HYPNOGRAPHY—A TECHNIQUE IN HYPNOANALYSIS

By

AINSLIE MEARES, M.B., B.S., B.Agr.Sc., D.P.M.

Clinical Assistant

Royal Melbourne Hospital, Melbourne, Australia

HYPNOANALYSIS is becoming more and more a recognized psychotherapeutic procedure. It is an analytical type of therapy which utilizes the hypnotic state to reduce the great time and cost of formal psychoanalysis. As with any new form of treatment, there is great variation in the techniques used by different authors (1, 2, 3, 4, 5, 6, 7). This variation ranges from such extremes as attempts to imitate formal psychoanalysis with a hypnotized patient, to mere question and answer interviews interspersed with hypnotic suggestion.

Hypnography is a technique in hypnoanalysis in which the hypnotized patient projects psychic material graphically, and then while still under hypnosis, gives associations to the projected material.

INDUCTION OF HYPNOSIS

A detailed description of the technique used for the induction of hypnosis will not be attempted. The patient's suggestibility is estimated, and the choice of technique is decided by the patient's ability to relax while the tendon reflexes are being elicited during the physical examination (8). In general, those who relax easily are hypnotized by suggestions of relaxation; those who become tense, by arm levitation, and those who show evidence of negativism, by the induction of repetitive movements. Whichever method is used, the patient's defences are noted, and as far as possible incorporated into the suggestions (9). The only post-hypnotic suggestions given are for deeper hypnosis in the next session.

Before hypnotic painting can be induced, a certain critical depth of hypnosis must be attained. If this depth is not reached, the patient will wake up when it is suggested that he will paint. There is no single test which accurately measures the depth of hypnosis in all patients, but the induction of repetitive movement of the arm with the patient's eyes open, and the maintenance of the repetitive movement in spite of strong challenges to stop it, is a very useful criterion of a suitable depth of hypnosis for proceeding to hypnography. This is usually attained by the third session.

EARLY EXPERIMENTS

Various media of graphic expression have been tested. The first experiments were done with the patient using an ordinary lead pencil. It was found that patients were inclined to hold the pencil so loosely that often only a very indefinite outline resulted. It was the same with a heavy black crayon. Experiments in the use of coloured crayons and coloured paints were not very successful. There was always the tendency to continue painting in the one colour, so that it was necessary to give practically continuous suggestions reminding the patient that he could use other colours. The conclusion was reached that, in general,

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patients do not handle colour well while under hypnosis, and that any therapeutic advantages were over-shadowed by the technical difficulties in getting the hypnotized patient to use colour. In this respect it is interesting to note that dreams are usually monochromatic. It is found that painting with black paint on white paper is probably the most satisfactory medium of graphic expression for the hypnotized patient.

Technique of Hypnography

The patient is given no indication that he is going to be asked to paint. He is hypnotized sitting at a table or desk, and repetitive movements of the arm are induced. The patient almost always closes his eyes so as to avoid witnessing the uncontrolled movement of his arm. In these circumstances, suggestions are given that his eyes open, and his gaze is then directed to the moving hand. When it is felt that the patient is hypnotized to a sufficient depth, the movement is stopped, and the patient is put to sleep with a few appropriate suggestions.

At this stage, paint-brush, black paint and a painting book are brought in from an adjacent room and are placed in front of the patient. The painting materials have been kept concealed from the patient, and the question of drawing or painting has not previously been discussed.

An interesting feature has been that the sudden and unexpected production of the painting materials has never provoked evidence of anxiety in the patient. It has been observed that, under similar circumstances in the waking state, patients almost invariably reacted with initial anxiety.

To be sure that an adequate depth of hypnosis is maintained, repetitive movements of the arm are again induced. The patient is given suggestions to open his eyes, and is strongly challenged to stop the movements of the arm. The movement is finally halted by suggestions from the therapist. The patient is then told, "Here is a paint-brush; this is the paint; this is a paint-book; I dip the brush in the paint; your hand takes the brush; it paints it; it paints it whatever it is."

These suggestions are given slowly and deliberately, if necessary they are repeated. The object is to get the patient to paint something which represents traumatic psychic material, either repressed material, or ideas of which he is aware but is unable to express verbally. The suggestions may be repeated in different words, but the non-specific nature of the suggestions is always maintained. "Your hand will paint it." "Your hand will paint something." "It paints what is in your mind." "It paints it no matter what it is." "It paints the things in your mind."

