

HYPNOSIS AS AN ADJUNCT TO BROAD SPECTRUM PSYCHOTHERAPY IN THE TREATMENT OF SIMPLE PHOBIA

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Hypnosis was used as an adjunct to broad spectrum psychotherapy involving a 43-year-old female patient diagnosed as having an anxiety disorder — simple phobia. The successful treatment highlights the efficacy of hypnosis — particularly the use of age regression — in treating an anxiety-related disorder. Issues of abreaction, transference, pharmacology, self-hypnosis, and features of the psychotherapeutic process are dealt with in this case presentation.

DESCRIPTION OF THE PRESENTING PROBLEM

The patient, Mary, was a 43-year-old married woman living in an inner eastern suburb of Melbourne; she was employed full-time as a senior teacher in a private school for girls. She presented with recurrent moderately acute symptoms of anxiety that were situation-specific. Mary reported feeling “strange and anxious . . . quite unsettled and uncomfortable . . . I was aware of my heart thumping, feeling warm and flush.” She felt like this before, during, and after she passed The Childrens’ Centre (hereafter referred to as the Centre). The Centre was a large children’s home that flourished as a residential home for babies and children from 1940 to 1980. It is a huge Victorian mansion set in extensive gardens and is located close to Mary’s home.

Mary first noticed the onset of anxiety symptoms early in 1989 when she first drove past the Centre on her way to work. She reported that anxiety symptoms included quick shallow breathing, tightness of chest, intrusive thoughts, feeling clammy, and occasionally “getting the shakes” and feeling nauseous. These symptoms became more acute and frequent just prior to her making her first appointment.

When Mary elaborated on the emotional and behaviour changes that occurred when she passed the Centre she reported:

I have deep and uneasy feelings when I pass the Centre . . . I know I was there for about 8 to 10 months when I was nearly two . . . It was a very difficult time for my family. I don't know why I still seem to have such strong feelings about it . . . I can't recall particularly painful details and Mum can't remember much about it. She's 81 now and her memory is going . . . Anyhow she says she doesn't want to talk about that time in her life . . . occasionally I find myself thinking about driving another route to work so that I don't have to pass the Centre . . . I've actually done that a few times . . . driving past the Centre is the best and quickest route to work . . . trying to avoid it would be annoying and very inconvenient.

Mary wanted to pass the Centre without feeling uncomfortable and disturbed. "I want to arrive at work or home refreshed and ready for action."

Mary reported symptoms of anticipatory anxiety when about half a kilometre from the Centre. Anxiety symptoms remained for about 10–15 minutes after passing the Centre. Mary was seeking treatment because symptoms were persistent and recurrent, "uncomfortable and draining," and intrusive. She reported that at night and at other times (at work or weekends) she had "short phases" of feeling uncomfortable as "my thoughts wandered back to the Centre."

Mary outlined possible precipitating, alleviating, and aggravating circumstances.

Precipitating

Driving in the proximity of the Centre, increasing when the Centre actually came into view. She thought the sight of the Centre triggered memories related to the time when, as a two-year-old child, she was placed in the Centre for about nine months. Her mother had very high blood pressure and was "blind" for a time. Her father was also sick at the time — he subsequently died about 10 years later "after a long battle with cancer."

Aggravating

During the time the Centre was in view and shortly after (a minute or more). "Sometimes I can see or feel myself entering the place . . . the grand staircase . . . nurses . . . I remember I wanted to go home."

General

Mary presented as a happy, stable, well-adjusted person. Although oriented to present and future goals, she appears to be introspective with quite a focus on events of childhood. She reports being very happy in her married relationship. Her husband (47 years old) was employed as a secondary school teacher. "My husband has a well paid job — he is happy . . . he is very good to me and the children . . . I enjoy life." She has four teenage children (two boys and two girls) whom she finds "enjoyable but challenging." Mary is a primary

school teacher: "I like my work very much . . . I have never been at a better school . . . the people I work with are very supportive . . . last year I was promoted." She appears to be appropriately independent and assertive with a well-developed sense of self-worth and appropriate affect.

Mary recalls being strongly influenced by her mother's advice to continue studying after completing school. She has memories she "doesn't like" of sleeping in the same room as her mother when her father was sick, of her mother "using her" (e.g., keeping her home from school to do housework and using her money from part-time work as a student to help run the house). Her tone of voice and mood changes when she recalls: "I have fond memories of my father . . . I was dad's favourite, my sister was mum's." Mary recalls having a rather strained relationship with her sister. "My sister was rather domineering, aggressive and competitive." Mary said the competition between herself and her sister "was for parental affection as well as for day-to-day attention." Mary said that over the past few years she and her sister had grown a bit closer, "but Elizabeth doesn't really open up to me even now . . . we speak more to each other and give each other support — there is still a gap . . . she tells me very little about herself, even now when she is very ill . . . She wants to know a lot about me . . . in a sort of demanding way."

Mary felt that there was a deep bond between her mother, sister, and grandmother (who later lived in the family house). With this statement came some insight from Mary (later to be actively used for therapy): "perhaps being sent to a home confirmed to me that I was less valued, unwanted, not cared for. [tears] Perhaps the Centre brings back these feelings of being sad, about being discarded."

Able to think and act in a logical and competent manner, Mary described the way she organises, participates in, and evaluates her work and family life. She enjoys an active and involved social and cultural life: "I can be assertive in a quiet way. I'm really a bit of a feminist, not the extreme type."

Within the family she seems to function happily. "We are a cooperative lot, we share jobs." She appears to be coming to terms with letting go of her son who has chosen to live away from home with friends who will go to the same university for which he has been accepted. She reports her life as being full, satisfying, and enjoyable. She has future aspirations relating to the family, work, and recreation which she looks forward to with positive optimism.

She reports having made a satisfactory adjustment to life events. She recalls being very sad for a long time after her father's death: "I often still think of him. I don't think his life with mum was very happy. I wish he could have been with me as I grew up. He would be proud of me today." While Mary describes her current situation (marriage and family) as happy and satisfying, she says that she found it hard as a child to live with a very dominant grandmother for nine years and a "bossy older sister."

Mary has special interests in reading, art, music, writing, and home renovations — "I see myself as creative . . . I enjoy colour and design." She also likes cooking and gardening — "I enjoy both home and work."

When talking to Mary she offers a quiet, relaxed style with few signs of tension or anxiety. Her voice is soft and clear, firm and fluent. She will cry and blush when talking about strong emotions and feelings.

Sadness over the loss of her father, her unsatisfactory relationship with her mother, and her sense of closeness to her husband were recurring themes during clinical sessions.

Mary reports no drug or alcohol abuse; she is a moderate drinker, non-smoker, and has no experience with drugs other than those prescribed by her GP. She reports no experience of spouse abuse.

Child abuse is not reported. However, Mary recalls two events of significance:

1. When three years old, immediately following her stay at the Centre, she lived with her maternal aunt and uncle who were "hardline Methodists, who lived a very austere life. I remember running away from them. The year I lived with them was hard and unhappy."
2. Mary could not recall problems of sexual development but could recall feeling embarrassed when asked at age seven to sit on the lap of Panky (a boarder in the family house). She was aware of his erection and struggled to be free, then ran out of the room.

DEVELOPMENTAL HISTORY

Mary's early developmental history appears substantially uneventful, with milestones being reached within appropriate limits. Mary was delivered one month premature, Caesarean section.

Her general health she describes as good, with a life free from severe illness. She underwent a tonsillectomy at eight and a hysterectomy at 35.

She does not recall any serious depression requiring treatment but does recall occasionally "feeling a bit depressed . . . but I get myself up and on with life." Any depression seems associated with stressful life events (death of her father, premature birth of three of her four children, frequent relocation of residence during her childhood).

Mood variations seem appropriate to life circumstances (including recall of life events in clinical setting) and within normal limits.

The younger daughter in a family of two children, Mary's sister, Elizabeth, is four years her senior. Mary's mother is 81.

Mary reports normal sexual development and satisfactory sexual relationship with her husband. "I feel good about my sexuality despite my mother's conservative religious attitudes and an unfortunate experience with a dirty old man who boarded at our house." (These matters were addressed in therapy.)

SOCIAL HISTORY

Mary fulfils multiple roles in her family that comprises a husband (47), two daughters (15 and 16), and two sons (17 and 19). She and her husband have tertiary qualifications.

The extended family comprises her mother (81) and her sister (45) and her sister's husband (48), who have two children — a male (21) and a female (20).

None of Mary's paternal family is in Australia. Her mother has some cousins in Victoria and Tasmania and New South Wales. Mary and her sister share a supportive role with their mother (helping her with shopping, banking, and transport). Mary says the family rarely gets together. "It's not a close family."

Mary says that she has a very supportive group of friends: "some of my friends are at work, some are from college days and some I share with my husband." She seems to be able to sustain friendships over a long period of time, recalling at least seven friends she has had for over 15 years.

ACADEMIC HISTORY

Mary successfully completed Year 12 at a state high school and a three-year college course in primary education. She is currently completing a degree course in education.

She says she enjoyed school but recalls being "a bit of a loner" as a result of finding it difficult to settle after repeated moves to different schools. She went to more than seven schools in Gippsland and the metropolitan area. Mary remembers experiencing difficulty leaving friends and making new ones. She says she was an average student overall, being below average in maths and well above average for English, history and art.

CURRENT FAMILY HISTORY

Mary reports that she is closer to her sister now; they see each other at least every two weeks and speak to each other weekly. "My sister's illness has brought us closer," Mary said.

Although Mary is now closer to her sister, there appears to be a distancing between her mother and her sister. Mary states that her relationship with her mother is far from satisfactory: "Mum doesn't really want to discuss the past; she rarely confides in me; she seems a bit distant; she's getting old and forgetful."

Mary says she is not close to her mother or mother-in-law, "who is in many ways like my mother. We have a good but not a deep relationship." Of her husband's family, she is closest to her sister-in-law, who lives in rural Victoria. "She introduced me to my husband, we get on quite well but we don't see much of each other."

For Mary, her husband, friends, and work colleagues are identified as comprising "a good support system."

CURRENT LIVING ARRANGEMENTS

Mary lives in a comfortable Victorian house in an inner eastern suburb of Melbourne. She and her husband are in full-time employment and she reports that "we have enough money for our needs, except we would like to travel more and fix up the house."

CLINICAL OBSERVATIONS

Appearance

Female, 43 years old, short, medium build.

Dressed appropriately for the season, her age, and the occasion — clean, neat, well-groomed, and smart. Appeared to be younger than 43, clear skin, little make-up, Scandinavian features. Courteous, quietly assertive, comfortable in consulting room. She appeared fresh and reported no problems with sleep, appetite, or energy levels.

Motor Activity

Quantity and quality of gross and fine motor activity appeared appropriate (e.g., good posture, absence of habit behaviour). She presented as quiet, calm, attentive, and appropriately responsive.

Speech and Language

The speed and quality of speech were appropriate for her age and situation. Voice quality, prosody, and articulation all appropriate; no speech disturbance apparent. Receptive and expressive language indicated a good capacity to express ideas and feelings, to respond to questions, directions, and comments — no evidence of aphasic features. Use of “should . . . must . . . ought” was clinically significant for rational emotive therapy (RET). Use of colourful extended language, good recall of information, frequent reference to visual and olfactory senses were clinically significant for selection of dialogue in hypnotherapy.

