

THE USE OF HYPNOSIS IN THE TREATMENT OF A WOMAN WHO WAS SEXUALLY DISRESPECTED AS A CHILD, ADOLESCENT, AND ADULT

Marta Lohyn

Psychologist

This case study presents the use of a hypnotic intervention in the treatment of an adult woman presenting with problems related to sexual disrespect occurring in childhood, adolescence, and adulthood. While hypnosis was used as part of the overall treatment plan for the purposes of relaxation and ego-building, the case study will focus on one session in which hypnosis involved age regression. The purpose of this was to enable the client to deal with a rape experience and to bring into conscious awareness memories related to her father being sexual in her presence. The hypnosis was a critical intervention in that it promoted healing of the rape experience and provided the client's conscious mind with information which allowed her to make sense of her distrust towards her father. In doing the latter in particular, the client was able to overcome her fear of her father and gain a sense of control in that relationship. This was a very important step in her overall treatment.

THE PROBLEM

The problem addressed by the hypnosis was as follows. After nine months of involvement counselling, my client, Ms A, phoned me very late on a Friday afternoon. She was extremely distressed and reported that she had had a very upsetting night and day, because she was remembering fragments about herself as a child and her father's sexual response to her. She asked for an urgent appointment as she could not see herself waiting until the following week to meet with me. I agreed to see her at the end of the day.

THE CLIENT

Ms A was a 33-year-old woman with three children aged eight, ten and 16 years. The 16-year-old was living with her father, and the two younger children lived with Ms A, who had been divorced for five years.

Unemployed, Ms A considered herself unemployable. This was because she was not qualified in any area and abhorred the idea of working in unskilled

jobs or in those where she would have to be subservient to men. For the year and a half during which I worked with her, however, Ms A acquired two jobs — one at a nursery and, later on, one as a receptionist. Ms A was intelligent and articulate and was strongly committed to a feminist perspective and ideology. She presented as an intense, attractive woman whose major interest was in film-making. She reported a good and loving relationship with her two boys, while her relationship with her 16-year-old daughter was tense, with some conflict. There was no psychiatric history and her health was good overall, although she did suffer sinus problems.

The pertinent facts regarding psychological history are as follows:

1. Ms A reported a very fraught relationship with her father. She felt uneasy in his presence and described him as leering at her when she was an adolescent. She said that, as an adolescent, she had to take great care when she undressed or changed clothes, because she was afraid that he would find a way of watching her.
2. When she was 16 years old she was raped by three young men. She was taken to the police station to make the report and collected by her mother. Her mother's response to the rape was to tell her she must go to confession for her sin. Ms A reports that the priest to whom she was sent had, in the past, tried to fondle her.
3. Her marriage was very unhappy for her. She experienced her husband as dominating and emotionally abusive. In a subsequent relationship, her partner was disrespectful in his approach to women and insisted on keeping pornographic material in the house. After Ms A had ended the relationship and he had moved out, he entered the house early one morning and appeared in her room masturbating in front of her.
4. Ms A has a history of beginning things without ending them. She had, over the years, embarked on a number of endeavours — university, training courses and so on — but had not persisted. She experienced herself as a failure and someone who would never find satisfaction in her life.
5. Ms A's definition of herself was that she was ugly, stupid, unlovable, and unable to take control of her life. The only area in her life where she considered she had been successful was in caring for her children, whom she reported to be happy and well adjusted.
6. Ms A also described herself as "hating men." This was the issue that initially brought her to me; she wished to change this attitude, as she recognised that it would undermine her capacity to achieve satisfaction in her life.

SUITABILITY FOR HYPNOTIC INDUCTION

The literature tells us that hypnosis is contraindicated when the client is psychotic (Kroger, 1977, p. 106) and Ms A clearly was not psychotic.

The literature also tells us that susceptibility tests are predictors of people's capacity to develop trance. Crasilneck and Hall (1975), however, claim that they are not useful clinically and prefer to assess hypnotic response by conducting hypnosis. From an Ericksonian perspective, which is the basis of my hypnotic work, susceptibility tests are redundant. Erickson's view was that it is the clinician's job to find an approach to the client such that trance is induced.

