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Manuscripts and editorial matters should be addressed to the Editor, Dr Wendy-Louise Walker, 14 Hammond Avenue, Croydon, N.S.W. 2132, Australia. All journal business communications and subscriptions should be addressed to the Editor.

EDITOR'S NOTE

This is a special issue of our journal. Instead of offering reviewed papers in the usual way, this issue comprises a set of case studies offered as part of the examination process for the Diploma of the Australian Society of Hypnosis. The Board of Education provided a set of high-scoring case studies available from examinations over the last few years; authors were asked if they would be willing to have their work published and, if so, to obtain permission from the patient(s) whose studies were reported. The case studies were not further reviewed and it was not required that they be modified into the usual format of our journal articles.

The future editor plans to publish the best case study (as reflected in examination marks) each year and I believe that this will be a most appropriate recognition of hard work well done; it will also be of interest to our readers and a guide to future examination candidates.

Wendy-Louise Walker
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HYPNOSIS IN THE TREATMENT OF CHRONIC PAIN

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Dentist

This case report illustrates a multi-disciplinary approach, including the use of hypnosis, in the management of a patient who had been suffering chronic head, neck, and back pain over a four-year period. The patient had in that time seen a number of different practitioners in various health-care fields without a great deal of success. Hypnosis proved a flexible and useful treatment modality.

Although a patient of my practice, Karen (age 26 years) presented for treatment for chronic head, neck, and back pain a little indirectly. She had been receiving treatment from a physiotherapist for her problem and had been referred to a nearby dentist who referred her to me for assessment of her associated facial pain.

At the first consultation, Karen explained that she had been suffering from head, neck and back pain for some five years. It had started initially when she awoke with a stiff neck which she put down to having slept funnily, but now commonly involved her back, neck, and the side of her face and head. She had been starting to get headaches in the temporal area and also at the back of her head. Some of the facial pain and headache problems were characteristically not present when she went to bed but would be there when she awoke in the morning.

A general discussion found that Karen was in a busy job in a supervisory position. She thought that she handled the stress reasonably, was aware of clenching her teeth at times during the day but was uncertain as to whether or not she may have bruxed at night. Overall she did not think she was particularly stressed.

Karen said that, due to the treatment she had received over the previous few years, she had become very aware of her posture and work position. She thought that she had been able to eliminate them as factors contributing to her problem.

Dentally, Karen had an anterior open bite which precluded her from contacting her anterior teeth. She showed sensitivity in a number of the

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masticatory muscles and particularly the masseters and temporalis, which correlated with her complaint of aching in the side of her face. The right tempormandibular joint was slightly tender to palpate and she had no history of clicking or locking.

Towards the end of this visit, Karen mentioned that she and her husband had just bought a new house and had taken on a "huge overdraft." At present they were living in a caravan at her in-laws' house and apparently sleeping on a rather unsupportive mattress. In discussing this, Karen realised that she may have been dealing with more stress than she had at first realised.

At the second appointment I had Karen go through the history of her problem and describe what she could remember of the various treatments. The original stiff neck she had complained of had begun after falling asleep on the couch the night before. On awaking the next day, she had put this down to having slept in an abnormal position. Within several days she had little movement in her neck and a very bad headache in the temporal areas. She visited her doctor who had "cracked her neck." This produced an immediate improvement, for that day at least, in both the movement of her neck and in her headache. (This had greatly surprised the patient.) However, the problems returned the next day. She had then been referred to a physiotherapist, whom she had seen for months but with no satisfaction. The headache had passed after a week or so but the stiffness and restriction had remained.

An occupational therapist had made suggestions regarding her workplace. She had then tried massage for a number of months, with no longlasting effect. From there Karen had seen a chiropractor, who had treated her for her neck and back which were "out." She stopped this course of treatment after several months when she was not getting any improvement and found that her mid-back area, which previously was all right, had started becoming stiff. From there she had seen her doctor and been referred to an orthopaedic surgeon, before seeing another chiropractor for eight months. Each session with him left her "feeling a million dollars," but the next morning she would be back to where she started from. Eventually Karen lost confidence in this operator after he admitted he could not understand why she was waking with the problem again the next day.

Karen then saw her doctor again and was told that a lot of her problem was postural. She was referred to a physiotherapist who diagnosed a hypermobile spine. A program of gym work and swimming to develop her back muscles followed. Some improvement was noted but without removal of the symptoms to a level that satisfied the patient. The physiotherapist was about to cease working and had suggested referral to a dentist and if that did not work, then hypnosis. As a result, I was seeing Karen with both aspects in mind.

PRESENTING SYMPTOMS

When I first saw her, Karen was complaining of pain at the top of her neck and extending down into her shoulders and mid-back. She said that the pain was present most mornings and was accompanied by stiffness and limitation of movement. There was also aching in the side of her face which was noticeable on waking. It was not present every morning but was very bad when it occurred. Headaches had been occurring about twice a week although this had increased to about four times per week when she started the gym work. This increase had been attributed to her doing some of the exercises incorrectly and had been corrected. Headaches when they occurred tended to be present in the mornings and then persisted during the day.

FAMILY HISTORY

The eldest of four children, Karen has two sisters and one brother. No other members of the family have a history of pain.

Karen said her childhood was fine but that her teens until the age of 18 years were very traumatic. She does not like being told what to do and her relationship at that time with her mother was bad. However, this apparently improved when she turned 18 and she described their current relationship as good.

OTHER

Karen gets to sleep easily but is not a good sleeper. She said that she sleeps lightly, will sleep for a minimum of nine hours per night but with many interruptions, and rarely wakes feeling good or energetic. She finds it hard to get motivated. On questioning, Karen could remember waking at times with her teeth firmly clenched and was aware at other times of being tense but without the teeth in contact.

She said that she "gets bad dreams fairly often," and these nearly always see her locked up and held captive. She will try for quite a while before eventually escaping and then is pursued. She described the feeling throughout these dreams as "pure terror."

When we discussed hypnosis, Karen was quite positive in her approach. She had participated in a "mind power" course several years ago which she had found very interesting. She thought that hypnosis would be similar, but probably more powerful, and would offer more possibilities while still leaving her in control.

Dislikes included being at the dentist's, rowdy surroundings, spiders, and being on her own at home or coming home alone at night. She also is frightened of water and tried to overcome this about six years ago by going on a canoeing trip. The canoe she was in had capsized and she panicked and almost drowned. Karen thought her fear of water had started somewhere in her childhood

and that the canoeing episode did not relate at all to the pain she was experiencing now. Despite this fear, Karen can swim and likes being on boats.

Karen described things she liked as travelling, the bush and nature, learning, sunsets, and dogs. She said her favourite place was a beach near Port Lincoln named Memory Cove.

Eyeroll was assessed according to Spiegel (1972) and rated as between a 2 and a 3.

TREATMENT

It was decided to treat Karen using a number of approaches. I felt that perhaps some of her problem might relate to the areas that had been diagnosed previously (i.e., posture and perhaps a hypermobile spine). However, I felt there was a strong correlation between her facial pain and quite probably some of the neck and shoulder stiffness with parafunctional activities of the teeth and jaws. These problems can be very difficult to control, especially nocturnal bruxism, and are exacerbated by stress and life events. I suspected that with the previous treatments she had received, the pain recurred each morning due to bruxing at night. Karen's anterior open bite, I felt, left her more predisposed to clenching or bruxing problems and it was decided to also construct a bite plane or splint to wear at night to control these factors as much as possible. She was informed of the link between stress and craniomandibular pain dysfunction problems, and some of the potentially damaging stressors in her life were discussed.

She was referred to another physiotherapist, who is very familiar with handling patients with such facial pain problems, and to continue with treatment for the other areas such as the back and shoulders. The physiotherapist was also able to assist Karen with such factors as posture and work positions, discussions on mattresses and pillows, and in making Karen more aware of when she started clenching, etc. during the day. To aid dealing with stress and to help her learn to relax, it was decided to make a "relaxation tape" to use at home and also to teach her self-hypnosis. Several sessions of hypnosis were planned to see if she could learn methods for decreasing her pain and if necessary, to find if there was some other basis for it.

