup>	10	9	8	10	9	7	7	9
<i>r</i>	-	3.04	4.24	3.77	-	3.06	4.83	4.16
d.f.	-	8	7	9	-	6	6	8
<i>P</i>	-	< 0.05	< 0.005	< 0.005	-	< 0.05	< 0.005	< 0.005
<i>Control</i>								
Mean	4.00	3.75	3.60	3.33	3.67	3.38	2.80	2.89
s.d.	0.00	0.46	0.55	0.50	0.50	0.74	0.84	0.93
<i>n</i>	9	8	5	9	9	8	5	9
<i>t</i>	-	1.53	1.63	4.00	-	1.11	2.32	2.52
d.f.	-	7	4	8	-	7	4	8
<i>P</i>	-	NS	NS	< 0.005	-	NS	NS	< 0.05

Notes:

<sup>a</sup> Fear scale values: 0 = no fear, 1 = mild, 2 = moderate, 3 = severe, 4 = very severe. NS = not significant.

<sup>b</sup> There was a variability in *n*, for the 2-week post-therapy and 4-week follow-ups throughout the data due to the non-return of some mailed questionnaires.

<sup>c</sup> See results section for what *t*-tests were used.

pre-test to later expressions of both primary and secondary phobic fears in treatment subjects. By contrast, there are no significant differences from either primary or secondary pre-test fears until the 10-week follow-up in control subjects.

At 10 weeks follow-up, treatment subjects have significantly lower primary phobia fears than control subjects ( $t(18) = 2.35, P < 0.05$ ). The difference between secondary phobia fear levels of the two groups at the same time is not significant ( $t(17) = 0.70$ ) although treatment subjects have lower 10-week follow-up scores than control group subjects.

Mean ADIS-R Avoidance and Interference Scores at pre-test, post-test, at 4- and 10-week follow-up for treatment and control groups are shown in Table 2. Results from within groups tests of significance of differences between pre-test and post-test and pre-test and follow-up tests are shown in the same table. As results concerning avoidance show, there is a steady significant decline from pre-test to later tests in the primary phobic avoidance scores of subjects from the treatment group. By contrast there is no significant difference in these avoidance scores until week 10 in control subjects. At the 10-week follow-up treated subjects have significantly lower avoidance scores than control subjects ( $t(18) = 2.28, P < 0.05$ ). A similar pattern of differences between treatment and control subjects is also evident for interference scores. At the 10-week follow-up treated subjects have lower interference scores than control subjects. However, the difference between scores is not significant ( $t(18) = 1.04$ ).

The mean (s.d.) pre-treatment ADIS-R Symptom Severity Rating of subjects from the two groups are not significantly different ( $t(18) = 1.81$ ). The mean (s.d.) pre-treat-

Table 2. Mean scores on ADIS-R Scales of Primary Phobia Avoidance and Interference as a function of time and group.

Group	Primary Phobia Avoidance <sup>a</sup>				Primary Phobia Interference <sup>b</sup>			
	Pre-Post:	2 weeks	4 weeks	10 weeks	Pre-Post:	2 weeks	4 weeks	10 weeks
<i>Experimental</i>								
Mean	3.90	2.63	1.88	2.30	3.25	2.13	2.13	1.90
s.d.	0.32	1.30	1.64	1.49	1.17	1.46	1.36	1.45
n	10	8	8	10	8	8	8	10
t	-	2.77	3.49	3.39	-	2.18	2.35	2.95
d.f.	-	7	7	9	-	7	7	9
P	-	< 0.05	= 0.01	< 0.01	-	NS	= 0.05	< 0.05
<i>Control</i>								
Mean	4.00	3.63	3.67	3.44	3.00	3.00	3.00	2.56
s.d.	0.00	0.52	0.52	0.53	0.71	1.00	1.10	1.33
n	9	8	6	9	9	7	6	9
t	-	2.05	1.58	3.16	-	0.00	0.00	1.00
d.f.	-	7	5	8	-	6	5	8
P	-	NS	NS	< 0.05	-	NS	NS	NS

Notes:

<sup>a</sup> Scale values were: 0 = never avoid, 1 = rarely avoid, 2 = sometimes avoid, 3 = often avoid, 4 = always avoid. NS = not significant.

<sup>b</sup> Scale values were: 0 = no interference, 4 = severe interference.

Table 3. Mean Symptom Severity Rating (ADIS-R) by time and group.