On the first occasion of my use of hypnosis with Ms A, her response was a very positive one. She rated her level of relaxation and absorption at eight (on a scale of 0 to 10, 10 being the most relaxed she could feel). I had conducted hypnosis with her on three or four occasions prior to the session I will be describing below. When we did the age regression, rapport was very well established, as was her trust in me. From my point of view, I was familiar with Ms A's responsiveness to hypnosis and so made the judgment that to proceed with an age regression was appropriate.

THE HYPNOSIS

General Induction

Before proceeding to the age regression, a brief outline of the way in which hypnosis was conducted on previous occasions is in order. It was introduced as a way for Ms A to learn to relax and work on her self-image. I oriented Ms A in hypnosis by using my normal preamble which covers these points:

1. That many people think that hypnosis is something where their minds can be controlled. This is untrue, because hypnosis is just a highly focused state of attention, where one can be aware of many things outside of oneself, but they just don't seem to matter. In hypnosis one is not unconscious or asleep, and some people talk about hypnosis as though it were like the way we feel before we sleep — aware, but quite relaxed.
2. Clients will not go into trance unless they wish to, and that will depend on whether they feel trusting enough and comfortable enough with the therapist. There also has to be a purpose for doing the hypnosis which is discussed by the client and therapist. Once in trance, it is not possible for a client to stay in trance forever. Even if something should happen to the therapist, for example, they die of a heart attack while the client is in trance and cannot therefore reorientate the client, one of two things will happen to the client. They will either spontaneously reorient, or they will fall asleep and then wake.
3. While nobody really knows how hypnosis works, we do know that a person is more suggestible during hypnosis. Because of this hypnosis is used to give the client ideas or suggestions which will help with the problem.

4. The capacity for hypnosis, as everything else, will improve with practice. Some people need a great deal of practice to benefit from it, some need very little, and most need a certain amount.
5. The best way for us to find out whether hypnosis will be of benefit is to experiment and try it out. It may or may not be helpful, and after we've tried it we can decide whether we use it or not.

As mentioned above, the inductions were mainly Ericksonian in nature and consisted of indirect suggestions:

And so Ms A, I'd like you to begin the process of orienting yourself to trance in the way that you usually do by making yourself comfortable and relaxed. And as I remember a number of occasions in my office when we've done hypnosis together I've invited you to focus your visual attention on a spot. So do so now, remembering that the more relaxed you become the deeper into trance you'll go. So allow that sense of relaxation and comfort to go through your body in a way that's comfortable and just right for you. And as I recall the last time you went into a deep trance in my office I was struck by your ability to relax yourself and go inwards, focusing your attention on your own inner experience. So do so now and I can't remember whether you closed your eyes immediately or a little later, but your pulse rate changed and I was very aware that you were becoming more and more deeply entranced with your own inner experience. So allow yourself that comforting pleasure now, knowing that as you do so you continue to gain a deeper understanding of your ability to go deeply into trance, feeling comfortable and relaxed, relaxing, relaxing. And you know do you not Ms A, that the more relaxed you become the more deeply into trance you'll go, and that means that you don't have to do anything, you don't have to move, you don't have to talk, you don't even have to pay attention to the sound of my voice because your unconscious can do that all on its own.

This would in general be followed by progressive relaxation interspersed with suggestions to deepen the trance experience. After this I would often invite Ms A to go to a very comfortable, safe, and peaceful place where she could feel happy and positive about herself. I would then generally use a metaphor structure (Lankton & Lankton, 1982) to suggest growth, self-discovery, and general sense of well-being.

The Age Regression

When Ms A called me, extremely distressed, on that Friday afternoon, it was clear to me that she was ready to take some more steps of change and healing. The last three sessions had focused on her relationships within her family of origin and in particular with her father. Ms A reported that she had always been very anxious around her father and that he seemed to leer at her. She reported a feeling of nausea sometimes when she thought about

him, as well as an intense distaste at being physically close to him, which she was usually able to avoid now as an adult. She was quite clear, however, that she had no memory of him sexually touching her in any way.

