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A Method of Psychotherapy Based on Relaxation Techniques

By R. P. SNAITH

Introduction

In his review of psychotherapeutic practice today, Marks (1971) has pointed out that there is a decreasing tendency to make dogmatic assertions of universal applicability of one or other form of psychotherapy to all neurotic states. There is an increasing readiness among psychotherapists of different schools to recognize that genuine therapeutic potential may be found in a variety of techniques with widely differing underlying assumptions about the nature of neurosis. It seems increasingly probable that psychotherapists of the future will need to be conversant with many techniques and the clinical indications for each, for it is becoming unrealistic to expect all neurotic problems to be solved by one technique alone.

It is inevitable, and probably profitable also, that there will be an intermingling of the techniques by individual psychotherapists; the aspiring therapist who has a chance to look around the therapeutic scene will select from the many techniques those aspects which are most meaningful to him, which suit his personality and with which he therefore develops most confidence; and hence through his own self-confidence are most likely to help his patient. Franks (1961), in his masterly survey of American psychotherapeutic practice, leaves us in no doubt that the therapist who most helps his patient is the one who has confidence in what he does, and the patient who is most likely to be helped is the one who in fact believes the therapist knows what he is doing. He also quotes Lewis Carroll to advantage: 'What is it you want to buy?' the Sheep said at last . . . 'I don't *quite* know yet', Alice said very gently. 'I should like to look all around me first, if I might.'

It is in order to help those who would 'look around' that the author here presents the particular combination of elements of psychotherapies which he has found most helpful over a decade. There are elements of at least three systems of psychotherapy in the approach presented, i.e. behaviour therapy, hypnosis and Autogenic Training. The last procedure seems to be little known in Britain though widely used on the continent of Europe and in Japan. The other two are more familiar, although one, hypnosis, is widely regarded as defunct or discredited; this is arguable, and at least elements of hypnotic techniques are worth preserving.

The author makes no pretence of universal applicability of this particular amalgam of techniques. In fact patients subject to it are rather carefully selected by him on the following grounds: they should present with predominant anxiety, preferably focused to some extent on situations; they should be beyond childhood, and should show evident signs of preparedness to co-operate in the joint exercise. There are, however, some distinct advantages; the procedure is relatively brief, most patients being satisfactorily treated in under twelve 15-minute weekly sessions; and a large part of the responsibility for improvement is placed on the patient himself, a responsibility which many patients in fact welcome once they are shown a positive method of overcoming their difficulties.

Preliminaries

There are techniques of psychotherapy in which a clear exposition of the nature of the process is deliberately avoided. The patient has no understanding of how the treatment will help him, nor is he encouraged to enquire in just what way he will experience improvement or when to expect alleviation of his distress. This inscrutability may be part of the therapeutic process, for, as Franks (1961) has pointed out *a propos* of this approach, confusion increases suggestibility, ambiguity arouses unpleasant emotions such as anxiety and resentment, and

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these in turn heighten the patient's desire for relief and thus the degree to which he is subject to influence by the therapist.

In contrast, the method of therapy outlined here seeks to afford the patient an explanation of the nature of his disorder and one which he can readily understand even if quite unsophisticated in psychological terminology. The process and plan of treatment are explained to him in broad outline, and he is given to understand what part he himself must play and what is the role of the therapist. The patient and therapist work out, before treatment commences, what are the realistic and acceptable goals of symptom relief.

A simple outline of how neurotic or morbid anxiety differs from normal anxiety is given; this is important, for the patient gains confidence from the knowledge that his therapist is fully aware that he in fact suffers from an abnormal condition for which he requires help, and is not merely acting in a foolish way for self-interested or other ends; he has doubtless heard enough of the latter viewpoint from relatives and friends. The genesis of a persistent phobic state, or situation-linked anxiety is likewise explained in very simple terms: how, having once experienced anxiety in a particular situation, he came to expect a repetition of this unpleasant experience when the situation was again encountered, and this expectation alone was enough to increase the likelihood of a further attack of anxiety. Severe anxiety being a most unpleasant experience, situations likely to produce it came to be avoided, and in time this avoidance itself strengthened and perpetuated the anxiety state. The patient should be allowed time and opportunity to express his own views, to say whether he feels the explanations fit the facts of his case, and if not where he thinks he differs. In this way the imposed, and so perhaps resented, approach to his problems is avoided and co-operation is likely to be increased.

