

Hartland's Legacy (I): The Ego-Strengthening Procedure

Lindsay B. Yeates, Ph.D.,¹

School of Humanities & Languages, University of New South Wales

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Abstract

Hartland's powerful and efficacious "Ego-Strengthening Procedure" is examined. Designed to facilitate subsequent symptom-removal by direct hypnotic suggestion, and centred on a therapeutic monologue derived from the work of Émile Coué, its 1965 publication also positioned the term "ego-strengthening". Hartland published improved versions of his monologue in 1967 and 1971. Worldwide hypnotherapeutic practice benefitted greatly from this new, different, and easy to follow approach; especially in terms of developing strong therapist expectation of positive outcomes in otherwise ambiguous or poorly defined clinical circumstances. Clear, detailed descriptions in Hartland's textbooks encouraged many less-than-well-trained therapists to experiment with hypnotherapeutic interventions for the first time; and others with some experience, to apply hypnotism to a much wider range of subjects, social circumstances and clinical conditions. The benefit of Hartland's approach is discussed, and his emphatic, but oft-ignored instruction, that his "ego-strengthening" monologue must never be applied with its precise published wording, is strongly emphasized.

KEY WORDS: direct suggestion, ego strengthening, hypnotherapy, hypnotherapy scripts, hypnotic suggestion, symptom-removal

NOTE

Despite the author's numerous requests, this paper was published (in December 2014) without him being given any opportunity to check/correct/amend the journal's typesetting proofs of his original manuscript.

As a consequence, the journal's published version has (a) several unfortunate typographical errors, and (b) a number of rather misleading formatting mistakes, particularly in relation to quotations from the works of others. All of these errors/mistakes have been rectified in what follows.

Otherwise, the paper's content remains unchanged.

¹ **Biography:** Lindsay B. Yeates, Ph.D., F.A.S.C.H., F.A.H.A., practised as a specialist clinical hypnotherapist for more than forty years. He is currently a research assistant in the School of Humanities & Languages at the University of New South Wales, and the Editorial Assistant at the *Australasian Journal of Philosophy*.

The stream of derivative approaches still emerging fifty years later attest to the fact that the 1965 publication of Hartland's "Ego-Strengthening Procedure" (and its constituent monologue) was a watershed event (Yeates, 2000). The procedure's first version was published in 1965 (reprinted in 1966). A second version was published in 1967. The third, final version was revealed in a 1970 lecture (1971c) and, with minor variations (for British readers), was reprinted in his textbook's second edition (1971b) and two posthumous editions (Waxman, 1989; Heap and Aravind, 2001).

Of equal significance, Hartland's 1965 article positioned the "ego-strengthening" concept (Trout, 1969). Whilst Hartland didn't invent the concept, he did name it. Ever since then, the concept could be unequivocally named, identified, investigated, productively discussed, and generally understood by all concerned.

Although Hartland later discovered that his "ego-strengthening procedure" could successfully address a wide range of circumstances as *the sole form of therapy*, its original goal was to (pre-therapeutically) strengthen subjects' inner resources so that subsequent *symptom-removal* therapy would generate the sorts of improvements identified by Barron (1953a, p.235):

(a) The patient feels better, is more comfortable, takes more interest in life, and the like; (b) important interpersonal relations are straightened out a bit; (c) physical symptoms have been relieved or cured; (d) important health-tending decisions have been made; [and] (e) there has been an increase in insightful remarks and behavior.

From his *symptom-removal* orientation, Hartland concentrated on eliminating counter-productive conditions (e.g., "worry"); yet, despite Hartland's positive goals, the monologue's final verbal form was very negative (see Yeates, 2002). Modern "ego-strengthening" interventions "aim at suppressing feelings of demoralization or discouragement, at stimulating hope of improvement and finally at supporting efforts to make further progress" (van Dyck and Spinhoven, 1994, p.149); and, today, one can still strongly support Hartland's principles and admire his procedure — especially, its monologue — whilst, simultaneously, being greatly dismayed at their instantiation (see Yeates, 2014).