Group	Time					
	Pre-therapy			10-week post-therapy		
	<i>n</i>	<i>X</i>	s.d.	<i>n</i>	<i>X</i>	s.d.
Mean Symptom Severity Rating (ADIS-R)						
Experimental	10	1.86	0.69	10	1.17	0.75
Control	9	1.28	0.74	9	1.10	0.61

ment rating with the 10-week follow-up severity rating for the two groups are shown in Table 3. These results represent mean severity change scores of 0.69 for treatment subjects and 0.18 for control subjects. Changes in symptom severity are significantly higher for treatment subjects ( $t(18) = 2.13, P < 0.05$  and  $t(18) = 0.04, P = 0.69$  respectively).

In terms of DSM-III-R criteria, mild or moderate fear is not rated as phobic. Scores on the ADIS-R Scale of Primary Phobic Fear categorizes fear as: absent, mild, moderate, severe or very severe. In terms of their pre-test ADIS-R scores, subjects from this study were either severely or very severely fearful – all were clearly phobic. At the week 10 follow-up changes in the ADIS-R fear scores of control subjects represented a movement of six subjects from the very severe fear to the severe fear category and non-movement of the remaining three subjects from a very severe rating – all control subjects remained phobic. By contrast, at 2-, 4- and 10-week follow-ups changes in the ADIS-R scores of treatment subjects represented a movement of five subjects from the very severe or severe fear categories to the mild or moderate fear categories and movements of the other five subjects within the severe or very severe categories: 50% of treatment subjects became non-phobic by 2-week follow-up and these same subjects maintained this status through to the 10-week follow-up. Further

Table 4. Pearson Correlations between the difference scores on fear ratings pre-therapy to 10-week follow-up and other variables.

Variable	<i>r</i>	<i>n</i>	<i>P</i>
SHCS – Total score	-0.28	8	0.25
Session 1 – hypnotic depth	0.36	10	0.16
Session 2 – hypnotic depth	0.47	9	0.10
QMI – total	0.35	10	0.16
Time with primary phobia <sup>a</sup>	-0.58	10	0.04
No. of memories processed <sup>b</sup>	0.82	10	0.002
Maximum discomfort – session 2 <sup>c</sup>	-0.44	10	0.10

<sup>a</sup> Time duration of the primary phobia for the five changed subjects was  $X = 16.2$  years (s.d. = 14.0), and for the unchanged subjects,  $X = 31.8$  (s.d. = 19.0).

<sup>b</sup> Number of memories located and processed to resolution during two sessions of therapy. The total number of memories thus processed for treatment subjects was 35. Of these 24 (69%) used the dissociated viewing, and 11 (31%) used the ego-state procedure.

<sup>c</sup> Scale end-points were 0 = completely relaxed/very comfortable, and 10 = extremely tense and anxious. The mean maximal discomfort rating for session 1 was 5.3 (s.d. = 2.9,  $n = 10$ ), for session 2 the mean was 3.3 (s.d. = 3.1,  $n = 10$ ).

follow-ups at 16 and 20 weeks indicated that the relief from phobia for these subjects had been unbroken and was continuing.

Treated subjects' assessments of hypnotizability, their trance depths during treatments and their scores on other therapy process variables (Table 4) were correlated with outcome (level of change in fear to primary phobic stimuli from pre-test to 10-week follow-up). Correlations between outcome and measures of these kinds are included in Table 4 only when the correlation exceeded the level of 0.25. Given the sample size, only correlations:  $> 0.57$  were significant at  $P < 0.05$ ;  $> 0.66$  were significant at  $P < 0.02$  and  $> 0.71$  were significant at  $P < 0.01$ .

## DISCUSSION

There was a significant decrease in fears of phobic stimuli among control subjects over a 10-week period. However, in terms of DSM-III-R none of the subjects from the control group 'lost' his or her phobia. On the other hand, there was a very rapid decrease in fears of phobic stimuli among half of the treatment subjects which was maintained by these subjects without relapse for at least 20 weeks after treatment. In terms of DSM-III-R, half of the treatment group became non-phobic within two weeks. All subjects were encouraged to learn 'relaxation' and during the orientation session heard suggestions aimed at 'reframing' their phobic symptoms. The small but significant reduction in fear control subjects may therefore have resulted from their enhanced capacity for relaxation and/or 'cognitive restructuring' of their phobic symptoms. It is possible that these factors also promoted small changes in fear for some of the treatment sample. However, given the rapidity of the fear reduction reported by 50% of the treatment sample, over all control subjects, it seems reasonable to assume that their substantially enhanced fear reduction resulted in the main from some component of the hypnotherapy context. With the 50% of individuals where treatment was successful, phobias disappeared rapidly; often after the first session of therapy. Analysis of material from recorded treatment sessions indicated that this occurred without prolonged imaginative exposure to phobic stimuli, without discussion of the content of memories, and without declarations about obtaining 'insight'.