The next stage is to explain to the patient that he can learn quite simply a technique by which he can control his anxiety. At this point three fundamental ideas are firmly instilled: First, that it is the patient who learns (and must therefore make the effort) and the therapist does no more than induct him into the method of learning which will require persistent and serious application on his part; as an encouragement at this stage it can be added that the process of learning anxiety control is both enjoyable and interesting. Secondly he is not to expect sudden dramatic relief, for if he sets out with such expectation he will probably be disappointed and become discouraged; he is told instead that improvement will come gradually and perhaps barely perceptibly; that it may not be until he looks back over a period of time that he will realize that he has indeed made progress. The third point is that the technique he will be given to learn is basically simple, completely natural and does not depend for its success on his being particularly adept at it, or require special skills or traits of personality. This last statement, bold though it seems, is at least substantially true; in the treatment of over a hundred patients by the method the author recalls very few who reported any difficulty in carrying out the standard exercises of the Autogenic Relaxation Training programme.

Furthermore it is the author's experience that patients selected for this approach to therapy respond positively to the idea of self-help rather than to submission to a process controlled entirely by the therapist. This, of course, will not be so in those who have such marked secondary gain from their symptoms that they do not really wish for their removal; for such patients either no treatment, or a different therapeutic approach to the one here described, is indicated.

Hypnosis. Desensitization. Induction into Relaxation Training

These preliminaries over, and possibly at the next therapeutic session relaxation is induced by the therapist. Some discussion about this process is first necessary to allay any anxiety or suspicion that the patient may have. Sometimes it is asked if the process is the same as hypnosis; this affords an opportunity to clear away any misconceptions, for frequently the word is associated with stage demonstrations in which the subject 'came under the will' of the hypnotist and was made to act in a foolish or dramatic manner. The author's practice is to explain that on account of these connotations hypnosis is a word he rarely uses, but that the term signifies nothing more than a preparedness to co-operate

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and to be influenced by suggestion. The patient is assured that no attempt will be made to make him do anything he does not wish to do, and that indeed without his wilful co-operation relaxation will not be induced at all. This is followed by an explanation that most people find it easier to commence self-training in relaxation if they have first experienced deep relaxation, and that this state is easier to achieve initially in association with a therapist than on one's own.

Patients may also worry that they will prove to be bad subjects or that on account of their tension they will not be able to relax. They can be confidently assured that in due course they will relax, that some people find the process easier than others, but that in the end they will do it because the process is extremely simple. The author finds it helpful to stress the simplicity of the procedure, and this is in accord with the experimental findings of Barber (1969) that subjects attained significantly higher scores on a suggestibility scale if they had first been given information that it is 'easy to respond' (to hypnotic suggestion).

The induction of hypnosis by the therapist has a function beside that of initiation into relaxation training. In the suggestible state the patient can experience himself in situations suggested to him with a far clearer sense of reality than if he had not first been hypnotized. This of course is an aid to desensitization, which may be incorporated into the therapeutic procedure.

The author finds it preferable to induce hypnotic relaxation in his own office or clinic room. The patient may by this stage have become accustomed to the room, and find transferral to another situation slightly disturbing. Furthermore, absolute darkness and quiet are generally to be avoided rather than sought; for most patients such protection from sensory experience is unnatural and in no way an aid to relaxation. The room should probably be slightly dimmed by the use of a window curtain if available, since this in itself has a suggestive effect of relaxation; it is also well, at least in the early sessions, to reduce noise exterior to the room as far as reasonable, but even much unwelcome noise is more likely to disturb the therapist than the patient.