John Hartland

John Heywood Hartland (1901-1977), B.Sc. (Birmingham, 1921), M.B. Ch.B. (Birmingham, 1925), M.R.C.S. (England, 1925), L.R.C.P. (London, 1925), a G.P. and, later, consultant psychiatrist, served as Vice-President of the British Society for Medical and Dental Hypnosis, and as editor of the *British Journal of Clinical Hypnosis*.

For most of the twentieth-century hypnotism was greatly misunderstood and misapplied. Its clinical applications were actively ignored; and, for many, hypnotism was far from respectable, regardless of whether delivered by a medical practitioner, or not (Upshaw, 2006). Hartland was both medical practitioner and psychiatrist (making him, in a manner of speaking, doubly legitimate); and his ideas and practices were disseminated worldwide. He gave countless lectures, demonstrations, and seminars throughout the U.K. (Hartland, 1968) – and, once retired, in France, Sweden, Australia (Hartland, 1974), Singapore, and U.S.A. – to encourage G.P.s to apply hypnotism to a wide range of clinical conditions, regardless of their familiarity with hypnotic theories and practices (Hartland, 1966, pp.xiv-xv):

It is seldom realized what a wide and varied field can be covered by [hypnotic intervention] in general practice. Many of the common conditions that are regularly seen in the practitioner's surgery can be successfully treated by this method. These include bad habits in children such as nail-biting, thumb-sucking, bed-wetting and tics; complaints such as asthma, migraine, constipation, insomnia and dysmenorrhoea; and certain disorders of the skin such as warts and neurodermatoses, to name but a few. Most of these are particularly responsive to hypnotic suggestion, since the symptoms are often distressing to the patient whilst having no great protective value in themselves. [Hypnotic intervention] can also be invaluable in allaying fears, removing anxiety and producing both mental and physical relaxation. It can sometimes be used for the relief of pain in minor surgical procedures, but rarely can it be employed to secure complete anaesthesia for major surgical operations. But in obstetrics, with which the general practitioner is usually much concerned, it can frequently succeed in reducing the pain, apprehension and even the duration of the average confinement. Its scope can also include many of the milder yet obstinate psychosomatic symptoms and illnesses, so that its application in general practice is much more extensive than might have been imagined.

In 1966, based on more than thirty years' experience, "the first ten in general practice and the last twenty in psychiatric practice" (1971c, p.2), Hartland's *Medical*

and Dental Hypnosis and its Clinical Applications (1966; 1971b) was published: “probably the most authoritative British work on hypnosis” (D.T.B. & S.N.T., 1978). Although it may be risky (even unfair) to use today's understanding to appraise his contributions, it's important to re-visit Hartland, and examine what he actually did, why and how he did it, and just how relevant those things are today.

“Symptom-Removal”

U.S. psychiatrist Lewis Wolberg was a strong advocate of hypnotism for *symptom-removal*: an approach derived from the (c.1880) work of Liébeault and Bernheim. Liébeault's treatment “consisted essentially in directing the [hypnotized] invalid's attention on the part affected, and suggesting an amelioration or disappearance of the morbid condition and symptoms” (Tuckey, 1891, pp.43-4). Émile Coué, who studied extensively with Liébeault and Bernheim in the mid-1880s, developed his own, analogous, self-administered treatment c.1910 (1922b):

Every time in the course of the day or night that you feel any distress physical or mental, immediately *affirm to yourself* that you will not consciously contribute to it, and that you are going to make it disappear; then isolate yourself as much as possible, shut your eyes, and passing your hand over your forehead if it is something mental, or over the part which is painful, if it is something physical, repeat *extremely quickly*, moving your lips, the words: “It is going, it is going —”, etc., etc., as long as it may be necessary. With a little practice the physical or mental distress will have vanished in 20 to 25 seconds. Begin again whenever it is necessary.

By the time of his 1923 New York visit, Coué had established that the French, “*ça passe*”, was far more efficacious than the English, “*it is going*” — even for those who only spoke English.