First Visit

Initially a tape was made using a technique for hypnotic relaxation via sensory awareness (Clarke & Jackson, 1983). This technique was developed to overcome resistance and is particularly good at "sneaking" people into hypnosis. Karen was told that I was making her a relaxation tape that I wanted her to listen to each day. Having her follow her reactions to the questions put to her while making the tape allowed me to assess her response and gain some insight into her hypnotic capacity. In fact, Karen did enter a trance and became very relaxed during this procedure. The tape contains a great deal of ego-strengthening and suggestions specific to her situation were incorporated.

On "waking," Karen described feeling very relaxed and said that she found the sensation to be most pleasant. She was then told that we would use an hypnotic induction technique to see how effectively she could enter a trance and the Chiasson technique (American Society of Clinical Hypnosis, 1973; Crasilneck & Hall, 1975) was explained to her. She entered a trance quite rapidly and this was deepened by focusing on her breathing, followed by progressive relaxation. Karen was then encouraged to imagine being at Memory Cove after which the image — of a fairground (the Royal Show) and some helium-filled balloons — was used to produce levitation of her arm. This was quite effective, with the entire arm lifting from the chair.

A procedure to induce self-hypnosis was described to her, after which Karen was "awakened." She described being able to visualise Memory Cove and the fairground very well and found the levitation of her arm to be most impressive. After this, she was guided back into hypnosis using the technique she had been taught and then allowed to take herself in and out several times. Karen did this very well.

Second Visit

Karen reported having used the tape at least once or twice a day and found it to be relaxing, especially at the end of the day. She said that she became very relaxed when listening, and while the aches or stiffness might remain, she felt in a better frame of mind and so coped better. The worries of the day tended to bother her when trying to get off to sleep, but Karen volunteered that she had been sleeping much better since using the tape.

I intended at this visit to give the patient suggestions which might be useful to help her decrease or alter her pain. It was also decided to see if the patient could be helped to get off to sleep better by giving her some means of eliminating the day's worries. We talked for some time about how she saw her pain to get some insight into what images might work best for her. Karen said that it helped her if she was given specific directives to work with and could have a final objective in mind.

The patient induced a trance which was deepened by focusing on her breathing and then using the image of an elevator to deepen further (Kroger, 1977). I directed the patient's conscious mind to imagine being at Memory Cove and directed a number of suggestions to the subconscious mind. The first was in trance, to visualise taking the day's worries in her fist and crushing them until they were so small and insignificant that they no longer bothered her. They would then be set aside, allowing the patient to get off to sleep. To alter the level of pain, I suggested that she visualise the size, shape, or colour of the pain (Crasilneck & Hall, 1975), and then alter these to a more soothing colour, a softer shape, or a smaller size to decrease her discomfort. She was told that she would be able to eliminate any unnecessary pain but stressed that it would not work for necessary pain. Similar ideas were presented to decrease tension in muscles by imagining the muscles "unknotting" or perhaps

seeing the redness and inflammation go from a sore or stiff area. She was told that she could use any of the various methods as appropriate to make her discomfort less significant.

Karen was told that she should practise self-hypnosis regularly, and that she would become better and better. It was suggested that she would be able to visualise herself attaining her final goal of being able to waken and function without discomfort.

I was a little concerned that Karen tended to dwell on her problems and that this may have made things worse. Consequently, I assured her that her subconscious would know what had to be done and that she should not become obsessed with worrying about her problems. She was told that she should aim towards seeing herself taking control of her problems on her own, without relying on, constantly seeing, or needing various therapists.

At this stage, ideomotor signals (Cheek & Le Cron, 1968) were established and their use confirmed. The patient was instructed to bring on her pain and to indicate when she had been able to do this. She was then told to use the techniques described to reduce this level of discomfort and was successfully able to achieve this. She was given some positive reinforcement about this and the procedure was successfully repeated with the patient this time bringing on a greater level of pain. A similar procedure was carried out getting the patient to reduce tension in her neck, back, shoulder, and facial muscles.

Finally, it was suggested to the patient that she practise self-hypnosis several times a day, including at work or as required if her problems became apparent. I stressed the role the power of her mind could play in helping her to overcome her problems. After this, Karen was "awakened."

In discussing this session with Karen, she disclosed that she had been quite successful in visualising her pain. It had had a sharp outline with long spikes and was coloured black and red. She said that she had been more successful in bringing on her pain the first time but the second attempt had resulted in better removal of the pain, with reduction everywhere except her neck. Overall, she felt happy about having what she saw as positive things to work with.

Third Visit

At this visit, the occlusal splint to be worn at night was inserted and adjusted.

Karen initially had some trouble wearing the splint and said that she had problems with dry retching. However, she had listened to the relaxation tape with the splint in place and had been all right ever since.

Fourth Visit

After wearing the splint for a week, Karen had experienced no facial pain whatsoever. However, in the last three days she had experienced pain in her back and neck as intensely as ever. She had been moving house at that time and described being "flat chat." In that time she had not listened to the tape,

nor had she used self-hypnosis. Prior to commencing moving, though, she had quite a reasonable time at work with back pain at a low level which she could handle. She had not been controlling her pain using hypnosis but described being more relaxed and said she was coping better.

Karen expressed some dissatisfaction with using the techniques given her last time for removing or altering her pain. Rather than just assigning a colour or shape, she preferred to be able to visualise the affected areas with more "true life" images of muscles, etc. It was decided at this visit to provide her with alternative methods for controlling her pain along these lines, and to use ideomotor questioning to ask questions of the subconscious mind about its nature.

Karen carried out her induction procedure and the trance was deepened by getting her to focus on her breathing, followed by progressive relaxation. I again used the image of helium-filled balloons to get levitation of her arm, and used this to reinforce relaxation throughout her body, but particularly in the head, neck and back. The subconscious mind was addressed and some ego-strengthening given. Karen was told that she would, with time, get better at seeing herself the way she wanted to be, waking without pain, stiffness, or discomfort, and able to function comfortably throughout the day. She was told that by practising self-hypnosis she would improve her own hypnotic ability and be better able to control her problems. I reinforced the idea of her being able to see herself at an end point in treatment.

At this stage the levitation was reversed by getting the patient to imagine seeing the balloons released. She was told to imagine herself at Memory Cove and told that she could stay there while I addressed the subconscious mind. The understanding of ideomotor signals was checked before proceeding.

I gave Karen a far more anatomical description of her back and neck muscles by peeling away layers, working from the skin in. I described the muscle layers complete with associated blood vessels and nerves. Karen indicated that she was able to visualise this image quite well, so I proceeded to get her to follow the nerves back to a "switchboard" in the brain (Crasilneck & Hall, 1975). She was told that by disconnecting or switching off the connection from an area of her body, the feeling from that area could be blocked. She was told to indicate when she could see the connection to the middle finger of her right hand and to then disconnect it. This resulted in loss of feeling to that finger which she restored by replacing the connection. I then had her repeat this for the painful areas of her back. After this, she brought on some back pain and successfully removed it using this model.

Since Karen had wanted some image of blood flow through these areas, I then gave her a picture of the vessels supplying her muscles as a form of plumbing system. She was told that, with increased blood supply to the areas, they would receive more nutrients and become more comfortable and relaxed. She was given a cue to use when required of taking and holding a deep breath while she pinched the finger and thumb of her right hand. On releasing

the finger pressure, she would breathe out and relax. As she did this she would feel increased blood flow to the tender areas, causing feelings of relaxation and comfort. I then tied together the need for her to continue to work on all of the things that had been discussed with her (i.e. working on her back strength, ability to relax, practising her hypnosis, and visualising herself the way she wanted to be) with some positive input on the more relaxed sleep she would obtain when she had delivery of the new bed she had ordered (after discussion with the physiotherapist).

I then proceeded to ask questions of the subconscious mind, with the first being whether it knew of any other reasons for her to be experiencing the problems she has.

Significantly, the answer was *no*. When asked if she could see herself achieving her goals, she replied in the affirmative. She was given positive reinforcement that she could take control of her problems herself. I then had her experience bad back pain and remove it, using any of the techniques she knew of, and she was able to do this. I finished by having the patient relax more and more and had her carry that feeling with her on awakening. After some further ego-strengthening, she was "awakened."

On discussing the session, Karen said that she was struck by the amount of emotion she felt when she experienced the pain. Each time I brought on the pain she said she just wanted to cry and was feeling pent up feelings of frustration and anger. She was aware of her thumb answering *no* to whether there was any other reason for her to be experiencing the pain, but at the same time she described seeing an image of the capsized canoe. It seemed to me that the subconscious had answered here and I wondered if the image she described might have been due to her bridging on the emotions she was experiencing when thinking about the pain. I thought it might be worth exploring any possible connection here at the next visit. Karen had developed the image of the switchboard very well and had found it to be very good at removing pain, but she hadn't been able to get as good a picture of the blood vessels. I discussed a picture she could try working on.