Cognitive Skills and General Intelligence

Mary appeared to have a good attention span and ability to focus. Memory (LTM-STM) was very good, as were orientation and judgment. Level of abstraction and fund of general knowledge both appeared to be excellent. Skills and intelligence referred to here indicated that Mary might present as a good subject for hypnosis.

She stated that sometimes she found “being decisive” a difficulty.

Mary’s cognitive style seemed to suggest that both permissive and directive approaches to hypnosis could be useful, with selective use of both.

Emotional State — Mood and Affect

During interviews Mary demonstrated a range and modulations of emotions that were appropriate. There was congruence between mood and affect. Tears would well in her eyes during the recall of upsetting or stressful experiences and, at other times, appropriate expressions of smiles and laughter.

Sensory Experiences

No extraordinary experiences were noted or recalled by Mary (no hallucinations or sensory disorders observed). Her use of language seemed to demonstrate

keen observation of people, events, and places, with a sensitivity to the sense of sight and smell.

Thought Characteristics

Speed, continuity, and clarity of thought all appeared appropriate. Content did not reveal morbid preoccupation although there were some clinically significant preoccupations in relation to her father, mother, sister, and husband (consistent with the presenting symptoms). Her beliefs, experiences of self, body, mood, and impulses all seemed consistent with a healthy well-adjusted adult within the context of her presenting problem.

Relatedness

Mary presented an enthusiastic, warm, and easy style of interaction with good eye contact. She was aware of the impact of her behaviour on others. Usually she shook hands when greeted and seemed comfortable sitting at an appropriate distance. Mary's positive attitude and strong motivation to overcome her problem augured well for the use of hypnosis as an adjunct to psychotherapy.

Transference

Therapeutic transference was established early; trust and rapport were gained easily. Care was taken to avoid "over transference" dependence and psychosexual transference given age and gender, by adopting a brief therapy model following preliminary interviews.

The potential for a distorted transference existed (e.g., symbolic substitution of father/husband/therapist emanating from feelings of being abandoned or rejected as a child). Using a model of brief therapy, rather than exploring transference, was the preferred option, given the presenting problem and its potential to respond to patient's desire to remove symptoms as quickly as possible.

PSYCHIATRIC HISTORY

No previous history of psychiatric illness. Episodes of mild transient depression? Not treated. No family history of psychiatric treatment.

Acrophobia reported — managed adequately by avoiding high places that are exposed (a high platform with no roof or a mesh railing). Inside tall buildings does not evoke anxiety unless Mary stands close to windows and looks out. This information is of particular clinical significance when considering dialogue appropriate for visualisation under hypnosis.

Although Mary suggested that previous episodes of depression were mild, they were fully investigated given the contraindications for use of hypnosis with patients with a history or current symptoms of moderate to severe depression. There was no doubt that previous episodes of depression were mild to very mild.

The diagnosis (DSM III-R) was as follows:

- Axis I and II (Clinical syndrome/Developmental disorder,
Personality disorder)
Anxiety Disorder (or Anxiety and Phobic Neuroses)
300.29 Simple Phobia
- Axis III (Physical disorders and conditions)
Nil
- Axis IV (Severity of psychosocial stresses)
(2) Acute events
Time spent in Children's Home
Moving home (country to city)
Eldest first child leaving home
Sister's illness (recognised)
Enduring events
Family stress (relationship with mother
and sister)
Sister's illness (ongoing)
- Axis V (Global assessment of functioning)
(70) GAF
Some mild symptoms (mood, sleep,
behaviour)
Some difficulties in functioning
Generally functioning pretty well

REVIEW OF THE LITERATURE

The efficacy of using hypnosis as an adjunct to the management of anxiety disorders is now well established (Burrows & Dennerstein, 1988). Medication may help enhance the hypnotic state while at the same time alleviating significant anxiety (Burrows, 1988). Where depression is present, Burrows (1988) suggests tricyclic medications are the best drugs to prescribe. It is interesting to note that Rickels (1968) found that for patients who are not severely ill, the response to a placebo may be as high as 70%. In terms of pharmacotherapy of anxiety, Burrows (1988) concludes:

Few experts recommend any drugs as the sole therapy of anxiety. The practitioner who has good interaction with a patient who wants to get well, can include drugs with which he feels at ease as adjunctive therapy. It is vital to remember and help the patient realise that no drug in itself will solve the problems which cause anxiety. Therapists should not underestimate the effect of seeing a patient regularly. (p. 157)

Since the adjunctive use of hypnosis in this case focused on age regression, the literature review will reflect this focus.

Weitzenhoffer (1953) describes three types of age regression: Type (1) Adult acts out or role plays an earlier age; Type (2) A true psychophysiological

return to an earlier age — revivification; and Type (3) Role play and shift to revivification.

Burrows and Dennerstein (1988) suggest that “the majority of psychological studies support the concept of a mixed regression rather than a true psychophysiological regression” (p. 75). In this case the patient reported a mixed regression with an emphasis on Type 1 age regression. My observation of the patient in trance, her voice, posture, motor movement, and dialogue supports her interpretation of the experience as being predominantly Type 1. The most obvious clue to the process of revivification I observed was the squeaky tonal quality of the patient’s voice when asked to talk about what she was doing and saying during age regression.

In terms of techniques and methods, it is useful to note that Reiff and Scheerer (1959) suggest that more direct methods are effective in achieving age regression. The patient in this case expressed a preference for direct methods both for deepening and for age regression, but had a more distinct preference for the more permissive approach for other aspects of hypnotherapy (visualisation, ego-strengthening, and recall of information under hypnosis). As a part of developing skills in self-hypnosis it was suggested to the patient that she could choose to adopt the less demanding observer role or the participant role or move between both — it seemed effective to introduce this “option” so she could select the role that she was most comfortable with.

Greenleaf (1969) suggests two types of experiences during the age regression: (a) a pure subjective regression (“I wasn’t aware of being four . . . I just was four”), and (b) mixed regression (“One part of me was going on four: I know the answer but something blocked my mind”).

According to Cameron (1963) the concept of age regression is often misunderstood. “The perceptual-cognitive systems of the adult are organised differently from those of a child; when adults regress they reactivate infantile conflicts, wishes and fears, but most of their adult and defensive and coping organisation remains” (Burrows & Dinnerstein, 1988, p. 80).

The regressed adult does not necessarily act, speak, or look like a child. In this case Mary’s regression reactivated infantile conflicts, wishes, and fears. Her abreaction tended to suggest that under hypnosis her adult defensive and coping organisation did not remain.

Burrows and Dennerstein (1988) state that most textbooks on psychopathology emphasise the negative component, reporting age regression in terms of disintegration of psychodynamic systems. Kris (1962) points to the positive component in regression — regression in service of the ego. Burrows (1988) notes that the concepts of controlled and uncontrolled regression are important and that controlled regression is a particularly important part of hypnotic age regression producing a new definition of age regression, a fluctuating state of the organism brought about by the reorganisation (not necessarily the disintegration) of the individual psychobiological systems. Further to this “fluctuating state,” Burrows (1988) adds,

when memory trace is available to the subject, there is actual regression; when it is not available, the subject will use other available memory traces from later stages of development or he/she will confabulate — consequently, it may be more appropriate to use the term “developmental stage regression” rather than “hypnotic age regression” *for the subject who regresses to a certain stage or age range of functioning*, rather than a specific age . . . this is in accord with Wolberg’s (1948) contention that hypnosis is a fluctuating state. (p. 81).

This helps to explain why, at times, Mary could recall details and specific age-related experiences and yet at other times could recall only “general feelings and impressions” associated with a developmental stage.

Crasilneck and Hall (1975) indicate the usefulness of hypnotic age regression for cases that involve retrograde amnesia. Their reference to options available to the therapist following the patient’s recall are useful. The therapist can decide if it is preferable for the patient to:

1. remember all the facts immediately;
2. recall some facts;
3. slowly recall all the facts;
4. allow the hypnotherapist to help recall the facts (p. 60).

At different stages of therapy in this case various options were chosen (e.g., after an abreaction and deepening process option 3 was chosen; where the relationship between patient and mother was explored, option 4 was chosen).

As Crasilneck and Hall (1975) contend that the release of material (through age regression) helps in the resolution of a patient’s neuroses, and given the diagnosis in this case, the use of age regression seemed appropriate.

Crasilneck and Hall (1975) cautioned that if the goal is achieved after giving hypnotic suggestions in relation to past traumatic events, it is not necessary to prolong or increase the severity of the abreaction. This caution was observed in therapy. However, the therapist used careful discretion in deciding when to avert prolonged abreaction through the application of deepening techniques and when it was productive to prolong abreaction. The latter case arose only when abreaction was mild and when the continued release of feelings, energies, and information was seen as therapeutic at the time and of use in post-hypnosis therapy — for example: (a) when the patient recalled some aspects of life in the Centre, (b) when the patient recalled events that occurred when she was left at the Centre, and (c) when the patient recalled being picked up from the Centre.

The basic script for age regression was modelled on Crasilneck and Hall’s (1975) suggestion that the therapist systematically count back to the “target age” as a form of deepening; they suggest the following format as a guide:

Nothing is ever forgotten . . . You can recall any fact or memory no matter how unpleasant . . . no matter how long ago . . . you can remember . . . going back in time and space . . . in your life . . . to the date when . . . you can

remember what is happening . . . you can see and feel . . . you are there . . . you may see or be a part of the events or both . . . (p. 60)

Mary reported that she felt a script which essentially followed the above format had helped her; she felt comfortable with it.

Beck (1976) has commented upon the possible relationship between cognitive and physiological components of anxiety in the genesis of anxiety disorders. Given Beck's comments, it seemed appropriate to use cognitive/behavioural procedures in psychotherapy. Given the role of fear and issues of control, the use of logotherapy (Frankl, 1962) seemed warranted.

The treatment plan followed was an individualised adaptation of the well formulation broad spectrum therapy suggested by Elton, Stanley, and Burrows (1983):

1. Exposure of the patient (via imaging or reality) to the situation provoking anxiety, thereby allowed deconditioning, habituation, and desensitisation.
2. Cognitive re-evaluations of the situation(s) to alter the perception of threat.
3. Determining the personal significance (symbolic) of the anxiety provocation (e.g., children's home as a symbol of being abandoned, of lack of control and hopelessness, and the associated repression of fear and anger, the separation anxiety that followed placement there).
4. Increasing the sense of self-efficacy, behaviourally or cognitively, in the patient's ability to deal with the anxiety eliciting situation and the symptoms; and the rehearsal and effecting of coping strategies.

The plan was implemented in a way and at a pace that recognised the uniqueness of the patient (Jackson & Stanley, 1987).

Finally, Frankel (1974) has presented evidence that phobic patients show greater hypnotic susceptibility than other patient groups. This case offers further support to Frankel's findings — Mary demonstrated a high score on the Stanford Scale of Hypnotisability.

It is not surprising that there appears to be a correlation between people who score highly on a standardised assessment of hypnotisability and people diagnosed as phobic, since both phobic and highly hypnotisable people could be seen to share characteristics such as the capacity to visualise, the ability to suspend logic/reality, and skill in focusing attention.

In this case it is important to note that, while Mary's separation anxiety experienced when her parents left her at the Centre seems to have been severe, it was appropriate given her developmental age and the circumstances of being left in a big unfamiliar place with strangers for a long period of time (Bowlby, 1982). Mary's reaction can be seen as "normal" reaction to an "abnormal" situation. It was the lack of opportunity that Mary had to understand and deal with her repressed thoughts and feelings that became an important issue

to resolve. Had Mary's separation anxiety persisted over time and generalised over situations, then she could have developed separation anxiety disorder and be seen to be at risk in adult years to developing agoraphobia or panic disorder.