Wolberg's interventions were strong and authoritarian: a dramatic induction procedure (to enhance therapist *prestige*), followed by direct (prestige) suggestions that the subject's symptoms would disappear upon de-hypnotizing (see Wolberg, 1948a; Meares, 1960; Slater and Flores, 1963; Clawson 1964; Weitzenhoffer, 2002, 2004; Ball, 2006, etc.). This approach was still widely used in the 1980s, especially by (hypnotically untrained) medical practitioners dabbling with hypnotism.

Hartland's Approach

Hartland was greatly influenced by Wolberg. Of symptom-removal, simple psychotherapy, and analytical psychotherapy, Hartland believed symptom-removal was the "most useful" strategy for a G.P. (1971b, p.194). Discussing its *pros* and *cons*, Hartland addressed three common objections; that (a) indiscriminate symptom-removal was dangerous; (b) it required very "deep" hypnosis, which was difficult to obtain; and (c) it only produced temporary relief (1966, p.189).

In 1971, Hartland (1971b, pp.195-196) expanded on his 1966 rebuttals, dismissing the first objection on the grounds that, the general principle, "the greater the need of the patient for the symptom as a defence mechanism, the more intractable it will prove to be to any method of psychotherapy", actually meant that even the most talented therapist, working with the most susceptible patient, would not attain the slightest success, because "patients of this type [are] unwilling to surrender their symptoms until they [feel] strong enough to do without them". He dismissed the second because very "deep" hypnosis was not required for the majority of cases a G.P. might treat, and the third on the grounds that, provided "measures are taken during the treatment to strengthen the patient's ability to cope with his difficulties and to encourage him to begin to stand on his own feet", the results were almost always permanent (p.196):

In all cases, direct symptom-removal will be most successful and such dangers entirely avoided if, at each and every session, it is preceded by a sequence of simple psychotherapeutic suggestions designed to remove tension, anxiety and apprehension, and to gradually restore the patient's confidence in himself and his ability to cope with his problems. (emphasis in original)

Apparent relapses "could always be attributed to some entirely new and unanticipated emotional disturbances, equally easy to deal with" (1971b, p.196). Whilst acknowledging (1966, p.189) that, "since symptom removal deals with effects rather than causes, it must necessarily possess certain limitations" and that, "[the] best results will always be obtained where the symptom has a minimal defensive value", Hartland argued that "little danger is likely to result from the simple removal of the offending symptom by direct hypnotic suggestion". Later (1971b, p.195), he produced a classic rebuttal analogy:

... in recent years the dangers of "direct symptom-removal" have been so grossly exaggerated that one wonders whether the adherents to this school of thought would be equally vociferous in demanding that no physician should prescribe aspirin for a headache without first seeing an angiogram ...

Reification of Metaphor

Before discussing "ego-strengthening", we must ask, "What is being strengthened?" This immediately raises the issue of *reification* (lit., 'thing-ification'), the mistaken belief that, "because there are certain words, there must necessarily be certain 'things' that correspond to them" (Caldwell, 1990, p.30); acting as if an abstract, metaphorical, or hypothetical concept — e.g., Berne's *parent*, *adult*, and *child*, Bradshaw's *inner child*, Freud's *id*, etc. — had a manifest objective reality, and earnestly searching for the substantial 'thing' that supposedly corresponded to the word(s).

From a purely rationalistic perspective [reification] is a cognitive/emotional act of children and other unsophisticated folk; in reality, it is one of the more seductive ways in which social scientists distort and misrepresent the status of many of their hypothetical entities and constructs. (Reber, 1985, pp.628-9)

"Ego-Strengthening"

Wolberg believed that *diminished* "ego strength" was inimical to therapeutic success (e.g., 1948a, pp.38-9):

[T]he chances of helping a person in a permanent sense are much greater where one ... permits the patient to develop ego strength and security within himself. In [this case], the person has the best chance of remaining symptom free even in the face of disturbing life situations and pressures. In symptomatic treatment, where no change has occurred in the ego strength, there is always the possibility of a relapse.

For Wolberg, *diminished* "ego strength" was precisely that: *impaired* (*less robust, less coherent, etc.*) in relation to what it was before; not compared with an average, or an ideal individual (Lake, 1985, p.474). Often the impairment was due to factors other than the treated condition: unassociated illness, surgical intervention, physical injury, previous psychotherapy, stressful life events (Holmes and Rahe, 1967), prescribed medication, recreational drugs, etc.