An interesting example among others was of a male subject who ran a delivery service and who had suffered from an intense phobia of heights for 30 years. This subject was his family's only survivor of the Nazi Holocaust and after the war prior to the development of the height phobia had suffered from a profound fear of death. Before his second treatment session the subject reported that his phobia had 'gone'. In describing the absence of his fear reaction he talked about 'finding' himself 'standing and quietly appreciating the view' from a window on the twelfth floor of a building where he made regular deliveries. Previously he had needed to 'look away and squeeze up against the opposite wall' to get past this window. Over the months this subject 'experimented' with heights and reported a number of accounts of freedom from fear, for example, when peering over the edge of a Blue Mountains look-out. On the basis of the experimenter's observations, subject's depth estimates and responses to the SHCS-A (in which he responded successfully only to the ideomotor item) this subject was minimally hypnotizable. Furthermore, ideomotor signals were initially difficult to establish although he was clearly cooperative and motivated. He chose the non-imagoc procedure for all treatment cycles and spontaneously commented on a total absence of imagoic experience, unpleasant affect or insight during his therapy. This case offers evidence that a memory reformulation

approach is possible with minimally hypnotizable subjects, in the apparent absence of imagoic experience, 'desensitization', catharsis, unpleasant affect, talking through or 'insight'.

As noted above, half of the treatment sample was in effect cured of their phobias. Some of the other half of the treatment sample, like controls, had small but significant reductions in fears. There was a positive correlation between changes in phobic fear and capacity for mental imagery which suggests that this may be one relevant variable in predicting response to memory reformulating therapy. A case by case review pointed to other factors that may account for the differential success of the therapy among treated subjects. One subject during the SHCS dream item, collected 10 weeks after therapy, emotionally relived a previously forgotten autobiographical memory that was apparently related to her phobia. So she and other subjects who did not 'lose' their phobias may have done so if the number of therapy sessions offering the chance to 'discover' problematic memories had not been restricted. Perhaps more likely, additional 'memory reformulation' for many subjects would not lead to symptom relief. In these cases there were hints that other procedures, for example systemic family therapy, education regarding hyperventilation and panic, 'ego-strengthening', or in vivo exposure, may have been required.

There was a negative correlation between changes in fear and hypnotic responsiveness. So, a successful therapeutic outcome was obviously not limited to highly hypnotizable subjects. Hypnotizability was assessed in a careful and standardized manner but because of the possible effects on subjects' responses to the therapy caused by their attention to the SHCS-A items (in particular the age-regression and dream items) hypnotizability testing was conducted 10 weeks following therapy. This meant that subjects had a substantial experience of hypnotherapy at assessment. Furthermore, at the time of assessment subjects were aware of the outcome of therapy and of the kinds of memories located during therapy. Consequently, their attitudes to testing would have been influenced in complex ways *vis-à-vis* hypnotic responsiveness and outcome. A positive association was found between subjects' estimates of the hypnotic depth they had achieved during treatment sessions and the extent to which they had changes in phobic fear following treatments. It may be that depth estimates assess levels of hypnotizedness achieved during hypnosis (Perry & Laurence, 1980; Jupp, Collins, McCabe & Walker, 1986) and it has been suggested that an association between level of hypnotizedness achieved during treatment and outcome rather than an association between degree of hypnotizability possible during therapy and outcome, taps an hypnotic effect (Spiegel & Spiegel, 1978).

There was a significant negative association between reduced fear following treatment and duration of phobic fear. This result, that less, rather than more entrenched symptoms are more easily treated, is a fairly common clinical finding.

All therapy sessions were of equal duration and, as the inductions were standardized, all subjects had an approximately equal opportunity to engage in memory reformulations. However, there were individual differences in the number of memories located and a strong significant association was found between reduced fear and the number of these critical memories that were dealt with. This result suggests that the therapeutic effect may have derived either from factors specific to the therapy cycle or from differing levels of motivation among subjects to undertake the necessary 'work'.

Maximum discomfort experienced during session two of treatment was negatively correlated with relief from phobic fears. This relationship may again reflect the influence of unresolved problematic memories on subjects who had not achieved relief

by that time. It is clearly consistent with relief not being associated with painful abreaction. There were instances of 'emotional' reactions associated with non-hedonic memories and subjects sometimes shed a few tears. However, during the 44 hypnotherapy sessions with the 19 subjects of this study, there was only one overt abreactive incident, which was resolved quickly employing the dissociated viewing procedure described earlier.