PREFACE TO SESSIONAL NOTES

Each session was for one hour — 45 minutes consultation; 15 minutes to write up notes.

Sessions were held in a consulting room; one session per week over a period of eight weeks with a review session three months after the final therapy session. Hypnosis was used as an adjunct to psychotherapy over that period.

Each session had a basic format:

1. Introduction — informal discussion (this would include a review of progress made and activities undertaken since the previous session);
2. Psychotherapy;
3. Hypnosis (including a review of the experience and content of hypnosis);
4. Psychotherapy (if appropriate as a follow up to hypnosis); and
5. Homework.

A flexible approach was adopted to accommodate the varying needs of the patient and the goals of therapy. Some sessions involved more than one experience of hypnosis.

SESSION 1

The initial session involved an extensive interview and the taking of a personal history. The patient was relaxed and spoke freely and easily. She was keen to reduce or eliminate the anxiety she experienced when passing the Children's Centre.

Hypnosis was suggested as an adjunct to therapy. The nature and use of hypnosis was explained and Mary was interested; she had heard about hypnosis. Discussion and elaboration addressed some of her misconceptions, particularly the issues of "being out of control" and "not coming out of trance." Mary was given a pamphlet on hypnosis and asked to think about it during the interval preceding our next session. She was encouraged to keep a diary during the therapeutic periods and introduced to deep breathing and progressive muscle relaxation — asked to practise these techniques and use them appropriately. Mary quickly appreciated the ideas and skills associated with anxiety reduction (she recalled pre-natal relaxation classes).

Mary said she felt better even now after she had taken action to face her problem (significant owning of the problem). She said she might chat to her mother and see if she could "tell me more about the early part of my life" (referring to the early period of her life that she spent in the Children's Centre). Mary's willingness to discuss her early life with her mother was encouraged,

as further information and insight could be helpful in reinterpreting and reframing the experience (cognitive restructuring, re-evaluation to alter perception).

SESSION 2

The previous week was reviewed in relation to feelings and events. Mary used diary notes in this session and some of the sessions that followed. Mary had used breathing and relaxation not only when she felt anxious driving past the Centre but also prior to discussions with her mother. Some useful details were gained by Mary as a result of discussions she had with her mother.

History-taking was completed.

Assessment of hypnotisability was undertaken using the Stanford Hypnotic Clinical Scales (SHCS; Morgan & Hilgard, 1979). Her score was:

Motor 1/2
 Dream 1
 Age Regression 1
 Post Hypnotic Suggestion 1
 Post Hypnotic Amnesia 1/2

This resulted in a total score of 4 out of 5, which placed Mary in the highly hypnotisable range.

Induction involved progressive muscle relaxation with deep breathing. Deepening involved counting. Visualisation was then suggested, of walking in the country, with a stream running, on a mild day with a cool breeze. Any references to heights, deep water, or excessive heat were avoided, given that Mary had indicated that these were things she disliked or feared. Mary was brought out of hypnosis by counting, with suggestion of returning fresh and alert from the trance experience.

In this session, a visual analogue was used as a form of evaluation midway through the therapy session and at the end. The visual analogue reflected a high level of anxiety experienced by Mary when in the phobic situation. Choice of a personalised visual assessment seemed to suit Mary's cognitive/sensory preference and she found this method motivating as time went on.

At the end of the hypnosis, Mary felt fresh and relaxed. She enjoyed the permissive presentation of visualisation; she felt heavy after progressive relaxation and she liked the experience. She was asked to practise the techniques taught during the hypnotherapy sessions before going to sleep each night. Discussion after hypnosis focused on the language Mary used: "I *should* not feel . . . I *ought* to . . . I *must* . . ." This was done as a prelude to a RET analysis of speech and to raising sensitivity to her cognitive style. She was asked to "hear" her own speech, to be aware of it, of the thinking-acting cycle and how it influences her level of anxiety and stress, including physiological responses/products of stress.

SESSION 3

In a review of the week, Mary indicated a growing awareness of "the way I lack confidence . . . the pressure I put on myself." The source of her lack of confidence, stress and anger, and the possibilities for change were discussed; this area provided an opportunity to deal with language/thinking/acting cycle, and to begin exploring the sources of her feelings.

Some issues covered were: feelings of fear, control, and confidence in relation to children and adults; feeling abandoned; institutional care in the 1950s; and memory of bad things — sad events dominating her memory of early years.

Mary found reframing and cognitive restructuring interesting and helpful. Some possibilities offered in the light of issues above were reinterpretation such as:

1. Were you abandoned or did you perceive/feel abandoned — since responsible people took you and picked you up?
2. As a child you felt lack of control; as an adult do you have more resources, experiences, and opportunities to access and develop control?
3. Bad/sad times are recalled — could there have been some times where love, friendship, and happiness could have been experienced? Would the total time have been all bad or is the perceptual memory of the overall experience one of badness and sadness?
4. If it was all bad/sad or perceived as such, then only a strong resourceful person would have come through it — to have "survived" is to have done well and to have illustrated strength. Imagine what such a person could do when things change, when more resources and supports are available?

This was the first session involving therapeutic hypnosis. Induction comprised deep breathing and progressive muscle relaxation. Deepening was conducted by a counting technique. Then visualisation was suggested, of driving past the Centre feeling calm and comfortable; introduction of "relaxation trigger" (finger to thumb — previously issues of safety whilst driving were discussed and resolved). After this, an ego-strengthening dialogue was directed towards the patient's capacity to develop and maintain greater personal control and the ability to make good and satisfying decisions. Dehypnotising comprised suggestions of return to a state of freshness and alertness associated with the present at the conclusion of the session.

The session was reviewed. Mary felt good and refreshed; she was a bit uncomfortable about the visualisation, "but nothing like the real thing." Mary agreed to drive past the Centre using relaxation techniques discussed. She said she would practise the techniques over the period between consultations.

SESSION 4

Review of the past week was carried out and again there was significant success in relation to progressive desensitisation, making use of visualisation as a prelude

to systematic approach to the phobic stimulus/situation. Mary had driven past the Centre on three occasions prior to this session. She reported a significant reduction in anxiety symptoms that occurred just prior to, during, and just after driving past it. Recognition of some progress in terms of symptom reduction proved to be motivating.

Mary reported how her thinking was beginning to change. She said that she thought her language and behaviour would take time to catch up with her "different way of thinking" because "habits are hard to break."

Some of the issues raised in the previous session were more formally addressed in therapy.

Hypnosis

The same format was adopted this session as in the previous one. In this session visualisation focused on stopping at the Centre and feeling quite comfortable in doing that and then driving on.

Review of Session

Mary was motivated to stop at the Centre and it was discussed that, perhaps later in the week, she might feel comfortable walking outside it. She said she felt a bit nervous but thought she could cope. Relaxation techniques and self-hypnosis were discussed. As a result of her experience of a bit of nervousness, she was re-entered into trance, using this opportunity for her to achieve the re-entry by self-hypnosis. While in trance, the dialogue used was designed to increase confidence and sense of well-being; she was taken out of trance and reported feeling more comfortable, more fresh, alert, and relaxed.

SESSION 5

The session began with review of the past week. Mary reported stopping outside the Centre on two occasions during the preceding week and "feeling okay, but a bit strange the first time." At the end of the week, on the second occasion that she actually stopped, she reported that she walked along the footpath outside the Centre and "wandered just inside the gate and around the gardens." As this was an extension of the visualisation of the matter discussed last session, it was decided to proceed past the next visualisation of going to the grounds and to use this session to actually support entry to the building and investigation of the records in the building and interviews with staff.

Hypnosis

The format of this was the same as in previous sessions, with the visualisation focusing on actually going into the grounds, having discussions with staff and looking at any written records.

Review of Session

Mary felt quite confident to enter the home and find out what she could. She indicated that she'd ring first and that she would probably use relaxation

and her "finger technique" prior to the call because "it will be the first time since being there that I will hear a voice from that place."

I gave Mary the opportunity to practise self-hypnosis and to visualise the successful phone call prior to visiting the Centre, talking to staff, and looking through records. She did this and I observed her finger and thumb coming together while she was in trance. She later recalled that she did it automatically as she heard the dial tone on the phone prior to somebody answering it.

The mid-term visual analogue was given — this indicated that Mary's perception of the anxiety associated with her phobia had significantly reduced.

SESSION 6

This session began with review of the week. Mary had entered the Centre and found the staff "kind and helpful," but she gained "little useful information." When she talked to the director she found herself crying: "I think I went a bit red, I had a cry but I felt all right, they gave me some tissues, talked to me. I had a cup of coffee and then walked around the Centre. At one stage I became aware of my finger and thumb being together."

Age regression was discussed as a process that could assist in the resolution of feelings that she found confusing and uncomfortable. It was also indicated that, through the process of age regression, some helpful information might become available.

It was agreed that an assessment should be made of Mary's capacity to undertake age regression. I asked her to select a time when she was aged around six to eight that she might recall as being happy. She selected her seventh birthday. A period of time for age regression had been chosen that could adequately assess age regression going back a significant number of years, but not too close to the period of time that Mary spent in the Centre.

Hypnosis

Induction and deepening were carried out in the same format as the previous session.

Age regression was achieved by counting back to Mary's seventh birthday in blocks of five years to when she was 10, and then back in one-year segments to when she was seven. She was now at her birthday party. Mary experienced abreaction. This response was quite unanticipated. Taken deeper into trance, she was moved towards a calmer more controlled state. The latter part of the session involved dialogue that focused on peacefulness, calmness, and control. Mary was led out of trance into a state where it was suggested that she would feel calm, alert and comfortable.

Review of Session

Mary was surprised that she had got so upset when in trance. She then said that she realised that it wasn't a happy birthday, but rather "a disguised farewell party." She talked a lot about how disruptive and upsetting the continuous

moving of house was: "I was never consulted, I became shy and lost confidence, I didn't look forward to having to make new friends and starting at a new school."

The issue of repressed fears and sadness at her party and the likelihood that she had repressed fears and sadness in relation to the Centre were addressed. Further discussion occurred in relation to Mary's experience while under hypnosis and her experience of age regression. Mary experienced a role performance during most of this process; however, she felt she actually lived the part, was seven when she had such strong feelings during the abreactive process. Her motoric movements and speech during that period of time suggested revivification.

Although she said she felt calm and settled, Mary added that she also felt a bit drained. Mary was encouraged to use self-hypnosis as a conclusion to the session. This was observed; while under hypnosis dialogue was presented that suggested energy renewal, freshness, and alertness. After this brief session Mary reported that she felt better.

Mary agreed to have some discussions during the week with her mother, in an effort to explore feelings, attitudes, and events that occurred on or around the time that Mary entered the Centre.

SESSION 7

Review of the previous week. Mary recalled that she was starting to understand what had occurred in her past a little bit better. She felt that going back to the Centre really focused her attention on being a child and her relationship with her parents. In this session we explored her thoughts and feelings in relation to her parents and some discussion included her sister.

Mary felt that going back to the Centre through hypnosis, age regression, could be helpful.

Hypnosis

Standard induction was carried out, with visualisation and deepening. Age regression was achieved to two years of age. Moving from entering the Centre, reviewing some of the good and bad days at the Centre, and leaving were all experienced, followed by further deepening; then followed suggestions for ego-strengthening and emergence from trance feeling refreshed, stronger, and more comfortable.