The patient usually takes the brush when it is handed to him. Many patients who have never been accustomed to drawing or painting take the brush and start painting without the slightest hesitation. Most commonly they paint the outline of some object which is associated with some significant conflict. After a little delay, most patients give the impression of knowing what they want to paint, even if they do not set about it in a very business-like manner. A few leave it to their hand to paint automatically. Others make a few tentative marks on the paper as if testing the effect of the paint on the paper. More marks are made, and then these unstructured marks are structured into something with meaning. The content of paintings started in this way is usually sexual.

Some patients have trouble in getting started. Sometimes this is due to the very natural difficulty of the patient in adjusting himself to do something new and unexpected. The hypnotized patient actually experiences much less difficulty

in adjusting himself to such a task than does the patient in the waking state. This difficulty is overcome by repeating the suggestions, and if necessary adding suggestions of ease and encouragement. Sometimes the trouble in getting started is due to blocking on account of the traumatic quality of the ideas seeking expression. In such cases the difficulty is met by emphasizing the idea of dissociation. "Your hand will paint something", rather than "You will paint something".

If the disclosure of psychic material in the painting is regarded by the patient as a threat to his ego, then various resistances appear. It is important that the defences are recognized as such, so that they may be circumvented by an appropriate change of technique.

Characteristically, the brush is held very loosely. It is inclined to flop about. The impression is given that the patient is exercising no proper control over the movement of the brush. In spite of appearances, the brush is actually controlled quite well. Some patients paint very slowly and the brush moves with tiny jerks as if emphasizing the automatic nature of the process. Others paint at great speed. There may be quite a manic quality about it. One object is painted and the patient hurries on to the next which is often put in the corner of the same page. It is enlarged, and soon overlaps the first painting. The ideas seem to pour from his mind and there is a feverish haste to give them expression. One object is not completed before proceeding to the next. Paintings may be superimposed one on another. To avoid this confusion, clean sheets of paper are placed in front of the patient, and as soon as one painting appears complete, it is withdrawn. This procedure does not seem to disturb the patient or arrest the rapid flow of his ideas.

Sometimes it appears that the patient would paint on and on indefinitely. Sometimes the association between the different ideas expressed can be seen, more often there is no obvious connection between them.

When the brush runs dry of paint, it is not uncommon for the patient to continue the action of painting with the dry brush. The initiative required to dip the brush in the paint seems to be lacking. This occurs with those who paint very slowly as well as with those who paint quickly. Accordingly, when the brush is seen to be running dry, it is the custom to tell the patient, "The brush is running out of paint, I take the brush and dip it in the paint". So saying, the brush is taken from the patient, dipped in the paint and returned to the patient. This procedure has never roused the patient from hypnosis, and does not appear to interrupt his train of thought. The patient invariably takes the brush and resumes painting. This technique has proved more satisfactory than suggesting to the patient that he dip the brush in the paint himself. This has usually resulted in the paint being spilt. The painting is spoilt; and once the hypnotized patient gets paint on his fingers, he is likely to soil his clothes and get paint on everything around him.

Another minor complication is that the painting often runs off the edge of the page and is continued on the top of the desk as if nothing has happened. Some patients habitually repeat the pattern of running off the paper. This type of behaviour often seems to have a symbolic significance. Frequently the original painting represents something unpleasant; then they proceed to paint something else a long way away from the unpleasant idea. To avoid danger from this contingency, a plastic cloth is placed over the desk. This minor difficulty takes a different form when starting a new painting book. The edge of a new book represents a drop of about a quarter of an inch to the surface of the desk. Under these circumstances when the brush has run off the edge of the page, occasionally

the action of painting has been continued with the tip of the brush gliding along in the air just above the surface of the desk. When this happens the patient is told, "Your brush has run off the paper, I lift up your hand and put it back on the paper". The patient's hand which is holding the brush is lifted back on the paper, or a new piece of paper is substituted. Again, this procedure does not appear to disturb the patient.

As far as possible, care is taken to see that the patient does not smudge the painting. It is not uncommon for the patient to put his hand on the wet paint. Sometimes this is done in apparent oblivion of what he is doing; sometimes it is done in pointing to some particular part of the painting; but often when abreacting his emotion, the patient rubs his finger into the picture, or thumps it with his fist.