The therapy permitted a pervading privacy through the options of non-imaginative processing of recalled material (which was used by a substantial minority of subjects) and conscious withholding of the content of memories from the therapist (which was employed to a large extent by all subjects). Their reports indicated that this 'privacy' was seen as attractive by both successfully and unsuccessfully treated subjects. Taken with other results mentioned above these process findings suggest that the treatment studied stood up quite well against other brief but highly stressful exposure treatments for phobia currently in use (e.g. Ost, 1989).

As the subjects treated in this investigation were simple phobics who volunteered for, rather than sought treatment, they cannot be taken as representative of patients who ordinarily seek psychotherapy. However, the therapy applied was effective, against controls, for 50% of the sample. Further, when therapy was successful it proved to be so very quickly and without apparent prolonged stress to subjects. The therapy was delivered in an hypnotic context and subjects who experienced more relief from fears tended to report that they were more hypnotized than others during treatment. So it may be that there is an hypnotic effect in the treatment. Alternatively, it may be that the more 'successful' subjects achieved a rapid relief of tensions and could therefore enter more freely and deeply into an hypnosis experience.

Further research needs to address the complex question as to what are the necessary and sufficient features of this procedure in producing therapeutic change. Unsolicited comments by subjects about their experience during treatment suggested that some of them were surprised by the 'involuntary' nature of their ideomotor signalling while others said that signalling was under their voluntary control. Some expressed surprise at the nature of the memories that came to them 'suddenly' during therapy. Some memories were of traumatic childhood experiences that were unexpected and considered to have 'nothing to do with my phobia'.

Future investigations of the procedure studied here might be of the subjective experiences of subjects during all its stages. A consideration of how these experiences relate to outcome may uncover why the approach works for some and not for others.

## REFERENCES

- American Psychiatric Association (1987). *Diagnostic and Statistical Manual of Mental Disorders*. 3rd edn revised. Washington, DC: American Psychiatric Association.
- Baker, S.R. & Boaz, D. (1983). The partial reformation of a traumatic memory of a dental phobia during trance: A case study. *International Journal of Clinical and Experimental Hypnosis* 31, 14-18.
- Bandler, R. & Grinder, J. (1979). *Frogs into Princes, NLP*. Moab, Utah: Real People Press.
- Barnett, E.A. (1981). *Analytical Hypnotherapy: Principles and Practices*. Kingston, Ontario: Junica Publishing.
- Bowers, K.S. & Meichenbaum, D. (Eds) (1984). *The Unconscious Reconsidered*. New York: Wiley.
- Brown, D.P. & Fromm, E. (1986). *Hypnotherapy and Hypnoanalysis*. Hillsdale, NJ: Lawrence Erlbaum.
- Cheek, D.B. & Lecron, L.M. (1968). *Clinical Hypnotherapy*. New York: Grune & Stratton.
- Derogatis, L.R., Lipman, R.S. & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale - Preliminary Report. *Psychopharmacology Bulletin* 9(1), 13.