In age regression Mary demonstrated both role playing and revivification. She'd recalled people (and their dress), situations (on the swings, singing, "Mummy's coming, Daddy's coming"), equipment (like her cot and her teddy), and feelings (confusion, abandonment, fear).

In psychotherapy that followed, information and feelings revealed during hypnosis session proved extremely useful, as Mary became aware of and understood the process of repression that had taken place since she was two

and the influence that this process had had on her relationship with her mother, her sister, and recollections that she had of her father.

Mary was offered a self-hypnosis tape, but she said that she felt able to practise self-hypnosis and relaxation without it.

SESSION 8

Mary began by saying that she felt "liberated" having recalled some of her experiences at the Centre, the circumstances of her arriving and departing, and feelings and experiences she had associated with life there.

Some matters raised in earlier sessions were reviewed. Some focus was given by Mary to her father and sister, and her relationship with them.

Mary completed the visual analogue and said that she would like to resolve her fear of height and her relationship with her sister at a later date. Concluding remarks covered matters Mary raised, like "I thought more about me as a mother, and how I treat my children. I think I'm a bit calmer with them now. I feel I understand myself and them much better now."

Mary agreed to attend a review session in three months' time (this is session 9).

SESSION 9

Mary reported that she felt well. She indicated that sometimes she got a little "tingle" when she passed the Centre but "nothing like it was."

She was practising "some self-hypnosis and relaxation, but in my busy life, I don't do it as often as I would like to; I especially do it when I find it difficult to get to sleep or I feel that I'm a bit stressed. I sometimes find I've got my thumb and finger together, not always when I'm stressed, only sometimes."

Mary talked about having had some discussion with her mother and sister since last session. Mary felt that things had improved but that she still had a long way to go in achieving the sort of relationship she would like to have with her mother and sister. She said that she now understood herself better and "I don't feel driven to solve everything." Again, she indicated that she would like to receive some treatment for her "fear of heights."

COMMENTS AND CONCLUSION

This case deals with the use of hypnosis as an adjunct to broad spectrum therapy (Lazarus, 1971). The patient was a 43-year-old female diagnosed as having an anxiety disorder — simple phobia.

Hypnosis enabled and facilitated the recall of information and feelings that appeared to have been repressed for over 30 years. Associated with memory recall was the patient's experience of abreaction, the therapist's management of this process, and recognition by the patient and therapist of the importance of abreaction in the healing process.

Some important features demonstrated by this case are:

1. The usefulness of age regression — or more particularly “developmental stage regression” (Burrows & Dennerstein, 1988) — in psychotherapy.
2. (i) The role of abreaction in resolving repressed thoughts and feelings (generally those with a focus on fear and/or anger).
(ii) The necessity of the therapist’s being alert to the possibility of abreaction when using regressive techniques, and to have the skills to manage it in the interests of the patient and the ongoing treatment process.
3. The significant role of (a) the patient’s motivation to take an active part in treatment, and (b) the process of transference in therapy, particularly when hypnosis is used.
4. The capacity to blend the behavioural (particularly systematic desensitisation) cognitive/rational emotive and a more “introspective approach” which can be used in hypnoanalysis — all within the broad parameters of logotherapy. This blend of psychological “schools of thought” demonstrates the possibility for adopting broad spectrum treatment as distinct from a treatment that reflects narrow boundaries imposed by the therapist’s adherence to a single school of thought.
5. The fact that pharmacological intervention was not seen as necessary in this case does not suggest that all cases diagnosed DSM III-R 300.29 Simple Phobia should be treated without the use of prescribed drugs. It is reasonable to suggest, for example, that when a person presents with a simple phobia (or other anxiety disorder) where anxiety symptoms more closely resemble a panic attack (e.g., DSM III-R 300.21, 300.01, 300.23, 300.03, 300.02) the prescribing of medication may well be part of the treatment of choice.
6. The ability of hypnosis, especially self-hypnosis, to enhance the process of overall patient health during active treatment with the therapist, and beyond, is demonstrated in this case. During treatment there seemed to be concurrent growth in self-awareness and self-control functions that generally enabled the patient to experience an improved quality of life.

The patient may be able to manage her anxiety in future without recourse to professional help. Mary’s ability to gain skills in self-hypnosis could empower her to take a more active role in both prevention and treatment of symptoms of anxiety she may experience in the future.

7. The basic therapeutic value of the therapist being “a good active listener” was illustrated by the substantial progress reported by the patient after the initial two sessions, in which a major intention was to gain data that would be useful for ongoing psychotherapy.
8. Associated or secondary conditions (in this case acrophobia) that appear during treatment of the primary presentation may be treated

during or after treatment of primary symptoms, depending on the expressed needs of the patient, the treatment provided in therapy, and the nature and extent of ongoing therapy. Self-hypnosis skills acquired during treatment of the primary condition may enable the patient to have sufficient skill and confidence to manage, by themselves, their secondary condition.

9. Memory trace was available and recall seemed consistent. Thus confabulation, an issue raised by Burrows (1988) did not occur.
10. This case reinforces the effectiveness of deepening techniques when managing abreaction.

Overall this case demonstrates effective use of hypnotherapy as an adjunct to psychotherapy; it highlights some of the inherent difficulties associated with the use of hypnosis in therapy.

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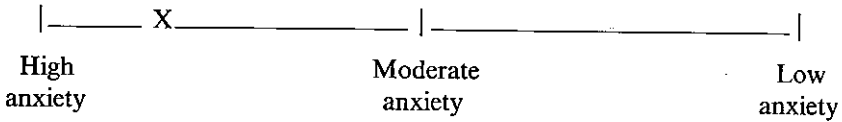
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APPENDIX I

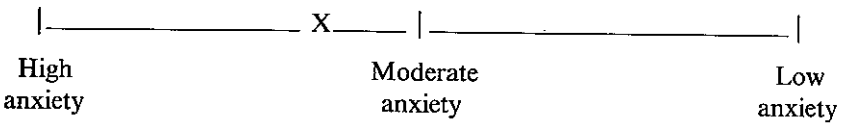
Visual Analogue

Patient's subjective response to level of anxiety at various stages of therapy. At each stage the patient was asked: "On a scale indicating the severity of anxiety you now experience when passing the Children's Centre, where would you place yourself?"

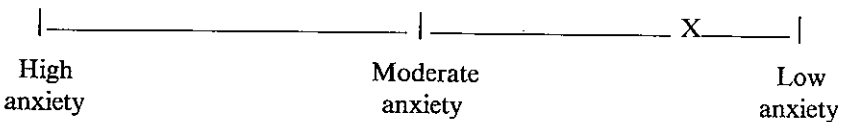
Stage 1 (beginning of therapy)

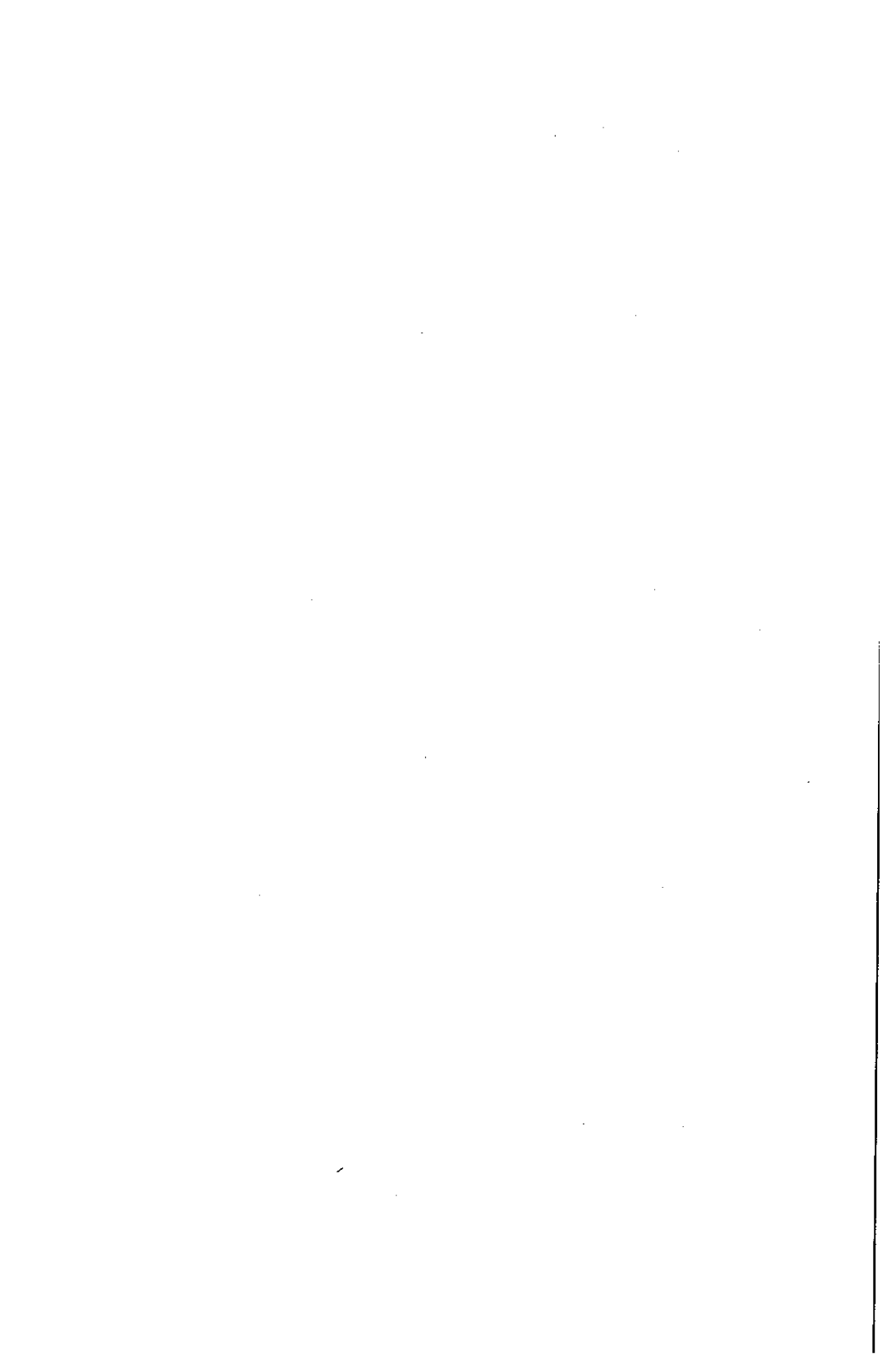


Stage 2 (approximately halfway through therapy)



Stage 3 (at the conclusion of the final therapy session)





HYPNOSIS IN THE TREATMENT OF REPRESSED GUILT

Danielle Jiranek

Psychologist

The case study describes the therapeutic intervention employed with a 39-year-old woman who was experiencing guilt over a work-related accident. Investigation revealed substantial levels of repressed guilt. Therapeutic techniques such as age regression, affect bridge, and self-hypnosis are described.

The case study described below took place in May and June 1991 as a part of the therapist's employment as a psychologist of OCAR (Occupational, Consultancy, Assessment and Referral Services). There are several factors associated with this study which may have impacted upon the therapeutic process and it is felt that some explanation of these is justified.

First, OCAR is an independent, non-profit service for individuals who are experiencing emotional or psychological difficulties which are affecting their work. The service is funded by employers who have chosen to establish an employee-assistance program for staff and the service is free for employees. This allows individuals of a lower socioeconomic background access to counselling and there can be more flexibility surrounding the length of sessions and the treatment.