When the patient has expressed the idea which is seeking expression, the brush is often dropped or allowed to flop about aimlessly, and the painting may be spoiled. To avoid this, as soon as the patient appears to be finished, he is told, "I take the brush and put it down", and the brush is taken from him. Other patients when they have given expression to a particular idea, remain immobile and statuesque, staring at the painting with unblinking gaze; others go into a deep sleep and may slump forward on to the desk. Sometimes when the painting is finished, the patient continues to paint over the outline again and again, apparently indefinitely, until the brush is taken from him.

There is great variation in the amount of emotion displayed during the painting. Some patients project highly traumatic material with very little outward show of emotion; others abreact with considerable violence. Agitation and restlessness are common. Some express their love or hate or aggression in words. Some would destroy the object of their hate, or fondle the object of their love with symbolic gestures at the painting. A loved object is caressed time and time again with the tip of the brush; sometimes with so much preoccupation that the projection of other ideas ceases. The action continues until the brush is taken from the patient. At other times the brush is bashed down on the paper to strike a hated figure. A frequent form of abreaction is an unverbalized phonation of emotion. Sometimes the patient becomes more and more preoccupied with a rhythmical action of painting. The sexual significance becomes obvious and is confirmed by the patient's associations.

The Associations

The main value of the hypnotic paintings in therapy lies in the patient's associations with the paintings. The associations are obtained while the patient is still in the hypnotic state. This seems quite important. As a general rule, as long as the patient is hypnotized, the potentially traumatic character of the ideas expressed in the painting and verbalized in the associations does not disturb the patient. Because of the obvious dangers, experience in obtaining associations to the paintings in the waking state has been very limited. But from experience to date, it appears that the patient's defences often become so active that he is denied conscious knowledge of the content of the paintings and can produce no associations at all. Alternatively he produces mere screen associations. On the other hand, if the patient becomes aware of the meaning of the painting, the knowledge may be so disturbing that anxiety reactions result.

Sometimes patients start to talk spontaneously. They mutter their thoughts as they do the paintings. Some have an air of abstraction about them. There is no emotion; it would seem that they were watching the event from a great way

off. With others, the spontaneous muttering is accompanied by great emotion, and it is obvious that the patient is actually reliving the traumatic experience.

When the patient rushes to express one idea after another, he is allowed to complete a series of paintings before giving his associations, otherwise the associations are obtained as each painting is finished.

The patient is given such suggestions as, "You won't wake up until I tell you, you can talk and you won't wake up. You talk in a dream and you don't wake up. What is this that your hand has painted?" The suggestions can be repeated. If thought advisable, emphasis can be placed on the dissociation. "Your voice talks and you don't wake up." Alternatively the dream-like qualities of the situation can be stressed. Patients almost invariably keep an unblinking gaze on the picture. There is however a good deal of variation in the way the associations are given. The voice may be quite clear and resemble the patient's ordinary speaking voice. More often it is a soft mumble which is difficult to hear. The ideas may be expressed fairly clearly and logically, with reasonable use of syntax. In other cases, the thought is rambling and incoherent. There is no attempt at logical expression. Unessential words are omitted. Speech may be reduced to nouns and verbs, with a few emotionally coloured adjectives. Other patients drawl out a whole series of associations and will continue for some time without any prompting from the therapist. The associations are almost always given slowly and with considerable pause between successive ideas. This has the happy result that it is usually quite easy to write down the associations verbatim in longhand. After some trial it was thought that the presence of a stenographer had a slight, but definite inhibitory effect on the patient, so it was discontinued.

The giving of the associations is often accompanied by a good deal of abreaction. Patients act out the traumatic event, sometimes weeping in sadness or guilt, sometimes screaming in rage. On the other hand, some patients verbalize extremely traumatic material and the while maintain a fixed, glassy stare and give no outward signs of emotion. The pattern of behaviour is constant with the individual patient and tends to be repeated in subsequent sessions.

As with the emotional content of the associations, so also ideational content varies greatly. In the main, the ideas expressed in the associations are those of basic human conflict. They are usually stark and unadorned. There is no watering down of the expressions to make them more acceptable to the listener. The ideas for the most part relate to biologically significant material, to love and hate, to guilt which is often sexual guilt, to striving for acceptance, and to doubt in the reality of God. Feelings of loneliness and the essential isolation of the individual are common themes. The period in time to which the associations refer is anything from the present day to childhood and infancy.

A clothed female figure produces the association, "My wife, I hate her". An outline of two naked figures lying together with a shapeless blob between them is, "Mum, dad, me".