Fifth Visit

Some two weeks later, Karen reported having had the best fortnight she had experienced in the last four years. There had been no pain in her back or face and she was very happy. However, three days before I saw her she had woken on the Saturday morning with mild stiffness across the neck and shoulders, which had persisted during the day. She also had a headache which lasted all day. The following day there was no headache but her neck and shoulders were worse and, when she started work on Monday, they were worse still as far as stiffness was concerned. She had been forced to see the physiotherapist that night as an emergency.

Nothing significant was found in the history of the period to suggest why she had undergone such a dramatic retrograde step, other than the fact that

she had been on holidays and was facing going back to work. She had stopped her headache getting worse on Saturday using self-hypnosis, but hadn't tried to remove it.

It was decided to explore some of the possible other reasons for her pain under hypnosis and the patient entered a trance using her technique for self-hypnosis. Again it was deepened using breathing and relaxation, followed by the image of going down on an escalator.

When questioning began, Karen's subconscious said there was no reason why she could not get rid of the pain. She was then asked to go back to the pain she had experienced on the weekend and describe her emotions at the time. To this she replied "fear" of the pain and "frustration" as to why. The subconscious indicated that there were no emotional reasons for her pain. No correlation was found between the first time she had experienced the problem and her canoe incident. Fear and frustration were used as an affect bridge (Watkins, 1963) and she described first feeling like this when going to the first chiropractor after she realised that the treatment she was receiving was not getting her better. I had her re-experience the first time she had her stiff neck but she indicated that there were no emotional overtones at that time. With the canoeing accident, Karen described feeling panic as she thought she would die, but this did not seem to correlate with her problem. I questioned her on how she felt about work and also about her teenage problems with her mother. On both counts, she indicated no connection with her problem although I noted that her replies relating to the relationship with her mother were directed very much by the conscious mind. She was directed to tell me how she felt about this period and she said that, although she had felt a deal of emotional pain at the time directed towards her mother, their relationship now was good. She did not think that this related to her troubles. I let this go at the time but wondered if it might be worthy of further investigation at a later date if her problems continued, as I thought some signs of resistance were apparent. Lastly, I asked again if there was any reason why she could not get better to which she replied *no*.

Before "awakening" the patient, I told her that the recent backward step might be nothing more than a minor hiccup in her progression towards being well again. I reinforced how well she had been going and told her that it was a little too much to expect to have all of her pain disappear so rapidly after having it for so long. I pointed out to her that she might have brought on the exaggerated response that was seen after waking with a small degree of discomfort by her emotional response to it. She was told to deal with each situation as it arose, using the techniques she had at her disposal. Again she was told to visualise herself at the end point she wanted to achieve and to experience how pleased she would feel. I reinforced that with what the subconscious mind had answered tonight: that there was no reason for her not to continue to improve and that this was something she could achieve herself.

Finally, I had the patient relax completely with particular emphasis on the painful and stiff areas of her neck and back. She was "awakened" with the inclusion of a suggestion that she would continue to feel much more comfortable than she had when she arrived.

On discussing this, Karen was pleased with what had transpired and showed dramatic improvement in the range of movement in her neck in particular. When seen by the physiotherapist at the end of the week, she was fine.

I told Karen that I had confidence in what her subconscious mind had answered and that from here on it was up to her to continue with her improvement. She could contact me at any time and perhaps continue to see the physiotherapist if required to discuss any problems for treatment of any symptoms that were proving difficult. An appointment was made for adjustment of the occlusal splint in a further six weeks' time.

Follow-up

Karen has maintained a positive mental attitude and feels that she is continuing to improve. She has still had slight headache and facial pain problems develop during the daytime and has been warned to beware of clenching her teeth when under stress. However, she uses the tape regularly and finds it invaluable. She is waking feeling much better and says she is coping better as well.

CONCLUSIONS

This patient presented with chronic pain in the head, neck, and shoulders which had defied efforts by many therapists in the various health-care professions. The approach taken was to combine some more traditional dental procedures with hypnosis, along with treatment from a physiotherapist who was familiar with the sort of procedures I would be performing. I feel that this last aspect was important as it gave a great deal of positive reinforcement to the patient to hear variations on the same theme coming from several sources.

Hypnosis was invaluable in helping the patient learn to relax better. She found the use of the relaxation tape to be most beneficial. Hypnosis also helped in giving the patient some means of controlling her problem herself, and was instrumental in the patient developing a much more positive attitude. While no underlying reasons for the pain were found with questioning of the subconscious mind, it is still quite likely if her pain persists that such a causative factor may be present. However, while Karen has a positive approach to her problem and is improving, I have decided to just continue to give her positive support.

In reviewing this case I feel that, in much of this, Karen has probably been her own worst enemy. It is in her nature to question and to think about her problem, and I think that this constant dwelling on it had a lot to do with her not getting any better. She has been encouraged to see herself being able to take care of her problems on her own and eventually to remove her reliance on therapists if possible.

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THE USE OF HYPNOSIS IN THE MANAGEMENT OF DENTAL PHOBIA

I. G. Bills

Dentist

This case outlines the rapid and effective treatment of a woman who had suffered a dental phobia for 47 years, since a traumatic experience at the age of eight years. Techniques employed in the two sessions included self-hypnosis, visualisation, and use of the affect bridge to re-access the early dental traumas.

This report outlines the use of hypnosis in the management of a patient suffering from a dental phobia. It was found that this patient's problem originated with a bad experience in a dental surgery some 47 years ago. So great was the impact of that experience that the patient has lived in fear of seeking dental treatment since.

HISTORY

The patient, Heather, aged 55 years, presented to my practice after referral from the South Australian Dental Service (SADS). She was in need of extraction of a tooth and construction of a part upper denture, but said that she was very worried about dental treatment. The dentist she had seen with SADS had suggested she see me for hypnosis in addition to her other needs.

On questioning the patient about her problem, I found that she related it to a bad experience at the age of eight years. At that time the dentist had apparently continued drilling her tooth despite the fact that she was experiencing considerable pain. Although Heather could accept that the treatment she currently required would not be painful and she was able to face having an extraction, her biggest problem was "getting to the chair." The suggestion of treatment using hypnosis was well accepted and she saw it as a chance to overcome her fear. Consequently, at the first visit, the nature of hypnosis, its use, and her feelings to it were discussed.

At a second visit, a more detailed history was taken. Heather said that her first visit to a dentist occurred during the Second World War, when she

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was about seven or eight years of age. She could quite vividly remember "the short, fat dentist with stumpy fingers" who placed local anaesthetic and then commenced drilling despite the patient being able to feel it. That was the only occasion on which she had seen that particular dentist, as the family had moved from Victoria to South Australia at that time. Despite seeing numerous other dentists over the years, Heather had not been able to get over her "terrible fear," which she described as "like being taken to the wall and shot." Prior to a visit to a dentist she would become "snappy and irritable" and her heart would start to pound. She said that she "could just about sit there and howl talking about it because other people can't understand what it is like." She described the feeling prior to each dental visit as in the nature of a panic attack. It would start when a problem arose with a tooth which she would then put off for as long as possible. As a result, her treatment over the years had tended to be with extractions rather than work of a conservative nature. In fact she said that injections didn't bother her at all; it was only "the drill" that did, and a fear of feeling pain.

Heather's parents apparently had no such similar fear, but her sister was much the same and Heather was concerned that her son had picked up on it as well, as he became very nervous about visiting the dentist.

Heather had had no prior experience with hypnosis, although she had nearly gone for help with stopping smoking. However, she had been able to give that up on her own.

Eye roll was checked according to Spiegel (1972), with the result that the patient's upgaze was rated as between 2 and 3 but the roll scored a 2. Heather's ability to visualise was tested by asking her, with her eyes closed, to imagine a lady walking a dog on the footpath in front of her house. She said that she had been able to see this quite well.

I asked Heather about her likes and dislikes, which she described. She liked walking along the beach, preferably on her own in the early morning and in the summer time; swimming was okay; she enjoyed walking generally, whether it was on the beach or in the bush. She disliked dentists, lifts (escalators were okay), spiders, and driving the car when she didn't know where she had to go, especially at night.