Second, individuals can refer to OCAR without the knowledge of their employer or they can be referred by their supervisors or managers. Often there is a dichotomy between those who self-refer and those who have been referred by supervisors with factors such as motivation for change and openness to the counselling process usually embraced more strongly by the former group. The client in this case referred herself. Texts indicate that when a patient/client has a personal motivation (reflected by self-referral), hypnotherapy is likely to be more successful (Crasilneck & Hall, 1975).

Third, OCAR is not primarily recognised as a hypnotherapy service. The promotional pamphlets highlight counselling and most individuals would not be aware of the availability of hypnotherapy. This may have implications for the case study described, as the client did not attend OCAR requesting

hypnotherapy as an intervention. It may be hypothesised that those individuals attending a service intentionally for hypnotherapy may have a higher degree of interest in, commitment to, or expectation of this form of intervention than those who present for "counselling" and with whom hypnotherapy is used. As a result, the expectation of success in a client who has not come specifically for hypnosis may be less than those who have attended for this type of therapy (Hammond, 1988a). In the case described, hypnotherapy was not the prime reason for referral.

Finally, it is important to highlight that the therapeutic intervention used in this case combined a number of different approaches, of which hypnosis was one. Hypnosis was not used in each session and at times it consumed less than half the session. Other strategies such as rational-emotive therapy, transactional analysis, and systems theory were combined to form a therapeutic framework. Therefore, in describing the intervention, the reader should be aware that other counselling tools were used in addition to hypnotherapy and while these have not been specifically stated they are likely to have impacted upon the outcome of the therapy.

DIAGNOSTIC INTERVENTION

Personal Presentation

The client was a 39-year-old woman of Welsh background. She will be referred to as Jill.¹ She presented as a casually dressed woman of short stature and average weight.

Her behaviour at the first session was anxious. She demonstrated signs of nervousness and agitation by frequently shifting her position and twisting her hands. When relating information, she would frequently appear to be uncomfortable and would remove her glasses and rub her eyes. She was frequently fearful and demonstrated signs of anger by raising her voice. She tended to speak quickly and often used emotive statements such as "My whole life is a disaster" and "I'm so tied up in knots."

During the first session she tended to see herself as a victim of circumstance and she produced information in support of this belief.

Personal History

Psychosocial Jill was born in Wales in 1951. Her father was an electrician and her mother a seamstress. She was the elder of two children.

She reported an unhappy childhood. Her earliest memories included arguments between her mother and father. She remembered at around age five being woken from sleep on a regular basis by her father to be taken downstairs, forced to listen to the argument, and asked by her father whom she thought was correct. She stated that this caused a great deal of distress and she believed it caused her to be a poor sleeper to the current time.

From approximately age nine, Jill was aware of her father's bizarre sexual preferences. She remembered on two occasions her father forcing her mother

to have sex with another man in front of him. Jill was not involved in watching this but she did recall the resistance from her mother around this issue. Jill did not remember any sexual abuse from her father.

During her childhood, Jill spent a great deal of time with other family members. She stated that she spent at least two years away from her parents, during which time she stayed with her grandparents and other family members. She remembered feeling very lonely during this period and believed herself to be a burden to others. As a child Jill could not understand the reason for the absence from her parents. As an adult Jill believed it was due in part to her mother being diagnosed as a schizophrenic, which required periods of hospitalisation.

The other significant experience Jill recalled from her childhood occurred when she was staying with an aunt and uncle in the country. Jill stated that the aunt and uncle were very dear to her and they had been like second parents. She remembered, at age 11, being in bed and her uncle bringing her a cup of tea. She remembered him attempting to touch her breast and him unzipping his pants and requesting oral sex. Jill stated: "I just went mad. I started to cry and then I hit him and I ran into my aunt's room. I couldn't tell her what had happened. I felt so guilty about it." Jill stated one further unsuccessful sexual attempt was made, which she did not reveal to anyone. Shortly after she returned to her parents' home.

Her next contact with her uncle was several years later when she was aged 16. She had returned to Wales from Australia with her new baby and she explained: "I thought because I was older, I could handle him and anyway I thought it wouldn't happen again." However, her uncle again attempted sexual contact and stated that he loved her. Jill described her fear and guilt in the following way: "My aunt must have known something was wrong. She would say, 'Why don't you go down to the pub with your uncle?' but I would say 'I'm happy here with you.' I avoided him as much as I could. I didn't know what else to do." Jill has had no contact with her uncle since that time. She stated that she felt very angry and bitter about the incidents and that they have affected her trust and sexual confidence with men.

Jill and her family moved to Australia in 1966. At age 16, Jill became pregnant and married. She states: "I was pleased in a way to get pregnant because it meant I could move out of home. I didn't know any other way to get out." The marriage lasted for seven years and produced a second child. Jill described the marriage as a failure and she had not maintained contact with her ex-husband.

At age 27, Jill married for a second time. She described her husband, Dennis, as violent. She reported physical abuse of both herself and the children. The marriage lasted for five years before she left with the children.

At the time of presentation, Jill had remarried and lived with her husband and youngest son Tony (aged 20). Jill described her marriage as "wonderful" and stated that she only felt relaxed when she was with her husband. She maintained infrequent contact with her parents, who are now separated.

Jill worked part-time as a residential care worker. This involved the domestic care of five severely intellectually and physically disabled children. Jill was also studying part-time at a technical college.

Medical Jill has experienced several noteworthy medical conditions. She has been an asthmatic from the age of two and continues to have asthma attacks irregularly, usually under times of stress.

She has had a sleep disorder for many years and she reports that she frequently gets only four to five hours sleep per night. Jill is not taking medication for this problem.

There has been no history of mental illness, although her mother has been diagnosed as a schizophrenic.

Jill reports several depressive episodes in her life, particularly at times of marital disharmony. She has taken prescribed antidepressants during these periods but she was not taking any medication at the time of consultation. Jill states she has not seriously entertained suicidal thoughts.

PRESENTING PROBLEM

Jill was referred to OCAR services following an incident at work which she stated caused her a great deal of grief and distress.

She explained that she had developed a very close relationship with one of the disabled children at work, Jason, aged eight.¹ According to Jill she had acted as a foster parent to him and for the past six years she had taken Jason home at weekends and at Christmas time. Jill explained that an accident had occurred at work in April this year. She explained the incident in the following way:

Jason was lying on the changing table and I turned my back to get some clean clothes for him. That was my mistake. I shouldn't have turned my back. Anyway, of course, the next thing I know is there is a bang and when I looked, Jason is lying on the floor. I didn't think. My mind was dead. I just thought, "That's odd, he's on the floor." Anyway of course I went over and tried to lift him up. I shouldn't have done that. I should have known better. I've done first aid and I know you should never lift anyone. Anyway, I tried to lift him but he was just a dead weight. I didn't know what to do. He had fallen from quite a height. Anyway in the end we took him to the hospital to get checked out . . . The thing is I can't get it out of my mind.

Jill went on to say that the incident had affected her judgment at work. She reported that she felt guilty constantly and she felt as if she had "killed" Jason. She said that since the accident he had been a "different person" and other staff members had also commented on the changes in him. The incident had led to difficulties amongst the staff members at work, as Jill had been particularly sensitive about issues and had refused to let other staff members

care for Jason. She had broken down at work on two occasions and she said she spent most of her time worrying about Jason and the effect the fall had on his well-being.

According to Jill, her supervisor had advised her to obtain some counselling to help her to deal with the incident. The supervisor had said that Jill's job was not in jeopardy because of the accident but as her work performance had suffered some improvement was required.

PREVIOUS HYPNOTIC EXPERIENCE

Jill had not experienced hypnosis previously. She stated that she had had some experience with relaxation training (as a part of a stress management course), but this was her only related experience.

When asked her expectations of hypnosis, she stated that she believed it would make her very relaxed but still in control and she might be able to remember some things she had forgotten. Overall, I evaluated her understanding of hypnosis as sound, with few misconceptions being mentioned.

SUITABILITY FOR HYPNOSIS

Jill's suitability for hypnosis was evaluated on the following criteria: personal attributes, nature of presenting problem, existence of contraindicators, and hypnotic capacity. I will address each of these in turn.

Personal Attributes

Jill possessed several personal attributes which I believed highlighted her suitability for hypnosis. As stated previously, she referred herself for counselling and this would suggest a motivation for change at the conscious level.

Second, when hypnosis was suggested as one possible form of intervention, Jill expressed a clear preference for this technique. Again a motivation at the conscious level is suggested.

Third, a good rapport had been established between the therapist and the client. It had been noted that rapport is a vital component to the success of any therapeutic intervention, but particularly to hypnosis (Crasilneck & Hall, 1975).

Presenting Problem

The presenting problem related to the accident at work and appeared to be tied to the emotions of guilt and responsibility. In taking Jill's case history, these emotions seemed to be recurring themes. Jill reported feelings of guilt and anger in respect of her uncle's sexual advances. These emotions also seemed to be a part of her experiences with her parents' arguments. Guilt and anger may have also been present when the young Jill was shifted from one family to another. The domestic violence she experienced in her second marriage may have also led to feelings of anger and guilt.

Research indicates that hypnosis is an effective tool when dealing with emotions such as guilt and anger, particularly where these emotions are not readily available at the conscious level (Hammond, 1990). Yapko (1988; cited in Hammond, 1990) states that "guilt can be an incredibly profound agent of paralysis in an individual's life" (p. 321). Hypnotic intervention can raise the individual's awareness of the root of the guilt and can resolve these emotions.

Hence the presenting problem of guilt over an accident at work appeared to be highly suitable for hypnotic intervention. In addition, Jill's personal history suggested that there might be other repressed material which contributed to these guilt feelings. Again hypnosis was, in my opinion, an appropriate intervention to access this material.

Existence of Contraindicators

There were no apparent contraindicators to the use of hypnosis. Jill did not present with a psychiatric disorder. Further, the administration of the Beck Depression Inventory suggested an absence of severe depression and the therapist's professional opinion was that Jill was not suicidal. Jill had clearly stated therapeutic goals and she did not demonstrate resistance at the conscious level. In addition, she had demonstrated a reasonable intellectual ability. Finally, as the presenting problem was one that I could competently address as a psychologist, hypnosis was seen to be appropriate.

Hypnotic Capacity

A standard test of hypnotic capacity was not administered in this situation. While the author is aware of such scales and has utilised the Stanford Hypnotic Scale in the past, it was felt that less formal testing would be used in this case to determine hypnotic capacity, which is usually determined by the demonstration of particular phenomena. Throughout the course of therapy, Jill adequately demonstrated phenomena such as hand levitation, age regression, and completion of a post-hypnotic suggestion. As these phenomena are frequently components of hypnotic measurement scales and an ability to perform them is usually associated with medium to deep trance states (Hammond, 1988b), it was believed that Jill had a good hypnotic capacity.

TREATMENT PLAN

The treatment plan in part was determined by the client's therapeutic goals. The following three client goals were stated: to develop better coping abilities and let go of guilt, and to obtain better sleep. From these goals, a treatment plan was devised. It was agreed that hypnosis would be used to alleviate the guilt surrounding her uncle's sexual approaches. It was hypothesised that there may have been other repressed issues at an unconscious level that might be resolved through hypnotic intervention.

The treatment plan included age regression to access repressed information, hypnoanalytical techniques and direct hypnotic suggestion, and the teaching

of self-hypnosis to address the sleep disorder. In addition it was felt that ego-strengthening techniques would increase Jill's self-esteem and confidence.