Given that those with stronger “egos” should respond better to the same treatments, Barron developed the *Barron Ego Strength Scale* (BESS) in 1953 to measure “ego strength”: an individual’s overall “adaptability” and “personal resourcefulness” (1953b, p.327) – a characteristic amenable to change, evident in variables such as “physiological stability and good health, a strong sense of reality, feelings of personal adequacy and vitality, permissive morality, lack of ethnic prejudice, emotional outgoingness and spontaneity, and intelligence” (p.333). Designed to predict who *might* benefit from verbal psychotherapy, the BESS also calibrated individual gains from psychotherapy – by comparing pre- and post-therapeutic ratings (1953a).

Although “ego strength” was universally accepted as a significant predictor of psychotherapeutic success (Kernberg, et al., 1972), there was widespread *disagreement* on the identity, description, and measurement of “ego strength” itself, due to the reluctance of conflicting theoretical positions to unequivocally define and clearly distinguish between often reified terms like “identity”, “self”, and “ego” (compounded by the oft-mistaken view that all uses of the term “ego” were more or less synonymous). There were substantial differences in the way different theoretical orientations applied the concept; e.g., many worked from the perspective of absence of “ego” *deficit*, rather than presence of “ego” *strength*.

“Ego strength” is not necessarily a homogeneous entity. Certain parts may be *strong* at the same time that others are *weak*. Because it depends on the relationship between various functions, its *strength* can be viewed from two perspectives: (a) the degree to which the functions continue to operate when placed under load; and (b) the degree to which impaired functions are restored to efficiency.

Lake suggested a simple solution: “presenting ego strength as personal and social competence” (p.473); and, whilst “competence” (“an overall measure of the ego’s ability to interact efficiently with the environment and to perform its adaptive tasks”) signified “sufficient strength to perform a task”, “strength” (“a measure of force”) “[did] not necessarily signify competence” (p.474). Lake identified nine competencies (pp.474-6) that could be objectively observed as present or absent; and, if present, could be “[qualitatively] measured in approximate terms of rank ordering, ranging from very much to very little” (p.477):

(1) The ability to look after essential needs for food and shelter and to be self-supporting ... (2) The capacity to establish and maintain mutually helpful and supportive relationships, at home, at work, and at leisure ... (3) The capacity to adapt and adjust to relationships which are, for the most part, difficult and upsetting at home, at work, or at leisure ... (4) The capacity to establish and maintain interesting, stimulating and enjoyable relationships at home, at work, or at leisure ... (5) The capacity to derive interest and satisfaction, from the performance of skills at work and leisure ... (6) The capacity to maintain a realistic sense of self-confidence and self-esteem ... (7) The capacity to cope adaptively with change, loss, and uncertainty (e.g., loss of family member, friends, jobs, money, change of routine, illness) ... (8) The capacity to express sexuality within a mutually satisfying and established relationship ... [and] (9) Level of achievements requiring intelligence.

Simple Psychotherapeutic Suggestions

In the 1960s, standard psychotherapy involved 20 to 22 sessions, for Wolberg's "short term psychotherapy" and Wolpe's "behavior therapy" (Barrios, 1970), respectively. Hartland's standard approach was 20 half-hour sessions, with 7-8 minutes of suggestions each hypnotherapy session (1971b, pp.xiv, 203). Because Hartland's interventions demanded a particular hypnotic "depth", he spent at least three of the first four sessions ensuring his patients were trained such that, later, they "[could] be induced deeply enough to enter the hypnotic state immediately it was suggested that they should do so" (p.xiv). Similarly, whilst he "frequently did brief therapy" (Hammond, 1984, p.242), Milton Erickson (who wrote the foreword to the first edition of Hartland's *Medical and Dental Hypnosis*) routinely engaged his own patients in "four to eight hours of initial induction training" before commencing treatment (Erickson, 1952); and, within each subsequent treatment session, "Erickson rarely [gave] therapeutic suggestions until the trance [had] developed for at least 20 minutes" (Erickson and Rossi, 1974, p.238). In 1957, Erickson stated that he had "seen patients for as long as 16 consecutive hours", taking no meal breaks ("I had the patient hallucinate his meals, but during that time I went hungry!") and, with others, depending on their condition, the frequency of his regular (2-4 hour) consultations ranged from "from once a month to [as many as] seven sessions per week" (Erickson and Rossi, 1981).