TREATMENT

First Visit

At the first visit, a relaxation tape was made for the patient utilising a technique for hypnotic relaxation via sensory awareness (Clarke & Jackson, 1983). She was instructed to listen to the tape, which included quite a lot of ego-strengthening, at least once each day. The patient appeared to respond very well to the suggestion and became very relaxed.

It was interesting to note that the patient was quite nervous at the history-taking, talking in a loud voice and with a great deal of nervous laughter.

Heather was then induced with a Chiasson induction technique (American Society of Clinical Hypnosis, 1973; Crasilneck & Hall, 1975) and the trance was deepened using breathing and progressive relaxation. She was asked to picture being at a fairground as a young girl and the image of a bunch of helium-filled balloons produced levitation of the whole arm. It was interesting to note that Heather's arm was jerking quite sharply at times. When questioned about this later she explained that she had never had balloons as a child so she was not going to let them go when she could feel the breeze blowing them. Following this she was given suggestions that would allow her to use self-hypnosis and the trance was terminated.

Heather said she thought she might have been resisting a little through being worried about losing control, but had been very relaxed and had been able to visualise very well. The aspect of control was discussed and the patient was told that, by practising self-hypnosis, I was sure that she would become more comfortable. Heather then said that she did not think it would be a problem now that she had experienced hypnosis, but rather that it had been due to some uncertainty on the first occasion.

Heather was then guided back into hypnosis using the technique she had been given and allowed to terminate the trance in her own time. She was able to successfully demonstrate the technique several times on her own before the session was ended.

Second Visit

At the second treatment session, Heather reported that the tape was working very well. She was getting very relaxed and had found she was sleeping much better than normal. Her usual pattern had been to have a quite disturbed sleep, waking a number of times during the night and then arising at about 6 a.m. Since using the tape, though, Heather had been sleeping through to 9 a.m. without waking.

Heather induced a trance using the technique she had been practising and quite some time was spent with deepening procedures to obtain a greater depth of trance and to increase the degree of relaxation. These techniques included progressive relaxation, having the patient visualise going for an early-morning walk along the beach and then a repeat of the fairground experience with arm levitation from the previous week. Once again a very good levitation was produced, with the entire arm lifting from the chair.

On reviewing this session later, I felt that probably more time than was necessary was spent in these deepening procedures. The patient had been quite relaxed from the start but I was concerned by the presence in my rooms at the time of one of my partners, who had decided to work late that night. It was quite disconcerting, to me at least, to have a quite high level of background noise with the sound of his high speed drill and the evacuator motors. I thought that, with the patient's particular problem, the background noise might produce an undesirable increase in her anxiety level. Suggestions were given

that she would become less aware of any background noise and more focused on the sound of my voice. Heather reported afterwards that this was quite successful as she was virtually unaware of the proceedings in the adjacent surgery for the entire time.

Ideomotor signals were established and confirmed (Cheek & Le Cron, 1968), and the patient was told that questions would be directed to the subconscious mind. Questioning revealed that the patient's response to dental treatment was not serving a worthwhile purpose, but also that the subconscious mind was not prepared to let go of these feelings. Consequently, the feelings the patient experienced on visiting the dentist were used to establish an affect bridge (Watkins, 1963) to identify the first occasion on which the patient had experienced these feelings. The patient started hyperventilating and became visibly upset. She indicated that she had been able to take herself back in time to her first dental experience and at that stage became quite frightened and started crying. She was asked to describe where she was and proceeded to explain in a most upset voice that she was eight years old and had been taken by her mother to the dental surgery for some fillings. She complained that she didn't want to go into the surgery, and then described being given "needles" for fillings on both sides of her mouth. When the dentist started drilling she felt pain, but he continued for what seemed to her to be forever. Heather was able to describe her surroundings and the events that occurred quite vividly.

At the end of this experience, Heather was still quite upset. I reassured her that she was safe and then spent some time reconciling the events that had taken place. It was suggested that what she had experienced as an eight-year-old was quite unnecessary and that with modern techniques there was no need for her to have to go through a similar experience. It was suggested that the protective mechanism that the subconscious mind had enforced was no longer necessary. Her subconscious mind from the "here and now," with its wealth of experience, was encouraged to talk with that of the eight-year-old Heather to reassure her that she was safe. It was suggested that the present-day Heather could comfort the eight-year-old and help her to accept that her reactions to dental treatment were no longer necessary.

Ideomotor questioning revealed that, while Heather was confident that she could now have painless dental treatment, she was still unsure about removing the protective mechanisms. Consequently the affect bridge was used to examine other experiences after Heather's first traumatic episode. She revealed that the second dentist she had seen had been in Adelaide and that he had been quite a nice man whom she had seen a number of times to the age of 16 years. However, she felt that he was not much better than the first dentist she had seen as she had always felt pain. She expressed always having "horrible fear" on each occasion she had to receive treatment.

By this stage, while still in trance, Heather was complaining of a headache so the decision was made to end the session. The mental image of riding

down on an escalator (Kroger, 1977) was used to deepen the level of trance and this worked very effectively. When she was once again relaxed, Heather was given some very positive feedback about what she had achieved in this session and told that she could be well pleased. Again the present-day Heather's subconscious mind was asked to speak with that from the younger years and to reassure them about dental treatment. She was told that over the next week or so she would become aware that she was far more confident that she could receive treatment without feeling pain and would therefore not need to experience the fear which had previously accompanied dental visits. She was told that she could feel proud that, despite her fear, she had managed to save as many teeth as she had, and been able to still obtain treatment when it was necessary. The trance was terminated with a suggestion which included stressing the disappearance of the headache she had experienced.

In discussion afterwards, Heather said that she had really re-experienced the feelings she had felt at the time of her early dental visits and had been absolutely terrified. She said that she had developed a shocking headache but was all right now. Since she had an appointment to carry out some dental procedures shortly it was decided to see what results were produced by this session. It was stressed to the patient that she would be able to enter a trance if she so wished and "remain at her favourite place" for the entire time.

Follow-up

At the dental appointment, Heather said that she had not slept at all well the night after the last visit but was back to normal now. When asked how she had felt prior to coming in for this appointment she said that she had been far more relaxed than normal and in fact it hadn't really bothered her at all.

The required work, which was of a relatively minor nature, was carried out on this and a subsequent visit with the patient in trance and imagining herself walking along the beach early in the morning. She managed these visits without any problems whatsoever and was very pleased by this.

Despite the minor nature of the work required, I was very pleased that Heather had been able to attend for treatment without any of the usual feelings that had been present at every dental visit she had made over the last 47 years. I felt confident that more demanding procedures could be carried out at any stage in the future when required by using this same technique.

CONCLUSIONS

The case described here has illustrated how hypnosis may be used to bring about changes, quite rapidly in some instances, to overcome a dental phobia. The patient had suffered with her phobia for most of her life and it had resulted in a poor level of dental care as well as a diminished self-image.

Heather demonstrated a quite good hypnotic capacity and was readily able to learn a technique of self-hypnosis. Through practising self-hypnosis and listening to the tape made for her, she experienced an improved ability to

relax which had an additional benefit in markedly altering her sleep patterns. The "revivification" of her early dental experiences demonstrated a very strong emotional component and allowed a rationalization of the defensive mechanisms that had been active from that time.

The treatment carried out was effective in allowing the patient to quite comfortably present for dental treatment. Hypnosis can be used in the future when dental procedures become necessary to permit her to undergo the required procedures without undue anxiety.

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HYPNOSIS IN THE ALLEVIATION OF ANXIETY

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Dentist

This case illustrates the effectiveness of hypnosis in alleviating anxiety and any allied physical symptoms, which can be a considerable inconvenience and embarrassment to the person concerned. It is a case of a woman who presented in a state of panic about giving a paper at a seminar for colleagues in her profession. In reducing her anxiety she was also able to gain control over the extremely distressing problem of excessive sweating which had troubled her since her teenage years.

PRESENTING PROBLEMS

Terese was a very competent professional woman aged 38 years. She was a slightly built person, well spoken, smartly dressed and friendly, but was extremely tense when she contacted me at 6.30 p.m. the night before she was due to give a one-day seminar, asking to see me that night.