It is quite typical for women who have been sexually abused, or disrespected in any way as children, to doubt their own experience. One of the major patterns in sexual abuse or disrespect is the secrecy which accompanies the events. A critical aspect of therapeutic change is for the client to acknowledge the reality of the experience. This of course is often very traumatic in that the client must openly declare to herself that the events happened as she remembers them. This means she must then deal with the distress and pain, both as it is remembered from the earlier experience and as it is experienced now as an adult.

When Ms A came into my office she was very distressed, in tears, and clearly had not slept for most of the preceding night. She was shaky and wan. Ms A told me that she had had a dream last night during which she had been raped. This of course reminded her of the rape which occurred during her adolescence. During the day she had experienced "flashbacks" of a dark room and felt extremely frightened, panicky, and anxious.

After talking with Ms A, it was clear to me that her conscious mind was ready to deal with not only the rape, but also to address her experience as a child with her father. I talked with her about using hypnosis in order to both deal with the distress and gain an understanding of the "flashbacks." Ms A agreed with me and gave her permission for us to proceed.

It is my view that the ease with which Ms A gave her consent for us to deal with such sensitive and traumatic material was influenced by the fact that we had already been working together for some time, and trust and good rapport were well established. Further, my willingness to respond quickly to her marked her experience of the past day or so as very significant and requiring urgent attention.

I began the induction in my usual way, using indirect suggestions for comfort, relaxation, and trance. As usual, I included a progressive muscle relaxation, interspersing suggestions and seeding ideas for safety and dissociation. The suggestions for dissociation were important in setting the scene to be able to view the events from the past with safety and detachment.

So, Ms A, let that feeling of comfort and safety come into the muscles in your chest, relaxing, relaxing . . . not having to notice how easy it can be to become completely immersed in the comfort and safety and sense of peace. Because your conscious mind may wish to monitor my words and your experience, while your unconscious mind can help you stay detached, comfortable, or it may be that your conscious mind can focus itself entirely on that sense of comfort and relaxation while your unconscious allows you to step back and follow your own train of thought.

I also established ideomotor signals, and gave Ms A the suggestion that should she wish to talk with me at any time during the trance she would be able to do so easily and comfortably.

As Edelstien (1986) says, there are a number of techniques which can usefully be applied to achieve age regression. These include the use of imagery (e.g., "you will see yourself tearing pages off a calendar backwards from today, then yesterday, and back until you are back to . . ."). There is also the "affect bridge" which can be used with a problematic feeling of unknown origin. This involves telling the patient in trance to let himself experience the feeling there and then, and let the therapist know by use of a signal when the feeling is experienced. Then the therapist says: "Hold on to that feeling. We will use it as a bridge to the past, and as I count backwards from 10 you will travel backward in time and space to the very first time you ever experienced that feeling. Ten, nine, eight, going back further, seven, six . . ."

Another way of inducing age regression is the Ericksonian approach. Although my overall approach is Ericksonian, I chose in this instance, having induced trance in my usual Ericksonian way, to use a fairly straightforward regression technique. Not having had experience with the techniques of age regression up to this point, it seemed sensible to me to ask the client to return to the scene in question and review it from a position of safety. While not practised in age regression *per se*, I was confident that my therapeutic skills would enable me to deal with any material which emerged during the trance. I also knew the client had complete trust in me and in the therapeutic merit of our endeavour.

The reason I used age regression with this client was to achieve two things. Firstly to take her back to an event she already remembered (i.e., the rape) so that she could remember it without the attendant emotional trauma. The second reason was to take her back to the partially remembered material regarding her father.

Having induced trance with Ms A, I suggested that she take herself back in time to just before the rape happened, and let me know with her finger signal when she had done that. I then asked her unconscious mind if Ms A was ready to re-experience the rape so she could take another step in her healing. She signalled "yes." I then suggested that she was free to talk if that was preferable to her. She began to get distressed and began to speak in very simple short sentences. I suggested to her again that she was able to step back from this at any time she wished and asked questions so that she could recount the experience from beginning to end. I asked her to identify the most distressing part of the experience and she said: "The blood and I feel so embarrassed." When she had told the story once, I asked her how surprised and pleased with herself she might be to discover that she could see the movie of what had happened in her mind's eye and feel less and less pain. I asked her to do this, and Ms A was visibly far less distressed this time round. I then suggested to her that she could take even more pride in herself to do that all over again in her mind's eye and this time feel no distress whatsoever. Ms A did this and indeed this time around she showed no signals of emotional distress.