Hartland studied the “Curative Suggestion” monologue Coué used to prepare patients for self-administering his “*Every day, in every way, I’m getting better and better*” auto-suggestion (Coué, 1922a). From this, Hartland developed his own monologue. The monologue strengthened the patient’s “confidence” and “general ‘ego-defences’” (1971c, p.2); so, “for want of a better name”, Hartland called it an “ego-strengthening procedure” (1965, p.90). Over time, he continued polishing, “constantly changing the sequence and nature of the routine suggestions, omitting some, re-wording others, and including entirely new ones” (1971c, p.1), until it reached its final form in 1971.

It seems he had no access to Charles Baudouin’s Ph.D. dissertation (Baudouin, 1920): a detailed (18 month) eyewitness study and analysis of Coué’s work. For example, Hartland refers to three “laws that govern the effectiveness of suggestion” (1966, pp.36-7), rather than Baudouin’s four (1920, pp.114-18) – which were (a) “law of concentrated attention” (*loi de l’attention concentrée*), (b) “law of auxiliary emotion” (*loi de l’émotion auxiliaire*), (c) “law of reversed effort” (*loi de l’effort converti*), and (d) “law of subconscious teleology” (*loi de la finalité subconsciente*).

Making no mention of Baudouin’s “law of subconscious teleology”, “when the end has been suggested the subconscious finds a means for its realisation” (see Yeates, 2002), Hartland used sources such as Pierce (1924, p.131) and LeCron and Bordeaux (1947, p.85), speaking of (1966, p.37) the “law of reversed EFFECT” (viz., (c) above) and, again following LeCron and Bordeaux (1947, p.86), who had further adapted Pierce’s (1924, p.133) inappropriate label “law of dominant AFFECT” (viz., (b) above), speaking of a “law of dominant EFFECT” (1966, p.37): a title that could only mean *whatever it is that has the strongest effect, has the strongest effect* – Hartland later abandoned this meaningless title (1974, pp.28-9). Hartland’s work would have been greatly embellished by knowledge of Baudouin’s dissertation.

Consistent with the common-sense view that, “psychological and behavioral factors may adversely affect the course of medical conditions in almost every major disease category” (Stoudemire, 1995, p.187), Hartland’s interventions addressed two inter-connected issues: (a) emotions (anxiety, etc.) arising as a consequence of the illness; and (b) on-going defects of personality (lack of confidence, etc.) that could inhibit recovery (1965, p.190). Hartland felt his monologue, more or less unchanged

from case to case, would satisfactorily address both issues, enabling G.P.s "to deal successfully with the majority of cases without having to resort to the simplest form of analysis" (p.191), although, of course, it could be supplemented by suggestions (*in addition to, rather than instead of, his sequence*) to suit particular circumstances, whenever thought necessary (p.190).

Hartland's "ego-strengthening procedure" was (empirically) discovered to be just as efficacious as a prelude to hypno-analytical therapy – "not only was the average length of treatment substantially shortened, but the need for the more involved analytical techniques was also greatly reduced" (1971c, pp.1-2, 202) – as it was as a preliminary to direct symptom-removal (1971b, p.197):

[Using "ego-strengthening"] in every case that you treat under hypnosis before you proceed either with direct symptom-removal or hypnoanalysis as the main object of your therapy ... will pay handsome dividends. Not only will the patient obtain more rapid relief from his symptoms, but he will display obvious improvement in other ways. You will notice him becoming more self-reliant, more confident and more able to adjust to his environment, and thus much less prone to relapse. In fact, my own experience has led me to believe, and this has been confirmed by innumerable reports from professional colleagues, medical and dental both in this country and overseas, that this combination of ... *ego-strengthening* suggestions and symptom-removal will enable the general practitioner to deal successfully with the majority of his cases without having to resort to hypnoanalytical procedures.