No special equipment is required apart from a comfortable chair or couch; if a chair is used it should be one with a head support, and the ideal chair is one which is adjustable with extending leg support, so that the patient can assume a recumbent or semi-recumbent posture as he chooses. If a couch is used it should not be so narrow that the patient's arms hang over the edge. It is well to ask the patient whether any adjustments, such as a pillow under the knees, would make him more comfortable; by so doing he is encouraged to assume some sense of responsibility for his own state of relaxation. The therapist should sit just behind the line of forward vision of the patient, at a point where he can closely observe the patient without causing him to be self-conscious by awareness of scrutiny. The patient is now informed that all he must do is concentrate on the therapist's voice. As an aid to concentration the author requests the patient to fix his eyes on a spot on the opposite wall (if the wall is blank some mark can be placed there in preparation).

The exact form of words now employed by the therapist is a matter of individual choice; the formula described by Yorkston and Sergeant (1969) is entirely satisfactory. The content should be repetitious, delivered in a confident, slightly monotonous, though not unnatural, voice; it should guide the patient through thoughts of muscular relaxation of each part of the body in turn. Having progressed from arms to legs, abdominal muscles, neck and face muscles the therapist notices whether the eyes of the patient are still open; in most cases they will be, for he commenced with instructions to keep his eyes open, but in a few the eyes spontaneously close at an early stage. If they are open, the patient is now quietly told to close them so as 'to enjoy' even deeper relaxation. At all stages of the process the author avoids the challenging statements common to time-honoured hypnotic formulae. For instance, the statement: 'Your eyes are so heavy, you can't keep them open' is followed by satisfaction to both therapist and patient when the eyes do in fact close at this point; when they do not however, the therapist may feel irritated, and the confidence of the patient in the process may be shaken: both of these are poor states of

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mind for the optimal induction of relaxation, and are to be avoided.

After some ten minures of the procedure, and when the eyes are closed, the author's practice is to inform the patient that he now sees a calm scene, that he feels himself to be there, and is very aware of all the details of the scene. No attempt should be made to impose a scene on the patient, he should be advised to find his own fantasy of calmness; in this way he is more likely to find a scene which will, for him, induce a deeper sense of relaxation. Following a few seconds of this, the patient should be told to consider his own present state of relaxation and calmness. He can be told that he is now more relaxed than when he arrived at the therapist's office; this statement will certainly be true and so enhance the effect of further suggestion. He can be informed that he is probably more relaxed now, both in body and mind, than at any time in the past week (or month), and that this is the state of calmness and self-control which he will learn in time to bring about for himself. The patient's state of hypnotic suggestibility can be capitalized to effect; he can be told that at the next session he will find it even easier to relax, even more deeply. The session can now be brought to an end by a clear statement, e.g. that the therapist will now count backwards from six to one, and that when he reaches one, the eyes will open, the patient will take a deep breath and stretch a little, and that the intense feelings of heaviness of limbs will pass away. This statement is important: some very susceptible subjects may experience limb heaviness all day unless they are given a clear indication that effects induced by the process are at an end. It is however beneficial, and will increase subsequent co-operation, if the patient is left with the idea that he will be somewhat calmer following the session. No statement need be given as to how long this state of calm can be expected to endure.

Hypnosis is a process of communication, and the therapist must be aware that the hypnotized patient is dependent on him for clear statements so to how he should act. For instance, if a telephone should ring the therapist may get up to answer it, but should first say that while he is speaking on the phone the patient should continue to concentrate on his relaxation, his calm scene, or whatever other stage he has reached.

After one or two such sessions the patient should be encouraged to experience anxiety; he can be informed that he need not be alarmed by this thought for he will be able to bring the anxiety to an end by just returning to the thought of his calm scene. It is now necessary to arrange a clear signal of the experience of anxiety. The author's practice is to inform the patient that his hand, the hand nearest the therapist, will twitch or move slightly so soon as he feels anxious. The patient can be told that he need not deliberately concentrate on moving his hand, for this will happen automatically. The author has not known this manoeuvre to fail as an anxiety-detecting device; it is more reliable than watching the respiration rate, and is probably quite as reliable as a device monitoring psycho-galvanic reflex or forearm blood flow. All that is necessary is that the therapist should watch the hand very closely indeed. Sometimes there is the merest quiver of a finger but this is enough for the therapist to respond appropriately with some such words as: 'You now feel some anxiety but you do not find the experience too distressing, and you know that you can easily control it at will by simply switching to your calm scene.' It is reassuring to the patient, especially in the early stages of treatment, to know that the therapist is closely in contact with how he feels.