TREATMENT

Session 1

The first session involved history-taking, preparation for hypnosis, induction and utilisation of trance, and termination of trance.

The outcome of the history-taking has been described above. In order to prepare Jill for the hypnotic induction, some time was spent discussing the experience of hypnosis. The concept of the conscious and unconscious mind was addressed and we discussed common misconceptions of hypnosis. Jill was informed that she would still be in control and she would not be asleep. Other misconceptions such as the client being "unconscious" were discussed.

The goal of using hypnosis was then reviewed. It was agreed that the first induction would be simple and non-threatening and of about 20 minutes' duration. As Jill had not experienced hypnosis before, it was felt that a successful introduction using permissive suggestions would lead to increased confidence for future therapy.

Hypnosis was induced using an eye fixation technique as described by Hammond (1988c). Several common deepening techniques were then employed. These included arm levitation and forward counting. The arm levitation served a dual purpose of demonstrating the trance state to the client and deepening this trance state. Ideomotor finger signalling was also established at this point. This technique is the most common strategy for communication with the unconscious (Kroger, 1977). A "yes" finger, a "no" finger, and a "do not want to answer" finger were established by following the technique described by Hammond and Cheek (1988).

A guided relaxation exercise followed. The script in part is produced below:

Imagine you are at the top of a set of five steps which lead down to a perfect beach with white sand and gentle waves. The beach is quite empty. As you walk down the steps to the beach you may be curious to notice how relaxed you become. Indeed with each step down you may become more and more relaxed. I will count down the steps one at a time.

As a further deepening technique, the beach was described more fully using visual, auditory, and tactile descriptors.

As you relax on the beach, you may find a piece of sand by the shoreline which is damp and in which you can dig a hole. You can make the hole as big or as small as you like. Let me know when you have dug the hole by raising your yes finger. [Response obtained.] Now put into the hole all of the no-longer-needed worries and guilt which have been tying up

your life. Unburden those feelings and fill the hole. [Various descriptors of unburdening.] Let me know when you have done this by raising your yes finger. [Response obtained.]

The exercise continued with ego-strengthening comments and a reinforcement of the release of guilt and anger and other unnecessary feelings.

Now fill the hole with sand and watch as it is covered by a wave and knowing that all the unnecessary feelings and worries have been swept out to sea, no longer needing to be carried by you as a burden. When this has happened let me know by raising the yes finger.

At the completion of this guided imagery intervention, self-efficacy statements were provided and then the trance was terminated. Once out of trance, Jill was given the opportunity to discuss the experience. She stated that she had found it very easy to relax and had been successful in visualising the beach, the hole, and the unburdening of her guilt. She stated that she felt there was not enough room in the hole for all of her guilt. This comment suggested to the therapist that some further work was required to relinquish the feelings of guilt. Jill stated she had found the arm-levitation exercise interesting and it had confirmed for her the ability to use hypnosis to achieve her aims.

Session 2

At the commencement of the second session, Jill was asked to comment on her experiences over the previous two weeks. She felt there had been several improvements. According to Jill, one week after the last session her supervisor had called her into his office and had said how pleased he was with her change in attitude. He had expressed surprise at how quickly she had adjusted and returned to her previous level of work performance. He stated that other staff had found her much more approachable and she seemed more balanced in her care of Jason. Jill herself felt that she was allowing staff to be involved in the care of Jason rather than assuming full responsibility.

In addition, Jill stated her husband had commented on her "new attitude." Jill related the following incident as an example. Her youngest son had planned to marry in the new year and since the last session the wedding plans had been cancelled. Jill said: "Usually I would have hit the roof and cried and yelled and all those other things. But I thought about what we had talked about last week and all I said was 'It's your decision.' My son nearly fell over."

Jill stated she had felt more in control of her emotions and more able to react in an adult way.

Before inducing trance in this session, the aims of the session were clarified. Jill stated that she was still experiencing some guilt about the accident at work. In addition, since the last session Jill had considered further the issues surrounding her uncle. She felt this event in her life might be affecting her

ability to be responsible and guilt-free. In order to address these needs the following intervention was used.

Hypnosis was induced using the eye-fixation technique and deepening procedure as previously described. An affect bridge as developed by Watkins (1971) was then utilised. Jill was asked to focus her attention and concentrate on the guilt and anger she was experiencing at the current time. She was asked to let her mind take her back to a recent time when she had experienced these feelings. She indicated through ideomotor finger signals that she had located that time. When she was asked where she was, she reported she was at work, several days after the accident with Jason, and he was crying. Jill was then asked to intensify the emotions of anger and guilt so they were as strong as they could be. Once Jill had indicated "yes" through finger signals, she was asked if the unconscious mind would be willing to trace these emotions to their origin. She indicated "yes." Jill was then asked to trace these emotions back through time, as if she was going along the bridge of time, to the first time she had ever experienced these feelings. She was asked to indicate when she had arrived at such a time. A "yes" response was obtained.

Jill was then asked where she was, how old she was, and what was happening. She indicated that she was five years of age and was at home with her parents. She stated that she was feeling scared. Jill explained that her parents had been fighting for several hours and she believed her father was drunk. She had heard her father hitting her mother but suddenly everything was quiet and peaceful. She thought her mother might have been killed. She described feelings of powerlessness, neglect, anger, and guilt at not having had the courage to intervene earlier.

Having described this situation, Jill was asked if there was an earlier time when she experienced these emotions. She replied "no". This was confirmed by repeating the question and a "no" response was obtained for a second time. As the origin of the emotions had been determined the next goal of therapy was for these emotions to be accepted and relinquished as no longer functional. The interchange below indicates how this was achieved.

- Therapist:* Is your subconscious mind willing to resolve these feelings?
Client: Yes.
T: Is there any part of your subconscious mind which is unwilling to resolve these feelings?
C: No.
T: Then I want the subconscious part of Jill's mind, which is the 39-year-old, to listen to me. When this part of Jill's subconscious mind is willing to listen, the yes finger will raise. [Response obtained.] This 39-year-old part of Jill had 39 years of experience and understanding. It has much wisdom and love and caring. Is this part willing to talk with the five-year-old Jill?
C: Yes.

T: Then 39-year-old Jill, join with five-year-old Jill and tell each other how you feel. Perhaps 39-year-old Jill could give five-year-old Jill a big hug and comfort her and tell her she is loved and cared for. As these parts talk together, you will allow those emotions to blow away like a clean fresh breath of air is sweeping through you. You will feel more comfortable, calmer and at peace. When 39-year-old Jill has talked with five-year-old Jill the "yes" finger will raise.

Response was obtained after approximately five minutes.

T: Five-year-old Jill, do you feel more comfortable?

C: Yes.

T: Then you may find that those emotions which have been tying up your life are no longer needed. That part of your mind which cares for your health and well-being will care for five-year-old Jill and will continue to care for her even when I am not there. [Additional statements were made about the release of emotion and ability to cope.] When I see you next time, you may be pleasantly surprised at how much stronger and more capable you are.

The trance was terminated. It should be noted that as a therapist, it was decided to discontinue the session before the later incident regarding Jill's uncle was addressed. It was felt that Jill's subconscious mind had worked hard to resolve important issues in this session and further work on that day might have been too difficult. This decision was also based upon the consideration that a session to deal with the incident separately might be more powerful.

In summary, session 2 utilised hypnoanalytical techniques similar to those used by clinicians such as Edgar Barnett (1981). The use of an affect bridge allowed Jill to regress to the first critical experience of guilt and anger. Other emotions such as fear and abandonment were also revealed. The emotions, which no longer served their original purpose, were accepted and relinquished with the help of adult understanding.

Session 3

At the commencement of session 3 Jill continued to report improvements. She stated: "I just feel different. I'm not sure how. Just like a weight has been lifted off my shoulders I guess."

However, Jill continued to report guilt feelings about Jason and the accident. She explained that Jason was due to have a series of medical tests as he had continued to show signs of pain. Jill reported feeling nervous and uncomfortable about the outcome of these tests.

The goal of Session 3 was to address the emotions surrounding the sexual approaches made by Jill's uncle. The sub-goal was to resolve feelings of guilt

surrounding the work incident. It is noteworthy that to this point the presenting problem had not been specifically addressed. Nonetheless, Jill had experienced improvements in this area. These improvements were viewed as encouraging and in support of the therapist's belief that the resolution of past repressed emotions might allow the client to re-evaluate the current work incident more realistically.

Trance was induced and Jill was asked to return to the time and place when her uncle had made sexual advances. She indicated through ideomotor finger signals that she had done this. She was asked where she was, and how she was feeling. Her responses indicated that she was age 11 and her uncle was attempting to forcefully obtain oral sex.

At this point, visual imagery techniques were used. Jill was asked to imagine herself as the owner of a "shrinking gun" from outer space. This gun had the effect of shrinking any object it was used on. Jill was invited to use the gun on her uncle to shrink him to the size of a mouse. She was asked to indicate when she had done this. She was then invited to take her uncle to the toilet, drop him in, and flush him away. This situation was described in more detail than indicated here. Jill was invited to do any other thing she wished and was asked to indicate when she had done this by raising the yes finger. Several ego-strengthening comments followed and Jill was instructed to relinquish any remaining guilt surrounding this incident. The trance was terminated.

At the completion of the session Jill stated that she had enjoyed the experience of flushing her uncle down the toilet and she said: "I don't think I could ever look at him the same way. He was so helpless being so small and trying to stay afloat in the toilet."

Session 4

Jill arrived at session 4 sporting a new haircut and a smart new dress. She stated that she had felt it was "time for a change." Jill commenced the session by explaining that Jason had received a thorough medical examination and no injury was detected. She stated she felt relieved by this and felt that, overall, most issues which had been concerning her had been resolved. It was agreed that this would be the final session.

The goal of this session was to teach Jill self-hypnosis so she could use this technique on an ongoing basis, particularly to manage stress and her sleep disorder.

In order to teach self-hypnosis, Jill was asked to enter trance using the method she had learnt (namely eye fixation). Once in trance she was instructed to count from one to 10, becoming more relaxed as the numbers increased. Sentences were phrased as if the client were saying them (e.g., "I am now letting go of tension and stress") and Jill was encouraged to repeat the phrases in her own head. Progressive relaxation was taught and several self-efficacy statements were included. Jill was encouraged to use the visual imagery of

the beach and the letting go of tension (as described in session 1). While in hypnosis, Jill was given instructions for independent trance termination.

Several factors were considered when teaching Jill self-hypnosis. She was reassured that the cue for entering self-hypnosis would be specific to her and could only be used with her permission. Some time was spent increasing Jill's confidence in using this technique and she was required to independently enter and leave a trance twice during the session. The practice was seen as important, as clients frequently fear an inability to leave the trance while using self-hypnosis. In addition, some authors suggest this practice also has the effect of fractionation and can lead to a deepening of trance (Hammond, 1988) and practice was likely to increase Jill's confidence using self-hypnosis. Jill was informed of the possibility of moving from self-hypnosis into sleep and permission was given to do this, with a conditional statement of waking refreshed and alert. Finally, Jill was instructed to use only positive and reaffirming suggestions while in self-hypnosis so that the experience was pleasant and stress-releasing.

By the end of this session Jill had demonstrated induction and termination of trance on two occasions. Her ability to effectively use self-hypnosis was reinforced during the trance states.

It was agreed that contact would cease at this point with the provision of a follow-up telephone call in three months.