- DiNardo, P.A. & Barlow, D.M. (1988). *Anxiety Disorders Interview Schedule – Revised (ADIS-R)*. Albany: State University of New York.
- Domangue, B.B. (1985). Hypnotic regression and reframing in the treatment of insect phobias. *American Journal of Psychotherapy* **39**, 206–214.
- Erickson, M.H. (1961). Historical note on hand levitation and other ideomotor techniques. *American Journal of Clinical Hypnosis* **3**, 196–199.
- Erickson, M.H. & Rossi, E.L. (1979). *Hypnotherapy: An Exploratory Casebook*. New York: Irvington Publ.
- Freud, S. (1912). *A Note on the Unconscious in Psychoanalysis*, James Strachey (Trans., Ed.), The Standard Edition of the Complete Psychological Works of Sigmund Freud, 12, 260. London: Hogarth.
- Freud, S. (1915). *The Unconscious*, James Strachey (Trans., Ed.), The Standard Edition of the Complete Psychological Works of Sigmund Freud, 14, 166. London: Hogarth.
- Freud, S. (1960). *Inhibitions, Symptoms and Anxiety* (originally published 1926), James Strachey (Trans., Ed.), The Standard Edition of the Complete Psychological Works of Sigmund Freud, p. 77. London: Hogarth.
- Freud, S. (1962). *The Ego and the Id* (originally published 1923), James Strachey (Trans., Ed.), The Standard Edition of the Complete Psychological Works of Sigmund Freud, p. 12. London: Hogarth.
- Freud, S. (1966). *New Introductory Lectures on Psychoanalysis. Lecture 31: The Dissection of the Psychological Personality* (originally published 1933), James Strachey (Trans., Ed.), The Standard Edition of the Complete Psychological Works of Sigmund Freud, p. 57. London: Hogarth.
- Fromm, E. (1968). Dissociative and integrative processes in hypnoanalysis. *American Journal of Clinical Hypnosis* **10**, 174–177.
- Grinder, J. & Bandler, R. (1981). *Transformations: Neuro-Linguistic Programming and the Structure of Hypnosis*. Moab, Utah: Real People Press.
- Gruenewald, D. (1971). Agoraphobia: A case study in hypnosis. *International Journal of Clinical and Experimental Hypnosis* **19**, 10–20.
- Hilgard, E.R. (1973). A neodissociation interpretation of pain reduction in hypnosis. *Psychological Review* **80**, 396–411.
- Hilgard, E.R. (1977). *Divided Consciousness: Multiple Controls in Human Thought and Action*. New York: Wiley.
- Hilgard, E.R. (1979). Divided consciousness in hypnosis: The implications of the hidden observer. In: E. Fromm and R.E. Shor (Eds), *Hypnosis: Developments in Research and New Perspectives*. New York: Aldine.
- Hilgard, E.R., Morgan, A.H. & Macdonald, H. (1975). Pain and dissociation in the cold pressor test: A study of hypnotic analgesia with 'hidden reports' through automatic key pressing and automatic talking. *Journal of Abnormal Psychology* **84**, 280–289.
- Jupp, J.J., Collins, J.K., McCabe, Marita P. & Walker, W.L. (1986). Hypnotic susceptibility and depth: Predictors of outcome in a weight control therapy. *Australian Journal of Clinical and Experimental Hypnosis* **14**(1), 31–40.
- Kihlstrom, J.F. (1987). The cognitive unconscious. *Science* **237**, 1445–1452.
- Lamb, C.S. (1985). Hypnotically-induced deconditioning: Reconstruction of memories in the treatment of phobias. *American Journal of Clinical Hypnosis* **28**, 56–62.
- Lecron, L.M. (1954). A hypnotic technique for uncovering unconscious material. *International Journal of Clinical and Experimental Hypnosis* **1**, 76–79.
- Lecron, L.M. (1963). The uncovering of early memories by ideomotor responses to questioning. *International Journal of Clinical and Experimental Hypnosis* **11**, 137–142.
- Mariner, A.S. (1969). Resolving an impasse in systemic desentization. *Psychotherapy: Theory, Research, and Practice* **6**, 119.
- Morgan, A.H. & Hilgard, J.R. (1978/79). The Stanford Hypnotic Clinical Scale for Adults. *American Journal of Clinical Hypnosis* **21**, 134–147.
- Ost, L.-G. (1989). One-session treatment for specific phobias. *Behaviour Research and Therapy* **27**(1), 1–7.
- Perry, C. & Laurence J.R. (1980). Hypnotic depth and susceptibility: A replicated finding. *International Journal of Clinical and Experimental Hypnosis* **28**, 272–279.
- Rossi, E.L. (1986). *The Psychobiology of Mind-Body Healing: New Concepts of Therapeutic Hypnosis*. New York: Norton and Co.

- Rossi, E.L. & Cheek, D.B. (1988). *Mind-Body Therapy: Methods of Ideodynamic Healing in Hypnosis*. New York: Norton and Co.
- Rubin, D.C. (Ed.) (1986). *Autobiographical Memory*. Cambridge, England: Cambridge University Press.
- Sheehan, P.W. (1967). A shortened form of Bett's Questionnaire on Mental Imagery. *Journal of Clinical Psychology* 23, 386-389.
- Shevrin, H. & Dickman, S. (1980). The psychological unconscious: A necessary assumption for all psychological theory? *American Psychologist* 35(5), 421-434.
- Spiegel, H. & Spiegel, D. (1978). *Trance and Treatment: Clinical uses of Hypnosis*. New York: Basic Books.
- Van Dyke, P. & Harris, R. (1982). Phobia: A case report. *American Journal of Clinical Hypnosis* 24(4), 284-287.
- Wolpe, J. (1973). *The Practice of Behaviour Therapy*, 2nd edn. Elmsford, New York: Pergamon.

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