As she sounded extremely agitated, I agreed to see her. Terese told me she had agreed to present this seminar after successfully speaking to a small group of a dozen people on an allied topic, believing she would be facing approximately that number again. However, she had discovered that day that it was to be a much larger group. She said she had prepared all the information, she knew it thoroughly, had been over and over it, but had panicked at the thought of standing up in front of all those people, mostly colleagues, on the following day.

I had used hypnosis with her 11-year-old son, Daniel, approximately six months before this, originally to help him relax and reduce his anxiety level during dental treatment. However, as hypnosis had also helped with a sleep problem he had, Terese felt perhaps it could help her too.

Terese complained of excessive sweating whenever she became anxious, to the extent that sweat would drip from her clothes, and often she would have to throw away blouses or T-shirts after only wearing them once or twice.

The problem had arisen when she was in her mid-teens. Over the years she had been referred to many specialists concerning this problem, as her

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general practitioner had considered hers an exceptionally severe case and a serious problem for her, as she deals with people all the time in her profession. One endocrinologist had given her a prescription antiperspirant containing aluminium which had helped her in that it reduced the damage to her clothes.

She described feeling hot and uncomfortable when speaking to a group and was always preoccupied with the thought that the anti-perspirant would fail. She said she felt tense and uptight, went quite red in the face, felt very hot, and began to speak very quickly — she could hear herself getting faster and faster but could not seem to do anything about it.

Terese felt that she would either not be able to go to the seminar next day, or if she did, she would not be able to speak once she got there.

HISTORY

Psycho-Social History

Terese is happily married and lives with her husband, Sam, and their two children, a 13-year-old daughter and an 11-year-old son. She is the fourth of six children, all of whom were born in Europe. Her mother is French and her father, who died of cancer three years ago, was Scottish.

Terese gets on well with most of her siblings most of the time and has a variable relationship with her mother, as do all of the family. Her mother is a volatile but extremely competent businesswoman who has run her own business since arriving in Australia. She has always been a perfectionist and expected much of her children.

Having been very close to her father, Therese has taken some time getting over his death. She feels she has handled that adequately as she believes she did all she could during his illness and had the opportunity of telling him what she needed to tell him before his death.

Terese started school in Scotland and came with her family to Australia when she was seven years old. She completed school and went straight to university, then worked full-time, both in the U.S.A. (where she met her husband) and in South Australia, until her daughter was born. She resigned from her position and stayed at home with her children until her son went to school. When she returned to her profession she worked for a year and then decided to enrol for a higher degree while still working.

Medical History

Terese described herself as being exceptionally fit and healthy, walking or swimming every day and playing sport once a week.

She has only been to hospital for the births of her children. Apart from her many visits to her general practitioner and various specialists concerning her sweating problem, she has never needed medical attention.

SUITABILITY OF HYPNOSIS FOR THIS PATIENT

Terese had not herself experienced hypnosis before. However, she had sat in with her son during his four sessions and had been very supportive of its use with him. She had told me at the end of one session with Daniel that she felt as if she had been "up on that cloud with him," so she may have experienced trance already. As she had commented about this reaction to Daniel's session, I used only the Spiegel eye-roll test to assess hypnotisability formally. Terese was assessed as 3, using that test.

Although Terese seemed very tense and agitated on this occasion (much more than on previous occasions when she had accompanied her children for dental treatment), she appeared a sensible woman with a clear idea of what she wanted from hypnosis.

She did not have a history of psychiatric illness, nor did she present with any symptom which could have been a contra-indication for hypnosis, such as a psychotic illness, or depression with a suicidal component.

GOALS OF THERAPEUTIC MANAGEMENT

Terese's main aim was to be relaxed enough to be able to present her paper the following day, and to do it well, so she would not be embarrassed in front of her colleagues.

Together we worked through what Terese hoped to achieve using hypnosis.

1. Terese needed to feel confident, relaxed, and in control.
2. She wanted the level of anxiety to be reduced to a manageable level.
3. She wanted her body temperature, and in particular her sweating, to be under control.
4. She wanted to speak slowly and clearly when delivering her paper.
5. She wanted the feelings of achievement after presenting this paper to extend into the future and act as a springboard for future growth.

TREATMENT PLAN

As we only had the one session I decided to use a number of techniques to achieve our goals in the hope that one, some, or all would be successful. I planned to use:

1. Progressive relaxation to reduce her autonomic arousal.
2. Ego-strengthening to build her self-esteem and confidence.
3. Visualisation of a safe place for feelings of security and control.
4. Passages of the mind to control body temperature and sweating.
5. Suggestions that she will speak clearly and slowly.
6. Anchors for Terese to use to re-experience feelings of calm and serenity felt under hypnosis.
7. Systematic desensitisation and mental rehearsal of presenting her paper.

8. Self-hypnosis for Terese to use for reinforcing what she experienced under hypnosis and for her to give herself positive suggestions concerning self-esteem and confidence.

TREATMENT

I went through a very careful explanation about hypnosis, even though Terese had been present when I had treated her son. We discussed the myths about hypnosis as presented by Clarke and Jackson (1983) and also by Hammond (1990). Amongst these were the myths that it is a sleep state; that the hypnotherapist takes control of the person's mind and programmes that person; that it is magic; that it requires immobility; that it means the person has to try hard; that it is dangerous; that it can uncover and potentiate psychological disorders; and that it makes the person more difficult to live with, or otherwise do harm.

As I felt I needed to use a different technique from the one I had used with Daniel, I then used a Chiasson induction technique. Terese reacted quite quickly and, with the suggestion to concentrate on her breathing, and with each breath out to go deeper and deeper, she seemed rapidly to reach a very relaxed state.

I then went through a prolonged and very explicit progressive relaxation-deepening technique along the line of Hammond (1990), followed by further deepening using visualisation of safe, wide steps leading down to a garden which was described in detail, as Terese had told me (in earlier discussion about her likes and dislikes) that she loved gardens.

Arm levitation and hand clasping were then suggested by using visualisation to show Terese that she was a good hypnotic subject. The hand clasping is one of a number of "challenges" which, according to Crasilneck and Hall (1975), demonstrate to the patient that she/he has been hypnotised. I then set up ideomotor signals.

At that stage she was given the choice of staying in the garden or of going to "a place where you feel safe and secure, in control; it may be a place you have visited in the past, a place you enjoy visiting now or an imaginary place that you may wish to visit in the future but which you can imagine now, where you feel comfortable, relaxed and where you can return at any time you need or want to." Terese chose to leave the garden and go elsewhere, so I gave her the various sensory stimulatory suggestions that she see, hear, feel, smell and taste (if appropriate) all the special sensations associated with that place.

The ego-strengthening suggestions I then used were a combination of those of Barber (1984), Hartland (1971), and Stanton (1975), modified for Terese.

Then, via ideomotor signalling, I asked her when she was ready to leave that place (knowing she could return when necessary), to imagine a long passage with many doors. On each door was a sign indicating the part of the body which that room controlled; in each room a panel with lights and switches

which she could turn off or on. I took her into two rooms, the one controlling body temperature and the one controlling sweating, and, using ideomotor signalling to indicate to me what she was doing, she practised turning the switches on and off.

When she was ready I suggested she imagine being at the seminar, getting ready to speak, feeling very calm and relaxed.

I suggested that, as she was introduced to her colleagues the next day, she would feel a wave of relaxation flow through her body and she would stand up and walk to the podium; and as she was opening the cover of her paper a second wave of relaxation would flow through her. She would begin to speak, clearly and slowly, feeling very relaxed, comfortable, and perhaps even enjoying it. If at any stage she began to feel warm, or began to sweat, she could imagine the control switches without closing her eyes, and she would be able to switch them off in her mind while still speaking. She would look around at all those people and because she was concentrating on her talk they would not worry her.

She knew her work so well, she had prepared so thoroughly, that she would hardly need to refer to her notes.

I then gave her time to go through her whole paper, or as much as she wished, to feel absolutely confident about it. Not long after, she raised her finger to indicate she was ready to continue.

The last part of this session was teaching her self-hypnosis so she could practise at home and getting her to induce and terminate trance several times, utilising the last induction to again reinforce ego-strengthening, under the premise that the refraction occurring from rapidly going in and out of trance was taking her deeper each time.

We concluded the session in discussing how she felt about the various aspects of the experience. She appeared quite relaxed, which was a marked change from her appearance on arrival.