Follow-up

A follow-up telephone call was made three months after the last appointment. Jill reported feeling calm and confident. She had completed and passed the study course she had been doing and had achieved good results. At work she had received positive feedback and, as a part of a performance review, she had received a pay rise. She reported that Jason was coping well but he was not such a large part of her life any more.

Jill reported that her sleep had improved and she was now only experiencing sleeplessness a couple of times per month rather than several times per week. She stated: "All in all everything is fine."

When asked about her feelings of guilt and anger, Jill laughed and stated she had not recognised these feelings in the past few months and said: "Sometimes the hole at the beach gets pretty full." This was a reference to the self-hypnosis technique taught in Sessions 1 and 4. Jill said that she continued to use hypnosis two or three times per week. She stated that she did not require any further contact with the therapist.

DISCUSSION

The case study took place over four sessions and a range of therapeutic techniques were used. The rationale for these approaches is elaborated upon below.

After taking a case study from Jill, several issues were pertinent. When supplying information Jill demonstrated an excellent ability to describe events

in detail and her ability to visualise was also gleaned from the initial meeting. It was hypothesised that these abilities could be utilised as a part of the therapeutic process. Hence the initial trance included a guided relaxation component which included a large amount of visual imagery. The therapist had been aware of Jill's likes and dislikes and these were incorporated into the script. This initial experience of hypnosis was later used as a part of the client's self-hypnosis technique.

The rationale for utilising guided imagery techniques initially, rather than immediately attempting age regression, is a reflection of the therapist's philosophy of attempting the least traumatic option first. Hence it was considered possible that the client would relinquish the guilt from both the present time and the past by using a permissive visual-imagery intervention. However it was clear by the second session that in this case the technique had not adequately accessed all the repressed material and more complex and intrusive techniques were considered.

Therefore the technique of age regression was employed on two occasions. The tool was used primarily for Jill to access repressed material and to evaluate this material as an adult. This method was chosen as a result of Jill's recall of many events in her childhood which, even at a conscious level, had affected her coping abilities. It was hypothesised that these and perhaps other memories might be operating at the unconscious level and could be leading to maladaptive emotional behaviour. Barnett (1981) highlights the importance of an individual's discovery of critical events in the past which can lead to recovery and a balanced lifestyle. The methods employed with Jill provided the opportunity for her to meet the needs of the "young Jill" with the help of the mature understanding of the "older Jill". By reviewing childhood events with an adult mind, Jill was able to deal with and relinquish dysfunctional emotions and could then approach events in the present in a more positive manner.

Self-hypnosis was also used in this therapy. The philosophy of using this approach was to allow Jill to obtain independent control over her health and well-being. Jill had maintained a sense of abandonment and powerlessness from childhood experiences, and the approach used in this case study recognised these emotions. Indeed it may be noted that the initial interventions were largely therapist-controlled and directive. Trance was induced formally and in the first session Jill followed directive instructions. Throughout the therapy, control was slowly reassigned to the client. This was done by providing more permissive statements (such as in session 3 where Jill was invited to "do anything you like to your uncle"). It was felt that the provision of self-hypnosis would further serve to highlight the degree of control Jill had obtained. Hence in the final session, when self-hypnosis was taught, Jill was given reinforcement to be in control of her own well-being. The use of hypnosis was no longer seen as "something done to her." Instead the client was encouraged to view hypnosis as a tool available to her. It is believed that this allowed Jill to experience a sense of achievement in her own abilities.

CONCLUDING STATEMENTS

It is important to highlight that the success of this case study was due to several factors. First, a good rapport between client and therapist was evident. Second, the client was not resistant to hypnosis at the conscious or unconscious levels. Third, the therapeutic goals had been defined and agreed upon by both client and therapist. Fourth, the client was clearly motivated for change in this instance and was open to the exploration of repressed material. Finally, it is probable that other factors such as Jason's medical recovery influenced the overall success of the therapeutic process.

Nevertheless the case study highlights the value of the use of hypnosis in the therapeutic process. In this case the tool of hypnosis allowed the client to access repressed material which was affecting her present coping abilities. While this outcome might have been achieved by other therapies, it is probable that it would have been a lengthier process with more limited results.

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¹ All names have been changed to protect individual identity.

USE OF HYPNOSIS IN PAIN MANAGEMENT AND POST-TRAUMATIC STRESS DISORDER

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This case study describes the intervention used with a 34-year-old woman who had been involved in an industrial accident and was suffering post-traumatic stress disorder and pain. The hypnotic interventions included pain management techniques, guided imagery, and self-hypnosis.

The therapeutic work described below took place over two months in 1990, as a part of the therapist's private practice as a psychologist. There are several factors which may have impacted on the therapeutic process and these are detailed below.

The client was referred by an occupational health and safety officer following a work-related accident. The fact that the client was referred by a third person may have had some implications for the therapeutic process. Some clinicians argue that there is a decreased motivation in those individuals who are not self-referred. Indeed this tended to be confirmed in this case as there seemed to be some conflict between the referral source's goals and those of the client. The referral source's primary reason for referral was to ensure that the client made a successful and rapid return to work. The client's primary goal, on the other hand, was to reduce her levels of pain. This conflict in anticipated outcomes tended to lead to some resistance on the part of the client.

The presenting problem in this case was associated with a Worker's Compensation claim. Again some studies suggest that motivation for change may be reduced in these situations due to the possible financial losses associated with "becoming better." In addition, the therapy provided was free of charge to the client and some may argue that the impetus for change may be decreased when financial outlay is not involved.

These factors may have been potential blocks to therapeutic change.

DIAGNOSTIC INTERVIEW

Personal Presentation

Pat was a 34-year-old woman who was married with no children. She presented as a thin woman of short stature. Pat had an unsteady gait, which she explained was due to an injury she had sustained two weeks previously.

Throughout the first session Pat was cooperative but tended to speak in general terms. She often seemed vague and she expressed some confusion about the reason for referral as she felt her physical injury could not be helped by psychological intervention.

Psychosocial

Pat was Australian born and was the youngest of five children. She had a working-class background; her father was a plumber and her mother was a housewife. She had two elder sisters and two elder brothers.

Pat described her childhood as "average." She was on good terms with most of her siblings and had a good relationship with her parents. She stated that she had infrequent contact with family members as they lived interstate.

Pat had been employed in her current position as a process worker for eight years. She had left school at the age of 17 years.

Medical

According to Pat she had experienced very few medical complaints prior to the accident. She had suffered from asthma as a child but had not experienced this as an adult.

The medical diagnosis of the injury was a soft-tissue injury to the back and left hip. She had sustained severe bruising to the lumbar-sacral spine. The prognosis was good and full recovery was anticipated.

The treatment included physiotherapy twice per week and the medication included Feldene (20 mg once a day) and Digesic (2 every four to six hours).

Presenting Problem

Pat was referred for psychological assistance by the occupational health and safety officer from her workplace. The referral source stated that Pat had been involved in an industrial accident two weeks before, when she had been hit by a fork-lift and crushed underneath a pallet. Severe injuries were sustained to her hip and spine. The referral source stated that Pat had attempted to return to work on light duties on two occasions but was experiencing anxiety attacks, particularly when fork-lifts were visible.

The client's account closely followed that of the referral source. Pat explained that since the accident she had been unable to sleep, had relived the accident regularly, and experienced high levels of pain and anxiety. She expressed fears about returning to work due to the possibility of having another accident and to the anticipated increase in pain. Pat also said that she had attempted

to return to work on two occasions since the accident, but she had not coped, and had vomited and felt anxious on both occasions. She stated that she had begun to feel ill when she arrived at work but had become more distressed as she entered the production area where she had usually worked.

Pat expressed some doubts about the value of psychological intervention, as she tended to view the problem as a medical issue.

Previous Hypnotic Experience

Pat could not recall any specific hypnotic experience. However, she explained that, in her youth, she had been a state swimming medallist and as a part of her training she was taught "self-control" through relaxation, control of breathing and other meditative methods. It was felt that some of her earlier experiences might be utilised in the current situation.

ASSESSMENT OF HYPNOTISABILITY

The client's suitability for hypnosis was determined by examining the nature of the presenting problem, the existence of contraindicators, and hypnotic capacity.

The nature of the presenting problem was a major determinant in the use of hypnosis in this case. The client's presenting problem concerned (a) anxiety attacks and (b) pain management. Hypnosis has been shown to be an effective intervention in these areas. With respect to the former, research has shown that hypnosis can be paired with cognitive and behavioural strategies successfully to reduce and resolve anxiety disorders (Kroger, 1977; Crasilneck & Hall, 1975).

Hypnosis is also highly regarded as a pain-management intervention and Crasilneck and Hall (1975) comment that: "Management of pain problems remains one of the first and most enduring uses of hypnosis" (p. 78). Several studies have highlighted the value of hypnosis in reducing pain levels (Hilgard & Hilgard, 1975; Evans, 1990).

There appeared to be few contraindicators to the use of hypnosis. Pat did not have a psychiatric illness or severe depression. Although she was reserved about the effectiveness of hypnosis, she was not highly resistant to its use and she had demonstrated a rapport and trust with the therapist.

A good hypnotic capacity was demonstrated by the client. The Stanford Hypnotic Clinical Scale was administered and Pat fell within the medium hypnotisable range. Taking all these factors into consideration, hypnotic intervention was seen as appropriate.

TREATMENT PLAN

The two components of the presenting problem were considered separately when developing the treatment plan.

Anxiety Disorder

According to DSM-III, the anxiety disorder experienced by the client may be classified as Post Traumatic Stress Disorder. It was directly related to the recent work trauma she had experienced and this correlation allowed the intervention to be direct and structured to resolve the anxiety.

The treatment plan to alleviate the anxiety attacks relied on a combination of behavioural and cognitive interventions. Relaxation, guided imagery and in vivo exposure were the primary tools used. These will be described in more detail below.

Pain Management

As mentioned before, the recent nature of the injury meant that Pat was likely to be experiencing acute pain involving tissue damage and physiological symptoms, in contrast to chronic pain, which tends to develop later and which can be more psychosomatic in nature.

Research indicates that there are many hypnotic techniques which can be used effectively in pain management interventions. These include direct hypnotic suggestion for total abolition of pain, permissive indirect suggestions, amnesia, hypnotic analgesia, hypnotic replacement of pain, hypnotic displacement of pain, and reinterpretation of the pain experience.

In consideration of the presenting problem, the therapist's professional discipline and the client's goals, two techniques were selected as most appropriate. First, the use of imagery to modify the pain was seen as a suitable intervention, and second, as the therapist felt there might be some resistance to change at the conscious level, the more permissive and indirect suggestions were thought most likely to result in a successful outcome.

It is important to note at this stage that several precautions were taken before the pain-management therapy was commenced. As a psychologist, I was aware of my limitations to make medical assumptions about the injury or to assume that the pain could be modified safely. Therefore it was necessary to consult with the client's treating practitioner and to obtain information regarding the injury, diagnosis, and prognosis. Hence the overall treatment plan was discussed with the doctor and his approval was obtained before therapy was commenced.

TREATMENT

Session 1

The initial session involved taking a case history and determining Pat's goals for attending therapy. As the presenting problem involved issues of pain, some time was spent investigating this. Pat was asked to describe the pain in detail, to discuss the effect it had on her life, and to elaborate on the frequency and duration of the pain experience. She was also asked to rate her pain on a scale ranging from *painfree* (1) to *the worst pain you could imagine* (10).

As previously stated, Pat's goals for attending therapy were somewhat vague. However, she did communicate the following goals: (a) to reduce the level of pain; and (b) to be less anxious about going to work.