In relation to events in the past, particularly childhood experiences sometimes the patient will appear to be describing the event as he witnesses it, at other times the patient is actually reliving the experience. Both mechanisms involve spontaneous regression, but the character of the regression is different in the two cases (10).

There is nothing vague about the associations. They are blunt and realistic and to the point. In this respect there is a marked difference from the usual associations of waking psychotherapy.

Usually the patient's associations are isolated ideas, and are not connected

together by any logical sequence, but are each evoked by the central theme of the painting. Occasionally the associations tend more to resemble those of the waking state. One idea leads to the next, and soon the thought is far away from the content of the painting. It is the practice in such cases to bring the patient back to the painting from time to time, in the belief that the idea contained in the painting is the psychically significant conflict. It is often possible to do this by merely pointing to the painting. When a patient has given a long series of associations, it is not uncommon for him to fall into a deep sleep. A patient who gives many associations on one occasion, usually does likewise on other occasions.

The significance of the object depicted is often quite clear to the therapist, but sometimes the painting has no meaning at all without the patient's associations. This is so when the painting represents the place where some traumatic incident occurred.

It is clear that the expression of suppressed and repressed material by painting under hypnosis involves a good deal of psychic stress. Accordingly, it is thought wise to give the patient a rest after a series of paintings has been made. He is told, "You won't wake up until I tell you; you see the easy chair; you stand up; you won't wake up; you go over to the chair; you flop down in the chair; you go deep asleep, deep asleep; noises can't disturb you; you won't wake up until I tell you." The patient sometimes needs a little physical help in moving to the easy chair, but after the stress of the session, sleep comes easily with very little suggestion.

Patients who are given a half hour sleep after the session become calm and composed without any specific post-hypnotic suggestions. They are thus in a much better state to leave the consulting room and return home. For medico-legal considerations rather than doubt as to the completeness of the patient's recovery from the hypnotic experience, it is the practice to insist that the patient be accompanied home by a relative or friend.

While the patient is asleep, the painting materials are removed from the room and the subject is not discussed unless the patient brings it up. This is to avoid anxiety between the treatments. At the beginning of the next session, the patient is given the opportunity to discuss the matters of the previous session.

Post-hypnotic suggestions of amnesia for the session are not usually given. It is ordinarily left to the patient to recall what material he is capable to bear, and repress the remainder. The degree of spontaneous amnesia varies from a complete blackout for the whole period of hypnosis, to a crystal clear memory of all the details of the painting and the accompanying subjective feelings. Most commonly there is a partial amnesia. The patient remembers what he has done in a general way, but remembers it only vaguely.

Dangers and Difficulties

The dangers of hypnography are related in the first place to the dangers of hypnosis, and secondly to the dangers of an analytical type of psychotherapy. The dangers of hypnosis are discussed in several recent works on the subject (2, 3, 7, 11), as well as by the earlier writers (12, 13, 14) and are beyond the scope of the present paper. The other danger arises from the too sudden awareness of repressed traumatic material. This is a danger inherent in any form of analytical psychotherapy. It is probably greater in hypnoanalysis than in waking analytical techniques, and it is probably greater in hypnography than in verbal hypnoanalysis. The reason for this is that the spoken word is easily forgotten, repressed,

blotted out or denied by appropriate defence mechanisms. On the other hand, the same idea expressed in the symbolism of the painted object instead of the symbolism of words, cannot be handled so easily by the psychological defences. Accordingly, as a general rule, it is thought prudent to avoid showing the paintings to the patient in the waking state. Greater experience may prove that this precaution is unnecessary. So long as the patient remains hypnotized, it seems that there is little danger in confronting him with paintings representing even acutely traumatic material and obtaining his associations to the paintings. Minor anxiety attacks have occurred in hypnotized patients who have suddenly become aware of the sexual significance of their paintings, and a patient who likewise became suddenly aware of her aggression. These anxiety attacks were managed quite easily by increasing the depth of hypnosis, and giving the patient a rest.

Of the difficulties, there are the common difficulties of inducing hypnosis. When the surrender of voluntary control to hypnosis is interpreted by the patient as a threat to his ego, he unconsciously defends himself against hypnosis (9). It is important to regard difficulties in hypnotizing in terms of the patient's defences. These defences can usually be circumvented quite easily, but may resist a direct attack. Nearly all difficulties in hypnosis, whether in the induction or in getting the patient to paint, represent defences by the patient, and are the signal for an appropriate modification of technique on the part of the therapist in order to deal with the situation.