Although her comments were generally that it was a positive experience and that she had enjoyed the relaxation, she was quite surprised that she had felt so calm giving her paper. She had also been amused that her arm had risen at the suggestion that balloons were tied to her wrist.

When she left, she agreed to ring me during the next week to tell me how she went.

OUTCOME

I was not expecting to hear from Terese for a few days. However, the following evening I received a very excited telephone call from her. The seminar had finished only an hour before and she had rung me as soon as she could to tell me what a success she had been. In fact, she was highly elated, because she had been approached by a colleague at the end of the day and offered a lecturing position.

She said the presentation of the paper had gone almost exactly as she had rehearsed it. The only hiccup was during the first few minutes, when she began to sweat, but immediately she visualised the control switches and everything was under control again. She said she also used the clenched fist in the afternoon during question time, when she felt slightly anxious. She said she was surprised at how effective the technique was.

Approximately a month later, Terese came back for another session, in preparation for a follow-up seminar. She said she did not think she really needed the session but she wanted to reinforce what she had achieved, as she was feeling so positive about everything she did not want to revert to the anxious, agitated person she had been.

DISCUSSION

I had begun treatment with Terese with doubts about how effective hypnosis would be with just one session — one which I had not been able to prepare or think about in advance.

There were two positive aspects, however. The first was that she had seen how effective hypnosis had been with her son, so she came with the expectation that it would work for her too. The second was that there is the belief that the last suggestion given in hypnosis is the most powerful, and as she left me at 9.30 p.m. and had to be at the seminar at 8.30 a.m. the next day there was not much time for her to receive any other suggestions, either positive or negative, in or out of hypnosis.

I felt initially that the relaxation achieved in hypnosis would probably be of most benefit to her and that teaching her self-hypnosis as an adjunct to that would allow her to get through the next day's ordeal. But as we progressed through the session, and at one stage discussed several aspects of the session out of hypnosis (when I was teaching her self-hypnosis), it became clear that she had felt the mental rehearsal had been most effective. She told me on a subsequent visit that seeing herself get up and present the paper with such confidence had convinced her that she would be able to do it the following day.

The bonus for Terese was that the problem of excessive sweating, that she thought would always be with her as a source of continual embarrassment, was now under her control.

It seemed that "control" was a big issue for Terese, and that once her self-esteem and confidence had been restored by feeling she was in control of her anxiety and the allied physical symptoms, there was no stopping her, as her performance proved.

The fact that this case was so successful was probably due to Terese's motivation. Overall, it proved to me the power of hypnosis as a tool for reducing high levels of anxiety in patients, and as such has extensive application in my field by making dental treatment available to those who, because of their anxiety levels, find dental treatment very stressful.

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HYPNOTHERAPY IN THE TREATMENT OF PSEUDOSEIZURES IN A YOUNG MALE

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Psychologist

A 21-year-old male, diagnosed epileptic at age seven, presented, due to an increase in diurnal seizures over the preceding year. His history suggested, in addition to organic seizures, the presence of pseudoseizures, similar to a dissociative state. His predictably high level of hypnotisability was probably allowing him to use "trance as a coping mechanism" (Frankel, 1976). This skill was utilised and refined in therapy, using cognitive behavioural, rational emotive, and regression techniques. After 14 months of treatment, diurnal seizures ceased and natural seizures were significantly reduced.

PRESENTING PROBLEM

Relatively recently there has been considerable interest among clinicians and researchers in the interrelationships among the phenomena of dissociative mechanisms, phobic anxiety, and hypnosis. The following case study describes the use of hypnosis with a 21-year-old male, Justin, referred by his GP at his mother's request for stress management in June 1987. He was seen fortnightly for 14 months and is currently attending monthly sessions.

He presented with a high level of anxiety and a history of generalised complex partial seizures, in association with what appeared to be pseudoseizures. With the latter, the change in level of awareness, similar to trance, seemed to be a dissociative reaction to immediate stress and underlying dynamic conflict.

Justin had been employed by a large supermarket chain after completing Year 11 in 1985. In his final year at school he had been substantially free of seizures diurnally, although fitting two or three times per month prior to waking. His seizures at work gradually increased, until in the eight months prior to referral he had been experiencing seizures up to four times weekly, and had been hospitalised three times with status epilepticus, when he had become cyanosed. This coincided with ongoing conflict with a new manager.

The character of the diurnal seizures was changing, presenting a diagnostic dilemma for his neurologist, who preferred that the original diagnosis of general

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complex partial seizures be abandoned, and that "they should now remain unclassified to avoid malcategorisation."

At this time he was hospitalised for three weeks for complete neurological work-up and video observation. In that period he had no seizures apart from those deliberately induced by his neurologist. When he was informed that investigations had essentially proved unremarkable, and that he would be discharged, he promptly had two seizures that night. Justin's earlier prodromal symptoms tended to be olfactory (smell of smoke) and visual distortions (objects looked really bright), suggestive of temporal-lobe epilepsy. In addition, he often uttered single words or meaningless phrases repeatedly, and continuously clutched his arms or stroked his thighs, possibly indicating a psychomotor component. He would usually fall to the ground, apparently unconscious, for a few minutes. Tonic-clonic convulsions would be observed, and upon arousal, post-ictal stupor would be present, usually necessitating his being sent home.

At the time of referral the seizures experienced at work, as he described them, closely approximated the characteristics of seizures of psychogenic origin, as developed by Kanner (1972) following Charcot's earlier work (Glenn & Simmonds, 1977). Notably, they had an increasingly theatrical and bizarre quality, usually were precipitated by a high level of emotional arousal, and involved no unconsciousness as such (though lack of awareness) and no incontinence or tongue-biting. The issue of anxiety contributing to his current condition had been recognised by the neurologist and addressed by the addition of Frisium 5 mg b.d. to his considerable anticonvulsive medication regimen.

Although Justin's anxiety was apparently pervasive and free-floating, it is more useful in terms of treatment implications to view it, as would Clarke and Jackson (1983) as a multi- rather than uni-process phenomenon. The activation of the temporal-lobe arousal system underlying panic anxiety has been documented, notably by Frankel (1976) and Roth (1959). In addition to this biochemical/physiological aspect of anxiety there appeared to be other forms of anxiety — notably separation, cognitive, panic, and perseverative — operating with Justin.

The history suggested several factors implicated in the increase in severity of his seizures: (a) conflict with his superior; (b) frustration and anger with the realisation that his vocational goals would probably not be realised, and the fear that he might in fact lose his job; (c) the evident wish by his mother to alter the dependent relationship between Justin and herself; and (d) anxieties relating to sexuality.

HISTORY

Social

Justin is the eldest of three children with a sister two years younger and a brother fourteen years younger. The family unit has been reportedly under

some strain in the recent past while his mother undertook nursing training. Apparently the parents and extended family are accepting of his epilepsy and have offered constant support in the past. His mother was interviewed at her request and with Justin's consent, and it became quite apparent that her interest in seeking psychological treatment for Justin was in part influenced by her desire to attenuate what she perceived as his dependence upon her. An anxious lady, she freely expressed resentment of the way in which his epilepsy had negatively affected her personal development, and the "harmony of the family."

A recurring theme in the history is that of separation anxiety and dependence upon his mother. Separation anxiety occurred to a marked degree in kindergarten and up to Grade 3, during which time he was sent home occasionally when he failed to settle. Justin is aware of the relief he felt right through his school career upon going home with his mother or grandmother following a seizure at school.

Peer relationships were characterised by teasing and rejection. In primary school he tended to form utilitarian rather than close emotional ties with other isolates. In adolescence, his rather effeminate presentation added to the ridicule from his peers already engendered by his immaturity and his seizures. He left school at the end of Year 11, in large part to escape peer ridicule, and commenced his present job, with hopes of becoming a trainee manager. Currently, he reported that he had a small number of male friends from school, as well as a girlfriend with whom he did not appear particularly emotionally involved. He claimed not to be sexually active.

In eliciting Justin's conscious understanding of the nature of his seizures, he was well aware that he had never had a seizure when in a social situation with friends (even discos with strobe lighting) and never on public transport. Moreover, he volunteered that under these circumstances he controlled his seizures by positive self-talk and direct suggestion.

Medical

Pregnancy was normal, as was birthweight, although reportedly he was born with the umbilical cord around his neck. He had two febrile convulsions in infancy. Developmental milestones were normal. There is no history of epilepsy in the family and he had no recall of any family member suffering illnesses which may have served as a model for seizure behaviour. His mother suffers severe migraines.