Following discussion of the therapeutic goals, the concept of hypnosis was introduced. The client was asked to explain her understanding of hypnosis. Once this had been obtained, the therapist spent some time explaining hypnosis, taking care to correct and overcome some of the commonly held misconceptions which had been identified. In this case, Pat had expressed concern about being "under someone's control." This was discussed at length and Pat was assured of being alert, awake, and in control during hypnosis.

Trance was induced using the Spiegel induction technique. The client was successful in demonstrating the trance phenomenon of arm levitation. The exhibition of arm levitation acted both as a deepening procedure and as a demonstration of the difference between hypnosis and other forms of relaxation and meditation.

Once Pat had achieved trance, ideomotor finger signals were established using the method described by Hammond and Cheek (1988). Pat was then asked: "Is your unconscious mind willing to cooperate in the management of pain and anxiety?" Using ideomotor finger signals, a "yes" response was obtained. This suggested that Pat was willing, at an unconscious level, to work toward positive change.

Having obtained permission from the unconscious mind, a visual imagery script was utilised. This involved Pat's visualising a pain-control switch which could be turned up or down as required. She was asked to indicate on a scale of 1 to 10 the level of pain she was currently experiencing. She replied "5." Pat was then asked to use the pain-control switch to reduce the pain to 4, then to 3. By using ideomotor finger signals, she indicated her ability to carry out this task.

A post-hypnotic suggestion was given so that Pat could use this technique at any time. It may be recalled that Pat had been a successful competitive swimmer, and it was thought that her breathing control would be well-developed. With this in mind, the following was suggested:

Whenever you want to control your pain, you only need to take three deep breaths, each time breathing in calmness and breathing out tension and pain. You will find that you are then able to relax and to focus your energy on the pain switch and on reducing your pain levels.

This suggestion was used as a cue for self-hypnosis.

Before trance was terminated, a precautionary statement was given. Pat was told that her unconscious mind would be able to distinguish successfully between pain which was acting as a warning, and thus was necessary, and pain which was not needed. This precaution was to ensure that Pat did not ignore vital pain signals.

An audiotape was made of the first session and Pat was encouraged to listen to this each day for a week.

Session 2

Pat commenced the session by reporting that her pain levels had been stable over the last week. However, she said that her pain had been so severe on one occasion that she had taken additional medication to cope. On that day she reported that she had been unable to relax adequately to listen to the tape.

Pat continued to express some doubts about her ability to use hypnosis to relieve the pain entirely. At this stage the therapist considered that there may have been some resistance to relinquish the pain at the conscious level. However, it will be recalled that, in the first session, Pat's unconscious mind had agreed to work on the development of pain-management techniques. Where there is conscious resistance, many practitioners have utilised the more indirect techniques initially developed by Erickson (1988). It is thought that these techniques bypass the conscious mind but are understood by the unconscious mind (Grinder & Bandler, 1981.) In the case at hand, the use of metaphor was seen as a possible intervention as this technique would contain less obvious references to pain control.

To date, the anxiety attacks had not been directly addressed. It was hypothesised that they were indicators of Pat's remaining fear from the accident and also highlighted her fear of returning to work. Hence the goal for the second session was to resolve the anxiety disorder and to utilise indirect techniques to develop pain control.

Trance was induced as in the first session. Relaxation techniques were used to reduce autonomic arousal. Pat was asked to go to a favourite place where she had, in the past, experienced relaxation and calmness. She was asked to indicate, using ideomotor finger signals, when she was at this place. Once a "yes" response was obtained, Pat was asked to maintain the same level of calmness and relaxation while she visualised another situation. She was asked to imagine herself at the entrance of work and to observe the activity there. A detailed description of the workplace and the people and the equipment in it was provided. Varied sensory information, including the smell, the feel of the machinery, etc. was given. The therapist had recently visited the work site so the description was known to be accurate. Pat was asked to see herself walking into the work area with confidence and calmness. The script continued in this manner with the final outcome of Pat's being able to touch a fork-lift.

Throughout the session, Pat was asked to indicate her success in completing the tasks by using ideomotor finger signals. Pat indicated success at each stage. She was praised for her achievements and several positively reinforcing statements were included.

Once Pat had achieved the desired outcome (of visualising herself close to a fork-lift), she was asked to return to her "special place." At this stage the second goal of the session commenced and the metaphorical script was introduced. The script was introduced in the following way:

And now you are relaxed and comfortable, having achieved your desire to be confident and capable at work, I felt you may like to share a story my friend told me the other day about the experience she had when her bike broke down on the way to work. Pat, I know you often ride your bike to work so I knew you would appreciate this story.

The story told of "my friend," who owned a bicycle which she rode to work each day. She had the bike for many years and although it was a bit worn, she knew it was reliable and it had never given any trouble. I explained how one day recently, on her way to work, without her suspecting anything, the bike was hit by a stone which had been thrown up by a car. The stone had wedged in the wheel and the wheel wouldn't turn. The story told of her frustration and distress as she was abandoned by the side of the road with a bike which wouldn't work. I explained how frustrated she had been and how she had felt panic and distress. I then discussed how she had decided to be calm and examine the situation logically to see if there was a way the bike could be mended. I spoke of how my friend considered various solutions to fix the bike — how she had thought of one solution and discarded it, then thought of another, until finally she had found a special and individual way to fix her bike so it would work again. The story then went on to speak of her joy at having fixed the bike and how she had discovered hidden talents. In fact, I said, my friend in the end was rather pleased to have faced the challenge of fixing her bike because not only did she learn how strong, innovative, and capable she was, but she also learnt how much she appreciated and liked her old bike.

The story was told more extensively than indicated here, but the parallels with Pat's injury and pain management are obvious. The story recognises the unexpected nature of injury, the fear and distress of accidents, the frustration of being "broken," the uncertainty of recovery, and the sense of achievement after gaining a full recovery.

It may be noted that the metaphor was used at the end of the trance as it was believed that Pat would be less alert for therapeutic messages at this point and this would mean that the information might not meet conscious resistance.

Session 3

At the commencement of the third session, Pat reported several changes. She stated that she had returned to work three days before and had not experienced any anxiety attacks. "I have seen the fork-lifts," she said, "but they don't bother me any more. I'm a bit wary of course, like I don't go out of my way to be near them, but I'm okay." She also reported significantly reduced pain levels. She was working four hours per day on alternative duties at work and was planning to increase to eight hours per day the following week. She said that she had occasionally experienced back pain but felt this was something she was able to cope with.

It had been intended that the third session would include further pain management assistance as well as the preparation for in vivo exposure to fork-lifts. However, Pat had traversed these stages of her own accord and it was agreed that this would be the final session with the opportunity to refer again if necessary.

The final session reinforced the concepts developed in the first and second sessions. In trance, Pat was asked to review her achievements over the preceding three weeks and to congratulate herself for her strength and resolve. The continued use of the pain switch technique was encouraged when she felt the pain levels increasing. In trance, Pat was encouraged to note the continuing improvements she would experience in the following weeks.

Follow-up

A follow-up telephone call was made two months after the completion of the final session. Pat reported that she had returned to work full-time and was no longer experiencing any pain as a result of the injury. She had not felt the need to listen to the audiotape for approximately one month. Pat stated that she was not bothered by the fork-lifts at work and had not experienced any further anxiety attacks.

The health and safety officer who had referred Pat was also contacted at this time. She reported that Pat had made a very successful return to work. Indeed she stated that the company doctor had been surprised by the speediness of Pat's recovery.

DISCUSSION

It may be recalled that there were two therapeutic goals determined by the client: (a) resolution of the anxiety, and (b) development of pain management techniques. The approach used to achieve these goals reflected the needs of the client, but also the skills and background of the therapist.

The techniques which were used to resolve the anxiety attacks reflect the special properties and value of hypnosis. While behavioural and cognitive approaches may have resolved the issue with time, hypnosis provided additional support, as recognised by Kroger (1977):

Hypnosis can help to simulate real-life situations and make therapy easier by relaxing the patient, providing scene visualisation and imagery to help in reducing the associated anxiety and tension. (p. 168)

Hypnotic intervention was used as a powerful adjunct to the more traditional interventions used to resolve anxiety disorders. In the case described, behavioural change was combined with visual imagery in hypnosis to achieve a successful outcome. While behavioural and cognitive approaches alone might have been equally successful, the provision of hypnosis, in my opinion, allowed for a more rapid and less traumatic recovery. Indeed in this case the often

lengthy practice of in vivo exposure was reduced as the client had practised the situation through visual imagery in hypnosis.

As mentioned, there are a myriad of hypnotic interventions available for use with clients who perceive pain. The two approaches chosen in this case were determined by the nature of the presenting problem, the client's perception of pain, the client's hypnotic ability, and the skills and training of the therapist.

It may be recalled that the client had experienced a recent injury. This suggested that some or all of the pain was necessary for recovery and could act as a gauge, for the client, of becoming better. Hence techniques of total pain removal were not seen as appropriate.

Second, the client's perception of the pain was such that resistance was anticipated if total anaesthesia was attempted. Indeed the client had expressed some doubt about her ability to remove the pain entirely and had expressed concern about becoming pain free.

Third, the client's hypnotic capacity was adequate but as extensive anaesthesia is commonly associated with deep trance states, the results of the Stanford Hypnotic Scale suggested that the client could not successfully achieve this. While research indicates that a lower capacity may not be important where there is extremely high motivation (e.g., in the case of trauma victims; Crasilneck & Hall, 1975), in this case such motivation for change was not evident.

Finally and possibly most importantly, there was some reluctance on the part of the therapist to utilise pain-control methods such as anaesthesia, analgesia or even displacement of pain. This reluctance reflected my lack of confidence as a psychologist in dealing with medically related issues. Even though medical information had been obtained, it was considered safer to attempt pain reduction rather than removal.

Hence these four criteria largely determined the approaches considered most suitable for the treatment of Pat. The techniques provided the client with relaxation skills which would also serve to reduce anxiety and increase pain-management abilities. In addition, the provision of the audiotape ensured regular relaxation times which can be very useful with acute pain (Hilgard & Hilgard, 1975).

The second pain management intervention of indirect and permissive suggestion reflected a belief on the part of the therapist that there was some conscious resistance by the client. Research has shown that some individuals are unwilling to let go of their pain for reasons including punishment of self or others, or secondary gain factors such as sympathy or financial rewards from litigation (Evans, 1990). Therefore it was considered important to attempt to highlight the benefits of becoming better at a level where conscious resistance or rationalisation would not be available. For this reason, indirect suggestions using metaphor were used.

In developing the metaphor, several issues were considered. First, the metaphor had to be meaningful to the client. In taking the case history I had learned that Pat rode a bicycle to work many days, so I felt that a story

about a bicycle rider would be meaningful to her. Second, a metaphor should not be easily interpreted at the conscious level (Grinder & Bandler, 1981). It is believed that the metaphor used was not easily identified as a pain-management instruction but the parallels were likely to be recognised and accepted by the unconscious mind. Finally, the metaphor must contain the solution to the problem. The metaphor used in this situation highlighted the benefits of becoming better.

In conclusion, the case study described utilised a number of different techniques. Milton Erickson (1980) comments:

Hypnosis is essentially a communication of ideas and understanding to a patient in such a fashion that he will be most receptive to the presented ideas and thereby motivated to explore his own body potentials for the control of his psychological and physiological responses and behaviour.

It was with these comments in mind that the therapeutic approaches described in this case study were selected and the success of the intervention suggests that hypnosis was used most effectively to meet the client's needs.

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