The author makes no attempt to impose an anxiety-provoking scene on the patient, but invites him to select his own scene as he did with the calm scene. By doing so, valuable information can be gained. If the patient suffers from a relatively clear-cut phobic neurosis it is surprising how frequently he will select a scene which would come near the top if a deliberate attempt had been made to construct a hierarchy of anxiety-provoking situations as described by Wolpe (1958); in other words the patient may opt for an implosion approach to his problem rather than an approach through gradual desensitization. If the patient does not suffer from a clear-cut phobic state, this method may allow useful insights into the particular triggers

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of anxiety provocation which may not have been gained at initial history taking. For instance, the woman with severe asthma described below always selected scenes of interpersonal conflict within the household, as to which she had previously withheld information.

In subsequent sessions the patient is given increasing opportunity to practise anxiety control, moving to more intense anxiety-provoking scenes as necessary. Again the state of suggestibility is continually used to give the patient forceful suggestions that he is beginning to learn to cope with anxiety, that he will be able to do this increasingly well and more effectively as time goes on, and that he will find the process extending automatically from his sessions with the therapist to real life situations. Following the principle of learning theory, it is not good practice to allow the patient to continue to control his anxiety by 'escaping' back to his calm scene. Instead he is instructed to stay for increasingly long periods with his anxiety scene and to practise anxiety control while in it. When the patient finds this difficult the author has found the following a useful procedure: the patient is instructed to visualize his calm scene, to become completely calm with the help of it, and then, keeping the calm scene in the back of his mind, to re-enter the anxiety scene; to impose, as it were, one scene on top of the other. With the help of this method, the patient soon discovers that the calm scene acts as a mental anchor which prevents him being swept away on a flood of anxiety, and so he rapidly gains confidence to enter his anxiety scenes.

Finally the suggestible state induced by the therapist can be used to help the patient over any difficulties in the Autogenic Training exercises that he may encounter. If he finds any aspects of these exercises difficult he can be instructed to visualize himself carrying out the exercise while the therapist slowly repeats the words of the particular exercise. A confident suggestion is then given that he will find the exercise easier next time he tries it. Bearing in mind the findings of Edwards (1963) that even in some deep trance subjects post-hypnotic suggestibility may decline rather rapidly, the patient is advised to practise that particular exercise again on the same day. Once the patient has succeeded with the exercise he rarely experiences further difficulty.

Autogenic Training

Schultz devised a therapeutic approach to neurotic and psychosomatic cases based on autosuggestion. He attributes his interest in this approach to the work of Oskar Vogt, and he himself began experimenting with it in 1905. The first edition of his book *Das Autogene Training* was published in 1932, and an English language version of this work, revised and updated, was produced in association with his colleague Luthe in 1959. In this work are described the standard exercises based upon psychophysiological sensations, later to be followed by meditative exercises. The authors acknowledge the related approaches of E. Jacobson's *Progressive Relaxation* and G. D. Read's *Childbirth Without Fear*.

In the therapeutic programme here outlined, the present author has confined himself to the standard exercises alone, which are appended, in a slightly modified form (see Appendix). Some time is spent in explaining to the patient that if these exercises are worked through in a systematic and conscientious manner he will develop through them the mental control of unwelcome anxiety. It is explained that at first he must seek out distinct circumstances for carrying out the exercises, i.e. a comfortable position, a reasonably quiet and isolated environment and a regular time schedule; but that after he has progressed with the training he will find his increasing ability to induce bodily relaxation and mental tranquillity in himself generalizing to everyday circumstances where he wishes to induce mental calmness alone; for this to happen he will eventually not have to assume the set postures necessary in the early stages of his training.