The first seizure occurred at age seven, following a pre-medication injection, while in hospital for a tonsillectomy. He apparently fell face downwards and remained unconscious for several minutes. From that time, episodes of what his neurologist termed "a significantly impaired conscious state" and "strange behaviour" occurred periodically. A diagnosis of temporal-lobe epilepsy was made. This was confirmed by EEG showing a definite excess of slow components in the left temporal region, with spike discharges in the temporo-occipital region.

Seizures were essentially during middle childhood, punctuated by a few periods of multiple seizures. It is interesting to note that one of Justin's EEG reports following such a period suggests that "the left temporal focal features are only produced under conditions of *hyperventilaton.* At other times his EEG readings were normal." One wonders about a possible association between hyperventilation/anxiety/abnormal neurological activity.

As noted earlier, in the light of the seizures experienced since commencing work, his current neurologist declined to categorise them.

CLINICAL IMPRESSIONS

Justin presented as rather submissive and dependent. His initial lack of affect and spontaneity, and slow speech, may have been as much due to the effects of his medication as to a degree of depression engendered by his current situation. He appeared somewhat naive and emotionally immature but cooperative, and gave the impression he was waiting to be told what to do. Locus of control was externalised. His perception of the problem at this point was essentially that people's attitudes towards his disability were making him "upset" and preventing him from achieving his goal, which was a trainee managership. His relegation to "safe" jobs within the store was, in his perception, a result of the manager's ignorance and discrimination.

He claimed that having seizures per se did not bother him but, as they were apparently affecting his future, he was prepared to do whatever was suggested in order to curb their incidence.

ASSESSMENT

The first two sessions were spent taking a detailed developmenal and social history, as well as history of his seizure pattern, paying attention to precipitants and emotional state. This record-keeping would continue for the duration of the treatment. Justin took home a lengthy questionnaire which I give to all clients, and which he compliantly completed.

In session 3 objective assessment of depression and anxiety was undertaken as an adjunct to clinical impression. Depression was assessed by the Beck Depression Inventory. A score of 11 with an interpretation of "mild mood disturbance" was obtained. Administration of the IPAT Anxiety Scale yielded a sten score of 8 for combined state/trait anxiety normed on a mixed college student population (average age 22), indicating a high level of anxiety.

Justin's high level of anxiety alone, without considering his seizures, suggested that hypnosis would be a potentially useful adjunctive treatment modality. In addition, the literature has pointed to the fact that subjects suffering pseudoseizures are almost without exception highly hypnotisable and that the seizures themselves are probably dissociative states, similar to trance, or panic states (Spiegel, 1983, 1986). The observation that phobic individuals tend to

be highly hypnotisable has been made by Frankel and Orne (1976), and John, Hollander, and Perry (1983).

It is likely then that Justin had been, in Frankel's terms, already using "trance as a coping mechanism" for acute levels of stress and anxiety (Frankel, 1976). The task was therefore seen to involve using the client's level of responsivity in treatment to enhance control, and to enable him to use dissociation and trance capacity in a more adaptive fashion.

In session 4 the Stanford Hypnotic Clinical Scale (Morgan & Hilgard, 1979) was administered. Justin demonstrated deep trance capacity in obtaining a maximum score of 5. Retarded speech, and marked eye roll with partial amnesia persisting after post-hypnotic suggestion, were noted. His responses on the SHCS suggested that visual imagery dissociation, regression, and post-hypnotic suggestion could be incorporated successfully into a treatment program. Specifically, he could be taught to initiate or end a psychogenic seizure on cue, or to relegate both psychogenic and organic seizures to a more appropriate time or place.

As it appeared that Justin possessed the ability to induce spontaneous dissociative trance to cope with conflict or stress (Spiegel, 1986), it seemed critical to emphasise this to him as a personal skill in order to shift the locus of control and teach him how to use trance capacity to gain control more appropriately.

More generally, any tendency to dissociative nonvoluntariness could be modified by defocusing in hypnosis upon non-volitional functioning. This would be done by the use of structured induction techniques, utilising suggestions focusing on imaginal involvement and attention to subjective reality with metaphor, or direct suggestion for mastery/control. An emphasis upon cognitive strategies would further de-emphasise the need for dissociation (Strauss, 1986).

A further major goal of therapy was to increase self-esteem and a sense of personal effectiveness, which could be enhanced hypnotherapeutically with strategies such as ego-strengthening, cognitive restructuring, systematic desensitisation, and use of imagery.

More appropriate coping behaviours would be taught to remediate skill deficits exacerbating anxiety and stress, in the areas of assertiveness, social skill training, and anger management. Specific treatment techniques would be multi-modal, utilising cognitive-behavioural and rational-emotive techniques potentiated by hypnosis (e.g., behavioural rehearsal, self-talk).

As noted earlier, Clarke and Jackson (1983) have emphasised the multi-process nature of anxiety. Certainly Justin's anxiety appears to contain elements of cognitive anxiety (e.g., specific beliefs about superiors and attitudes of the community towards him) and phobic/panic/perseverative anxiety, as noted in separation anxiety and possible homosexual panic. The treatment approach needs to take account of these sub-categories and prescribe appropriate specific techniques, such as systematic desensitisation, flooding (in hypnosis), coping self-statements, and behavioural techniques. Underlying all of these anxiety

management techniques is, of course, the reduction of physiological arousal achieved by hypnotic relaxation and use of imagery.

A final goal of therapy involved uncovering the dynamic elements involved in the maintenance of the seizures, possibly covering sexual concerns and separation and dependency issues.

The use of regression in hypnosis to achieve insight into causation has indicated that most cases have been triggered by subconscious associations with single or multiple past initial sensitising events (Miller, 1986). This, however, may be contrasted directly with research into phobic anxiety, where it has been found consistently that, in the majority of cases, there is no apparent trauma to account for the development of a phobia.

In dynamic terms, it was hoped that age regression and the possibility of abreaction would allow Justin to achieve some degree of mastery over a possibly traumatic source of anxiety. In cognitive behavioural terms, through exposure to the anxiety-provoking stimulus via regression, flooding and, it was hoped, extinction would take place.

A final comment on the use of hypnotic regression techniques in the management of this case: Hypnotically facilitated memory recall of seizures is regarded as an important way of distinguishing between organic and psychogenic seizures (Gravitz, 1979), and Gross (1980) has suggested that recall under hypnosis be regarded as the criterion. Patients with organic seizures experience total amnesia for the event, in contrast with hysterical seizures where the patient is able to recall the experience. When hypnotic regression was used with Justin specifically to test memory recall, he did in fact produce an account of what purportedly transpired during his diurnal seizures. However, this gives rise to the question of whether this was true recall, or anecdotally based recollection.

It is recommended that the client be confronted with the likelihood that his seizures are partly emotional in origin and the therapeutic alliance be utilised to help the client find more appropriate ways of coping.

THERAPY APPLICATION

As Justin had been seen on a regular fortnightly basis from June 1987 to August 1988, then monthly from November 1988. It is probably more appropriate to outline major treatment phases with selected examples of hypnotherapeutic interventions rather than give a session-by-session account.

In session 5 hypnosis was induced with the following aims: relaxation training, self-hypnosis, to commence the shaping of self-esteem by ego-enhancement, and to rehearse simple assertive skills in his interaction with the manager.

Spiegel and Spiegel's (1974) finding that hand levitation is a means of evaluating hypnotisability and also initiating trance was used as a basis for Gross's (1980) further observation that subjects likely to experience spontaneous trance are more sensitive to ideomotor activity. Therefore hypnosis was induced

with Justin by hand levitation and he was instructed that, when his hand touched his cheek, he would be in a state of deep relaxation. A system of ideomotor finger signalling was established.

Dissociation was modulated by structured imagery, and by focusing his attention upon specific bodily sensations (change in skin temperature, feelings of lightness/heaviness, breathing, heart rate).

The concept of a "safe place" was introduced (he chose his bedroom) and direct suggestions were given for relaxation and ego-enhancement, emphasising inner strength and resources.

When Justin indicated by ideomotor signal that he had marshalled the necessary "strength," coping strategies were rehearsed in interacting with the manager, including covert assertive skills and set-breaking techniques for dealing with the cognitive component of his anxiety, as described by Clarke and Jackson (1983).