It was also highly efficacious as a stand-alone therapy. Hartland spoke of a previously untreated man who "had been suffering from 'claustrophobia' for about 7 years and was quite incapable of remaining in confined spaces without developing acute attacks of panic and anxiety" who had moved into the top floor of an 8-storey block of flats (1965, p.92). Unable to use the lift, he consulted Hartland because he was forced "to climb the stairs several times a day, and this was making his life intolerable". Hartland tried hypno-analysis; but the "simpler methods of analytical investigation failed to produce any clues". Although he "was easily taught to enter the hypnotic state upon a given signal ... it proved impossible to deepen his hypnosis sufficiently to use the more involved hypno-analytical techniques". Hartland continues (1971b, p.204):

He attended for treatment once a week, and since mentioning his incapacity seemed to distress him greatly, no further reference was made either to "*claustrophobia*" or to the difficulty he was experiencing with the lift. I consequently continued with the "ego-strengthening" technique alone, and made no attempt whatever at direct symptom-removal. I hoped that he would eventually improve sufficiently to permit this, or that it would become possible to obtain the greater [hypnotic] depth necessary for further analysis. Certainly after a few weeks he became much calmer and less tense, and seemed to be gaining more confidence in himself. Nevertheless, I was both surprised and gratified when he attended for his eleventh session, looking extremely pleased with himself. Apparently, several days before, he was carrying home a load of timber with which he intended to make book-cases, and whilst passing the lift and faced with eight flights of stairs to climb, he suddenly felt that he might be able to overcome his fears sufficiently to try to use it. This he did, on the spur of the moment, and subsequently experienced no further difficulty whatever.

Similarly, from more than 25 years' hypno-analytical experience, Meares discovered that, "without specific suggestions, and without any of the spectacular insights [of hypno-analysis] ... patients [treated with deep hypnotism alone] were getting better before they really achieved insight about [their] psychopathology" (1971, p.675).

Hartland's Published Procedure

Hartland's 1965 paper introduced the convention of indicating pauses with "..."
("more alert ... more energetic", etc.). Unusual for that era, it also provided the text. Von Dedenroth (1964) described the prevailing practice as follows: "When written in regard to a *specific* problem, most discussions of hypnotic induction are not instructive, i.e., 'A trance-like state was induced and suggestions made that the patient stop smoking'" (p.330). For Hartland, the suggestive sequence was *the* critical feature, not the monologue's wording. He insisted that the text was a guide only, and must never be used as written (1971b, p.203):

It is certainly not intended that this [transcript] should be adopted in the precise form that has been described. It is the principle that is worthy of attention, and the sequence outlined should be regarded simply as a guide to the individual therapist in framing his own suggestions to conform with his own personality, method of approach and style of delivery. It is impossible to suggest here the varying

inflections of the voice, but the same cardinal rules of construction, stresses and pauses etc. should be used in order to maintain a rhythmical quality from start to finish.

Hartland's Mixed Blessing

Hartland's user-friendly textbook (1966, 1971b), aimed directly at G.P.s, included many condition-specific monologues, and detailed induction, deepening, trance ratification, and de-hypnotizing procedures. However, it was a mixed blessing. Not only were many tempted to experiment with hypnotism and, from this, pursue further training, it also enticed the untrained and non-talented to dabble and fail. These failures were attributed to patient unsuitability and/or the inadequacy of hypnotism; never to practitioner incompetence.

Untrained dabblers were not restricted to the medical profession. In 1992, Yapko issued two inter-related questionnaires (1994, pp.46-9) to more than a thousand State-licensed health professionals attending the conventions of a number of prestigious groups, including the American Association for Marriage and Family Therapy (AAMFT), the Family Therapy Network, the American Society of Clinical Hypnosis (ASCH) and the Milton H. Erickson Foundation (p.50). A very significant number (viz., 864 and 869) of usable questionnaires were returned. The respondents were highly experienced therapists: more than 92% had Masters degree or better, more than 61% had ten or more years in clinical practice, and almost half were employed in private practice (p.230). Yet, whilst more than half (463) of Yapko's respondents used hypnotism in their clinical work, less than 45% of those using hypnotism had ever received any formal training in hypnotism at all (p.234).