The author has found the optimal time for advising the patient to commence the standard exercises of the Autogenic Training to be after the second or third hypnosis session. At this stage the patient has some experience in the sensation of deep relaxation, and, as it were, knows what to aim for in his exercises. The patient is told that he must devote at least one fifteen-minute session a day to the exercises, and preferably two such sessions a day (more than

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that would probably be counter-productive). He must be advised against defaulting and told that if he does not take the exercises seriously he must not expect good results.

This advice as to the use of the exercises is somewhat at variance with that of Schultz and Luthe, who instruct the patient in the initial stages not to exceed 60 seconds of passive concentration on the exercise, and to carry it out two or three times a day. Schultz and Luthe point out that if the patient develops the habit of taking a longer time to induce relaxation he will experience difficulty later in applying the exercises in everyday circumstances for practical purposes. This no doubt is true, but the present author's experience is that patients become discouraged when they produce no perceptible effect in themselves in the one-minute exercise, and are encouraged to continue by the distinctly perceptible effect of the longer practice session. Having developed some ability in technique they can then be advised to shorten the duration of the exercises and eventually to develop the ability to produce a sense of controlled tranquillity almost instantaneously, not only in regular sessions but in the situations of everyday life, e.g. whilst travelling on a bus, watching television or doing the washing-up. Although there is no diminution of consciousness during the exercise, the patient should be advised not to attempt it whilst handling dangerous implements or driving a vehicle (the therapist should bear in mind his own interest in protecting himself against litigation, for it is possible that a patient might impute the cause of a coincidental accident to relaxation induction).

Patients are advised not to seek absolute silence in the house when they carry out their relaxation exercises. It is pointed out that they will probably fail to obtain it, and that the subsequent irritation will only make concentration more difficult. It is also stressed that noise is an integral part of life, and it is in real life situations that they will have to put their training into practice. All they need seek is a room free from intrusion for the duration of the exercise.

It is useful for the patient to be given some idea of the rate to progress through the exercises, and sometimes patients request this information. The author tells the patient that there is no set time at which to proceed, and that he should not attempt to progress to a further exercise until he feels he has mastery of the present one. It is better on the whole not to attempt to go too fast, but for his guidance he can be told that on average people can master one exercise a week, but that he should not worry if he finds he takes longer.

After achievement of the therapeutic goal, the patient is advised to continue to carry out Autogenic Training as a long term, even a lifelong commitment. He can be informed that it is an invaluable insurance against further return of anxiety of neurotic intensity.

Sample Cases

Case 1

Mr. A.C., aged 16. This young man was an aspiring university entrant. His background was unremarkable and he complained only of attacks of anxiety which came on rather sharply and persisted for several minutes. The attacks usually came on in classroom, but could in fact occur in other situations or even in bed at night. A rather detailed case history did not enable the author to reach a satisfactory formulation of the case in psychodynamic terms, although the first such attack had occurred some years ago in relation to the request to repeat a badly prepared task to the rest of the school class. There was also some concern about leaving home were the patient to be successful in his application for a university place. Physical examination revealed no abnormality, and this was confirmed by a consultant physician. Treatment was commenced and anxiety fantasies were found to be entirely of social situations. No attempt at systematic desensitization was made, but instead therapy sessions focused on anxiety control in general. After six sessions the patient stated that he felt great confidence in the method and had noticed a decrease in his anxiety attacks. Regular sessions with the therapist were stopped, but he was given monthly appointments and advised to keep practising his exercises. After several months he reported that the anxiety was well under control; in fact he rarely experienced it and certainly did not worry about attacks occurring. He stated he felt well and happy in every way, and had gained a university place at one of the better known British universities some distance from his home.

Case 2

Mrs. M.W., aged 28. This woman had an incapacitating phobia of wasps, on account of which she was

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unable to go out in parks or her garden on a summer's day; on such a day she could not endure any window of her house to be opened. She was worried about the effect her phobic behaviour would have on her young child. This would be regarded by many therapists as a straightforward case for desensitization. The author, however, chose to institute the full therapeutic programme, although considerable emphasis was placed on a densensitization procedure in the sessions. After nine weeks the patient had overcome her fear of wasps sufficiently to sit in her garden; she had, to her intense surprise and delight, managed to swat a wasp in her kitchen with a rolled-up newspaper. The following summer she was still continuing the exercises, and her phobia was under even better control.