The integration of hypnography with waking psychotherapy represents a problem of management. The material disclosed in hypnography is intimately related to the patient's illness, at the same time its nature is such that any sudden disclosure of its meaning to the patient would be courting disaster. To make any attempt to deal with the content of the painting as soon as the patient is awakened from hypnosis means prolonging the session for a considerable length of time. At the beginning of each session, the patient is always allowed time to discuss any matter that he has a mind to ventilate. By this means, rapport is maintained, and the patient is given a chance to settle down and become composed prior to hypnosis. Then hypnosis is induced, the paintings are made and the associations obtained. Before waking, the patient is given a rest in hypnotic sleep. All this takes time, and the average length of a session is about an hour and a half. To proceed to waking psychotherapy would probably take as long again. Another difficulty is that after the hypnotic sleep, the patient is composed and in a fit state of mind to return home. This calm might easily be disturbed by psychotherapy. Accordingly, the waking psychotherapy has been done at separate sessions, interspersed with the hypnotic sessions. The general principle has been that, if the patient shields himself against the material disclosed in the hypnotic sessions by amnesia or rationalization, it is generally taken to mean that he is not yet ready for waking psychotherapy in this particular area. It is found that after several sessions of hypnotic painting, the patient is more prepared for waking psychotherapy. It is anticipated that experience will bring better ways of integrating the waking and hypnotic aspects of therapy, but it is an observed fact that many patients obtain symptomatic relief from hypnography without the traumatic material being fully worked through at a conscious level.

Uses of Hypnography

With psychiatry already over-full of complicated procedures that are technically difficult to master, it is well to consider whether the technique

described has anything of real value to offer. Its possible uses relate to two fields, to therapy and research.

In hypnoanalysis there is the fairly common difficulty that the patient does not verbalize his conflicts readily. Some patients seem to have an inherent difficulty in talking under hypnosis, yet many of these patients will express themselves quite readily in hypnography. Sometimes the difficulty in talking under hypnosis is a defence, the patient using the hypnotic situation to defend himself. The meaning of his behaviour is, "A hypnotized person cannot talk properly. I can't talk about these things." This type of defence may be circumvented by getting the patient to project his conflicts graphically. On first consideration this would seem unlikely. It would be thought that the patient who defends himself by an inability to express his conflict in words, would likewise defend himself by an inability to express his conflict in painting. But experience suggests that this is not so. The reason would appear to be in the greater element of dissociation in the hypnography. This can be emphasized, "Your hand paints it. You don't paint it. It's your hand that does it." Once the painting has been initiated by this dissociation, the patient will usually carry on without further stressing of the dissociation, and in subsequent sessions suggestions can be given increasing the patient's own responsibility. "You paint it, you paint it yourself."

Whatever the true explanation, the observed fact is that many hypnotized patients who do not express themselves readily in words, do so quite readily in painting.

There is another factor, The nature of some abstract ideas is such that it makes their expression in words very difficult. Sometimes such ideas can be expressed graphically. This concept is exemplified in both modern art and schizophrenic paintings. Some of the symbolic hypnotic paintings come into this category. For instance, a patient with no overt awareness of homosexual drives depicted himself as two babies, one male and one female, joined together.

In verbal hypnoanalysis there is often the tendency for the patient to wander off into irrelevancies by the process of association. One idea leads to another, and soon the patient is far from the area of conflict. This happens very much less when the patient is giving associations to his painting.

Another way in which hypnography differs from verbal hypnoanalysis is that there is a greater abruptness in the change of subject matter. In hypnography there is a greater tendency to the unexpected and spontaneous production of psychologically important material. There is much less continuity of thought between successive subjects.

Many authors refer to the necessity of dealing with recovered material in psychotherapy in normal waking consciousness (15). But it is an important clinical observation that many patients gain symptomatic relief from hypnography without adequate waking psychotherapy to account for their improvement, and without specific therapeutic suggestions. Those authors who refer to the necessity of waking psychotherapy deal with verbal hypnoanalysis. It may be that the expression of ideas in painting has a rather different therapeutic effect from the expression of the same ideas in words. There is at least some evidence to suggest that this is so in the waking state (16, 17, 18), but some authors doubt this (18). When a patient expresses a conflict in painting, he is literally confronted with the problem. He is faced with the conflict. This is quite different from the patient merely talking about it. It is felt that the process of expressing the repressed material in a symbolic, graphic way, and giving verbal associations, is in itself of therapeutic value. For example, one patient

drew an outline of a gallows on several successive occasions, each time saying that she was going to be hanged because she was going to kill the man who had wronged her. On account of the highly traumatic quality of the material, no attempt was made to hurry the psychotherapy. The theme gradually dropped out from subsequent hypnotic paintings, and was replaced by more superficial present day conflicts. It appeared that the gallows theme had, to some extent, been resolved, or had at least lost some of its traumatic quality during the hypnography. Later the subject was ventilated in psychotherapy without trouble.