In hypnosis, awareness of physiological change was heightened, and in conjunction with structured imagery and direct suggestion, Justin was taught to identify and head off prodromal symptoms.

He was taught several routes into self-hypnosis, his favourite being the concept of the "safe place," where he learned to use an ideomotor signal (usually stroking his face) to induce relaxation, confidence, and "inner strength."

It was suggested that, as he learned to control bodily and emotional responses, he might even be willing to give up some of his seizures when he was ready, and allow the others to occur in his bedroom while asleep.

This material was taped, and Justin proved enthusiastic and cooperative about practice, even adding music to the end of the tapes.

In the following session, these techniques were reinforced. Hierarchies of progressively more anxiety-provoking stimuli were constructed, and in hypnosis systematic sensitisaton was practised. Separate hierarchies for work-related and social concerns were created. It is interesting that the most anxiety-producing scene in the former involved the manager telling him he'd be out by the end of the week if he had another seizure, while in the latter Justin saw himself running the gauntlet of local youths at the station, calling him "poofter" and threatening him with physical violence.

Rational emotive techniques used in therapy were reinforced in hypnosis, involving the restructuring of his attitudes and the shifting feelings of anger and of being demeaned to those of mere irritation.

Age progression was used at this point in conjunction with ego-enhancing suggestions emphasising self-control, self-respect, and independence.

It is interesting that, as sessions progressed, Justin's perceptions shifted and he came to realise that a trainee managership was not what he really wanted. He was encouraged to explore and generate alternatives. In therapy, his aptitudes and interests were emphasised, with the additional aim of widening his social contacts and skills. Accordingly, he took up a short-term computer course and also enrolled in an advanced first-aid course. His interest in drama and

singing was reactivated. The integration of these skills into his self-concept was amplified by age-progression in hypnosis. It was clear that he needed to be regarded by others as "skilled" and in a position of some authority.

In October 1988, three months after Justin commenced sessions, his total number of seizures had reduced. They had ceased entirely at work, and those he experienced at home were all confined to just prior to waking. Retest on the IPAT Anxiety Scale gave a sten score of 5, indicating an average level of anxiety. Self-hypnosis was practised daily.

It was evident that he had been able to utilise hypnosis to reinforce the concept of control. Behavioural rehearsal of assertive techniques appeared to be most useful where the in vivo exposure was very similar, although some generalisation of training was beginning to occur.

At this point the manager was transferred and the new manager and Justin developed a good relationship.

In hypnotic sessions Justin rehearsed approaching the manager for more congenial tasks, and the personnel manager for a shift into the city office. He was able to successfully negotiate promotional work (meeting needs for attention and theatrical expression very appropriately), and in January 1988 gained an appointment as health and safety officer within the store. These two developments increased his confidence dramatically, especially the latter position, which he perceived (with some realism) as giving him a degree of power over management.

In late January 1988 Justin had a total of nine seizures in a fortnight. His record showed that he had been neglecting his neurologist's specific advice regarding absolutely regular medication, hours of sleep, and attention to diet. The need to acknowledge the organic aspect of his seizures was emphasised in therapy, and the need to take care of himself reinforced by direct suggestion in hypnosis. Suggestion of personal responsibility and imagery involving his successfully attaining his goals while attending to his physical requirements were used.

Another feature became evident at this point; focusing upon repetitive, monotonous tasks or stimuli (cash register, or watching the road while travelling) tended to precipitate seizure activity. Justin himself suggested that whenever he became aware of a repetitive stimulus, he would actively involve himself in imagery. In hypnosis it was suggested that he could allow the part of his mind engaged in the task to proceed automatically while he engaged his conscious attention in a more stimulating fashion.

It will be evident that treatment prior to this point emphasised a directive, structured, cognitive–behavioural focus. This represented a nice mesh between the personality attributes of the client (dependent, compliant, apparently well-motivated) and the sub-goals of therapy (to teach relaxation and coping skills and to reduce seizure incidence).

The more dynamic issues of separation/independence and sexuality were now tackled.

As the therapist is of similar age to the client's mother, transference issues were recognised. More independent behaviours and attitudes, presumably generated initially by ego-strengthening, were already occurring and it seemed that, without direct therapeutic intervention, Justin was working through and moving away from his excessive dependence upon his mother.

Use of indirect techniques was minimal in the management of the case, but at this point an adaptation of one of Erickson's metaphors was used to emphasise the necessity for constant change and growth in personal development. Two tapes were also made to deal indirectly with dependency needs, making use of the scripts of Shakti Gawain's (1985) "Meeting Your Guide," and "Gandor's Garden" (Gibbons, 1979) — which both centre "wisdom" within the client.

From February 1988 Justin began planning a three-month overseas trip alone. He was away from August to October 1988 and experienced the trip as a success. He had four seizures during this time: two presumably as a result of jetlag, one after being body searched at Heathrow, and one when he fell asleep on a coach tour during the day. He stated that self-hypnosis was practised regularly.

Upon his return, sessions were reduced to monthly. Previous attempts to explore directly his possible homosexual conflicts had been resisted, although when he recounted an alleged pack rape of his friend's retarded brother, he appeared to slip spontaneously into trance (La Barber & Dozier, 1980). In this session I suggested he might use hypnosis in a slightly different way, and described Wolberg's Theatre Technique (1948), which immediately appealed to him.

Hypnosis was induced by ideomotor cue, and deepened by suggestion of going down 10 steps into the theatre. He abreacted an experience when he was 19. A relative had obtained a Saturday morning job for Justin, assisting a DJ at a radio station. A homosexual advance was apparently made. Justin cried and called out "I'm not like that."

Suggestions were given to use amnesia if he wished, and upon termination of trance he chose to discuss his feelings of "disgust" and "upset." Presumably abreaction had allowed Justin to achieve some degree of mastery over the initial trauma, making lengthy discussion of the underlying conflict unnecessary (Moss, 1973).

To enhance that mastery, Justin was rehypnotised, using a recall induction technique which, in asking the client to recapture the past, in itself paves the way for further regressive work. He was encouraged to replay the scene, envisaging an outcome which would enhance feelings of personal effectiveness rather than vulnerability (Miller, 1986).

By September 1988 he had had no diurnal seizures for six months, and nocturnal seizures were occurring approximately fortnightly. He presented as much more relaxed and confident, and retest in IPAT Test of Anxiety confirmed an average level of anxiety. Self-hypnosis had become an integral part of his life, used during the day as required and practised before sleep.

CONCLUDING COMMENTS

As a treatment component in the management of epilepsy in the clinical setting, hypnosis has been reported in the literature relatively seldom, even though as early as 1843, Braid had drawn attention to the relationship between epilepsy and hysterical convulsions, and to the role of hypnosis in the management of both conditions (Braid, 1970).

A recent resurgence of interest in dissociative mechanisms and the particular forms they may take (eating disorders, epilepsy, fugue, psychogenic amnesia, multiple personality, panic disorder) has broadened the theoretical focus to include dissociation as a personality trait capable of triggering normal, creative, and adaptive behaviours as well as pathological ones. Beahrs (1982) and Watkins (1978) have in fact postulated that hypnosis is a controlled state of dissociation, and Spiegel (1986) sees dissociation as part of the individual's response to immediate or chronic stress.

The confirmation of high hypnotisability in subjects where dissociation takes the form of a pseudoseizure opened up the possibility of utilising this trance capacity/dissociative mechanism to promote more adaptive behaviour.

The most recent literature on the use of hypnosis in the treatment of psychogenic seizures has tended to emphasise a combination of direct suggestion and age regression technique, but to date does not appear to have utilised in a systematic fashion the cognitive strategies and structured imagery in hypnosis in order to modulate dissociation and minimise the sense of non-voluntariness, as has been done with other dissociative/phobic behaviours such as anorexia/bulimia (Crasilneck & Hall, 1975; Caldwell & Stewart, 1981).

With Justin's case, cognitive strategies were obviously very important in modifying the relationship between anxiety and seizure behaviour, as well as facilitating appropriate attitude change. The other hypnotic techniques such as direct regression, age regression, and the teaching of self-hypnosis were appropriate and effective.

Because of the dissociative component underlying the presentation of Justin's problem, the use of hypnotic techniques was probably more central than adjunctive, even though the importance and necessity for other therapeutic techniques is acknowledged.

The outcome of any psychotherapeutic process must take account of therapist/client rapport, which in itself is likely to have been enhanced by hypnosis.

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