Case 3

Mrs. A.C., aged 24. This woman, married six months, presented with vaginismus; she also experienced other less distressing neurotic symptoms, such as an inability to swallow tablets, and a general tendency to react with anxiety to many situations of minor stress. At the age of 15 she had somewhat unwillingly partaken in an attempt at sexual intercourse with a former boy-friend; the experience had proved painful and guilt-inducing, and she never again attempted intercourse until after marriage. She had never once been able to have actual intercourse on account of intense perineal spasm, and was distressed by this; she stated she had normal libido but just 'couldn't relax'. Her husband, a patient and supportive partner, confirmed this, and they both hoped for effective treatment to resolve the difficulty. The nature of the treatment was explained to both of them, and the husband was asked to desist from attempts at intercourse for the duration of the treatment. She had been examined by a gynaecologist (under anaesthetic, as that alone was possible) and been told that there was no abnormality. Therapy commenced, and after four sessions she reported she was progressing well with the Autogenic Training. Her anxiety fantasies under hypnosis were invariably concerned with attempts at sexual intercourse. When after six weeks she reported she had progressed through all the exercises she was given a glass vaginal dilator and some lubricant jelly, and told to practise relaxation in bed or in the bath and when she felt calm to insert the dilator. It took her two weeks and several attempts to do this, but she was strongly encouraged and finally succeeded. She was still doubtful about intercourse, but during a joint interview with the husband it was explained that the time was now right to commence trying again. The patient was told to concentrate on one of her exercises before intercourse and if necessary during it. This proved successful, and after a further two weeks the couple reported that intercourse was frequent and enjoyed by both of them. She also added that she considered herself to be a calmer person altogether.

Case 4

Mr. D.K., aged 56. This man was not a native of Britain. He had been through difficult wartime experiences, and had since led a rather quiet and solitary life. He had never experienced strong sexual urge, although he had masturbated occasionally. At the age of 50 he had married a widow of his own age. She was demanding sexually, but he found himself to be impotent with her and was distressed that his wife could not accept his deficiency. He said he experienced marked anxiety whenever he attempted intercourse, and in fact was beginning to feel generally miserable and anxious even on returning home from work.

He was not encouraged to expect achievement of full potency, but he agreed that therapy with the aim of anxiety reduction was worthwhile; it was also explained that once his anxiety was under control there was some chance of improvement in sexual activity. Therapy continued for twelve sessions and progress was slow though definite. He said his wife continually enquired when the treatment 'would work'. He was discharged from regular sessions to continue Autogenic Training and attend at monthly intervals. After about four months he said he had succeeded one or twice in intercourse, the experience had not interested him, but it did satisfy his wife and he felt less anxious about sexual activity.

Case 5

Mrs. L S., aged 53. This woman was referred by her general practitioner with a rather desperate note enquiring whether 'psychiatry could do anything to help?' She had been a severe asthmatic for many years, and recently suffered a mild coronary thrombosis; the doctor feared another thrombosis to be imminent unless her asthma could be relieved. She had been under the continuous supervision of an experienced chest physician for years, and was taking large amounts of drugs, including ten 5 mg. prednisone tablets a day. At the preparatory interview it was agreed that the asthma would not be cured, but that were she to become less tense and frightened of the attacks there was a good chance they would be less severe.

This proved to be so. It was found that anxiety provocation during hypnosis was always experienced in relation to minor domestic conflict. Anxiety gradually came under control after about ten weeks, and after another month she announced that her

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asthma was so much better that her physician had advised a substantial reduction of steroid medication. Six months later she had another mild coronary thrombosis and was taken into hospital. She stated she was quite calm in hospital and continued her exercises there. The asthma continued to be much less severe than at the time of her referral.