Research in psychiatry is always under a handicap on account of the intangible and ill-defined nature of varying states of mind. Descriptive notes are playthings of the subjectivity of the therapist, the tape recorder is cumbersome and difficult to use to full advantage. Hypnotic paintings on the other hand, give a permanent record which is easily filed, and is in itself a direct product of the patient.

The records provide fascinating material for the study of symbolism.

An important factor in assessing the value of the hypnotic paintings in research is that the paintings do not appear to be contaminated by conscious elaboration. On the first occasion with each patient when hypnography is attempted, the patient has no idea that he is going to be asked to paint. If, as is most common, the patient does not have a complete amnesia of the session, it would be expected that he would ruminate over the matter and consider what he would paint on the next occasion. Accordingly, it would be expected that the paintings of the second and subsequent sessions would differ from those of the first session on account of this conscious elaboration. In actual fact, no significant differences can be observed between the paintings. Hence it is believed that the paintings are not contaminated by conscious elaboration.

Any final assessment of the value of hypnography in treatment must bear in mind that it is not a form of therapy per se, that it is just a special technique in hypnoanalysis which is itself a special technique in psychotherapy. As such it must be integrated with waking psychotherapy, with verbal hypnoanalysis and with the indirect suggestive effect of the hypnotic situation.

Summary

Hypnography is a technique in hypnoanalysis in which the hypnotized patient projects psychic material in black and white painting, and, while still under hypnosis, gives associations to the painting. It is a useful technique with patients who do not talk readily under hypnosis. There are some reasons to believe that the graphic expression of conflicts has some therapeutic effect beyond the verbal expression of the same conflicts.

References

1. Wolberg, Lewis R., *Medical Hypnosis, Vol. II*, 1948, Part III. Grune and Stratton, N.Y.
2. *Idem*, *Hypnoanalysis*, 1945. Grune and Stratton, N.Y.
3. Brenman, Margaret and Gill, Merton M., *Hypnotherapy*, 1947. The Pushkin Press, London.
4. Gindes, Bernard C., *New Concepts of Hypnosis*, 1951. The Julian Press, N.Y.
5. Lindner, Robert M., *Rebel without a Cause*, 1945. Research Books Ltd., London.
6. Rosen, Harold, *Hypnotherapy in Clinical Psychiatry*, 1953. Julian Press, N.Y.
7. Le Cron, L. M., and Bordeaux, J., *Hypnotism today*, 1949. Grune and Stratton, N.Y.
8. Meares, Ainslie, "The Clinical Estimation of Suggestibility", *Journal of Clinical and Experimental Hypnosis*. In the press.
9. *Idem*. "The Defences against Hypnosis", *British Journal of Medical Hypnotism*, **5**, No. 3.
10. Erickson, M. H., and Kubie, L. S., *Psychoanalytical Quart.*, 1941, **10**, 592.
11. Steger, Margaret, *Hypnoidal Psychotherapy*, 1951. Frobin Press, N.Y.
12. Bramwell, J. Milne, *Hypnotism, its history, practice and theory*, 1903. Reder and Co., London.
13. Bernheim, H., *Suggestive Therapeutics*, 1947. Reprinted London Book Co., N.Y.

14. JANET, PIERRE, *Psychological Healing*. George Allen and Unwin, London.
15. KUBIE, LAWRENCE S., *Manual of Military Neuropsychiatry*, 1944. p. 556. W. B. Saunders, Co.
16. DAX, E. CUNNINGHAM, *Experimental Studies in Psychiatric Art*, 1953. Faber and Faber, London.
17. SECHEHAYE, M. A., *Symbolic Realization*, 1951. International Universities Press, N.Y.
18. NAUMBURG, MARGARET, *Schizophrenic Art*, 1950. William Heinemann, London.
19. REITMAN, FRANCIS, *Psychotic Art*, 1950. Routledge and Kegan Paul, London.