Efficacy of Hartland's Procedure

Whilst there's overwhelming anecdotal evidence of the efficacy of Hartland's approach, there's little experimental evidence; primarily due to (a) the difficulty of constructing genuinely productive experiments, and (b) the fact that experimental subjects, unlike "anxious and critical" clinical patients, have a "detached state of mind" and, unlike patients in clinical situations, are not "intimately and vitally affect[ed]" by the intervention's outcomes (Gorman, 1974, p.209).

Stanton's (1979) subjects demonstrated a significantly increased internal locus of control. In the 1960s, Calnan studied the effectiveness of Hartland's 1965 monologue

on the sorts of subject Hartland thought would benefit most: (a) those reacting to the consequences of the illness itself, and (b) those with personality defects that might inhibit recovery. Fifty-four psychiatric outpatients were referred on the basis of meeting Calnan's definition of a "*dependent patient*" (Calnan, 1977, p.108); viz.:

Regardless of psychiatric diagnosis, a patient who says that he has little control over his behaviour and who readily acquiesces to directions given by authority figures; who exhibits little personal initiative and who seems both inhibited and fearful. The patient also needs to be in sufficient reality contact to be able to respond to the suggestions.

Fourteen were eliminated for various reasons. Of the rest, ten "experienced psychotic disturbance and were stabilised on a major tranquilliser", whilst "the remaining 30 had various kinds of neurotic disturbance". In the view of the referring clinicians, a "substantial number [of those referred] seemed unresponsive to conventional psychotherapy and chemotherapy" and, "on an *a priori* basis", seemed "unsuitable for psychotherapy" (p.116). Subjects were randomly allocated to one of four groups: (a) the standard Hartland method (viz., "ego strengthening" suggestions plus hypnosis); (b) hypnosis only; (c) the "ego strengthening" suggestions without hypnosis; and (d) the "wait-for-treatment" control group (who continued their usual medication). All had 12 treatments over 6 weeks. The experimental group demonstrated considerable progress compared with the other three (p.117, emphasis added):

The most striking commonality ... of subjects who received Hartland's entire treatment procedure ... was that *they all reported feeling more relaxed and self-confident. Very often they described their changes in exactly the same words as those used by Hartland in his ego strengthening suggestions and yet none of the subjects mentioned or seemed aware of their origin.* This observation has been independently corroborated by colleagues who used the treatment procedure in the [same] mental health centre. Seven of the 10 experimental subjects had complained of feelings of depression at the commencement of their training and at the completion of the 6 weeks, 6 of these [seven] reported no longer feeling depressed. The frequency with which subjects in the experimental group began to seem happier and more outgoing in social contacts within the centre contrasted with subjects in other groups in the research.

No doubt the final (1971) version of Hartland's monologue would have produced even better results.

Hartland's Contribution

According to Brown and Fromm (1986, p194), "while seeming simplistic ... ego-strengthening suggestions ... are quite valuable [therapeutically]", and "in certain instances ego-strengthening alone can bring about a successful treatment outcome without [any need to resort to either] symptomatic or dynamic hypnotherapy" (p.195). In their post-Hartland view (p.194):

There are three kinds of ego-strengthening suggestions:

- (a) general ego-strengthening suggestions,
- (b) specific ego-strengthening suggestions to facilitate the discovery and enhancement of the patient's inner coping strategies, and
- (c) specific suggestions to foster the patient's sense of self-efficacy.

The strategies and clinical examples in Hartland's textbooks made a considerable contribution to modern hypnotherapeutic practice, and the literature contains many reports of his monologue being successfully applied to a wide range of complaints (e.g., Rose, 1967; Wakeman and Kaplan, 1978; Gould and Tissler, 1984; Basker, Anderson and Dalton, 1978; Finkelstein, 1991; Torem, 1995; Spiegel, 1996; Freeman and Baxby, 1982, etc.).

[Continued in *Part II*]

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