Summary

A method of psychotherapy is described which is in fact an amalgam of techniques from other systems of psychotherapy, particularly behaviour therapy, hypnosis and Autogenic Training. No claim is made that the method is superior to other methods, but the author is of the opinion that increasingly psychotherapists will have to 'look around' and adapt existing therapies or elements of several therapies to suit their own personality style. Confidence of the therapist in what he is doing is probably of greater therapeutic potential than minute attention to theoretical premises of psychotherapy.

Appendix: Concentrative Relaxation

There are six exercises to be learned one after another, and before a new one is learned the one before it has to be mastered.

Please do not try a new exercise before you have mastered the one before.

For these exercises it is best to choose a quiet, warm room. Lie down (later you may be able to do exercises sitting when you are good at them). Put both hands on your stomach; your hands should not touch; your elbows rest at your sides, your arms are bent, your head is straight, your legs are straight and your feet should not quite touch and when relaxed will turn slightly outwards.

Shut your eyes to shut out the light. If you do the exercises sitting you must choose a chair so that your head can lean back comfortably or flop forward. Your lower arms should rest on the arms of the chair or your thighs, and your legs should be straight down, firmly planted on the floor.

Now say to yourself.

'I am quite still.'

You have to master this before doing any further exercises.

At the end of each exercise, unless you want to go off to sleep, you must never forget to 'take it back', or else you may feel heavy and too relaxed for quite some time afterwards.

In order to 'take it back', take a deep breath or two, open your eyes slowly, bend your arms smartly twice, saying to yourself:

'Deep breath, eyes open, quite strong.'

Different people take different lengths of time to learn all this, but in most cases one or two weeks should be enough to learn each exercise.

First exercise

Say to yourself:

'I am quite still. My right arm is quite heavy.'

You repeat this to yourself until you feel your right arm getting quite heavy, which happens when your arm relaxes properly and weighs down on the surface. You will find that sometimes, during the first practice, sometimes after several, the heaviness will spread to your left arm and then your legs.

Do not forget to 'take it back' after the exercise.

Second exercise

If you have mastered the first exercise, *but not before* you go onsaying to yourself.

'My right arm is quite warm.'

Often the warmth is felt first in the crook of the arm and spreads over the whole arm. You will find that, after some practice, the left arm and legs will also begin to feel warm. When you have mastered this, all you have to say to do the exercise is:

'I am quite still, I am quite heavy, I am quite warm.'

without having to go from one arm to the other and then to the legs. Do not forget to 'take it back' by saying as before:

'Deep breath, eyes open, quite strong.'

and saying so take a deep breath, open your eyes, bend your arms smartly twice.

Third exercise

Put your right hand on your left side of your chest and imagine where your heart is, which you will feel beating. Imagine your heart beating in your chest and then say to yourself:

'I am quite still; I am quite heavy; I am quite warm: my heart beats steadily and strongly.'

Do not forget to 'take it back' after finishing the exercise.

Fourth exercise

Now we concentrate on breathing. Do not try to change your breathing, do not try to breathe any faster or more slowly or deeply than you normally do, but simply concentrate on your breathing, 'watch it' and say to yourself:

'I am quite still; I am quite heavy; I am quite warm; my heart beats steadily and strongly; I am breathing steadily and strongly; it breathes me.'

(This means to say that it is not you making the effort or doing anything about it, but it comes quite by itself.)

Do not forget to 'take it back'.

Fifth exercise

Now concentrate on your stomach and say to yourself:

'I am quite still; I am quite heavy; I am quite warm; my heart beats steadily and strongly; I am breathing steadily and strongly; my stomach flows with warmth.'

Do not forget to 'take it back'.

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Sixth exercise

Now concentrate on your forehead and say:

'I am quite still; I am quite heavy; I am quite warm; my heart beats steadily and strongly; I am breathing steadily; my stomach flows with warmth and my forehead is nicely cool.'

Do not forget to 'take it back'.

This finishes the course of concentrative relaxation and you can use it to refresh yourself when impatient, tired, anxious, worried or in pain.

It is not a game but serious, and it is not advisable to do it without professional supervision.

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