I then congratulated her on good work and invited her to leave that experience and go to a beautiful, safe, and relaxing spot for a few minutes, after which I would speak with her again.

Following this I made a decision to continue and ask Ms A to go back to deal with the issue of her father. While normally I might have left this for another time, on this occasion Ms A was responding very well. Further, I felt that if left till after the current crisis, it might have been more difficult to do this particular piece of work.

Beginning to talk to her again, I asked Ms A whether her unconscious was prepared to go back further in time to resolve the problem around her feelings about her father. She signalled "yes," so I asked her unconscious to take her back through the years until she came to an occasion that was significantly connected to the current problem with her father, and to let me know when she had done so with her finger signal. Once again I reminded her of the ease of talking in trance. After she signalled that she was where I had asked her to go, I asked her to describe where she was. She told me, once again in short simple sentences, that she was in bed. It was warm and nice in bed but dark. I asked her if she was alone in bed. She said "yes." I asked her if she was alone in the room. She said "yes." Then she said that there was a noise, but she didn't know what it was, because her eyes were shut. As she was too scared to open her eyes, I told her that one of the great things about eyes is that you can open them just a little and see everything that you need to. I asked her to take a look two or three times before she did so. I asked her to tell me what she saw. She said she saw her father standing at the end of the bed. There was a rustling noise and he just stood there. His hand was in his pocket, she thought, but she wasn't sure, and his face was sort of red. The noise was like the rustling of clothes. She didn't know what he was doing with his hand. She felt very scared and didn't say anything. Then he went away. I asked her if it was all right to remember this consciously and she said "yes." I thanked her unconscious for helping us with the problem and asked if there was anything else we needed to know. She said "no."

I began my reorientation by asking her to leave that experience behind and begin to reorient herself. My usual reorientation patter goes something like:

And now I'm going to ask you to reorient, and I am going to ask you to open your eyes and be fully alert and refreshed and awake. So one, beginning to reorient, two, doing anything you need to do to reorient, moving your hands, your feet, your head, three, becoming increasingly aware of the sound of my voice, and the sounds around us, four, having any unwanted feelings of heaviness or lightness leave your body, five, opening your eyes, feeling refreshed, alert, awake and back here in this room with me...

During the trance Ms A talked in the first person. It is not clear to what extent this was a complete "revivification," where the client acts and talks like a child of whatever age is appropriate to the regression. Ms A's tone

of voice was her adult one, and her facial expressions were congruent with what she was talking about. The style of her speech was also far less sophisticated and articulate than her usual way of speaking. From a therapeutic point of view, the extent to which the trance resulted in revivification is not too relevant, as long as the experience is beneficial to the client.

After reorientation, we discussed her experiences. Ms A came to the conclusion that probably her father had masturbated at the end of her bed. She described a feeling of relief that she had always known there was something about him that made her feel distressed, and now she knew why. We discussed her work with the rape and she stated that the experience was a ghost that would no longer haunt her. It was clear to me that while Ms A was obviously very tired, she was calm and peaceful. The goals of the hypnosis had been achieved. Ms A had gained mastery over the remembered events of the rape, such that there were, at this time, no more associated feelings of distress and trauma. She had also made sense of something about her father which had bothered her since she was an adolescent. I congratulated her and suggested that during this weekend she nurture herself and simply relax as much as she could. As her children were staying with their father this weekend, she said she would spend it with a trusted friend.

This session had taken an hour and a half. Unfortunately I do not have any transcription of this session because I was unprepared and responded "on the hop," as it were.

The following session Ms A reported feeling well and in control of her emotional response about these matters. She at no point subsequent to the previous session expressed doubt about her experiences of mistrusting her father. Therapy from this point focused on her relationship with her father and how she felt about him now that it was clearer to her that there had been good reason to mistrust him. While she was sad, Ms A was clearly able to see the issue as being his problem rather than her own.

Some months down the track she talked about being able to "forgive" him in the sense that she no longer felt angry with him. Rather, she felt sad at what she considered to be his impoverishment as a person.

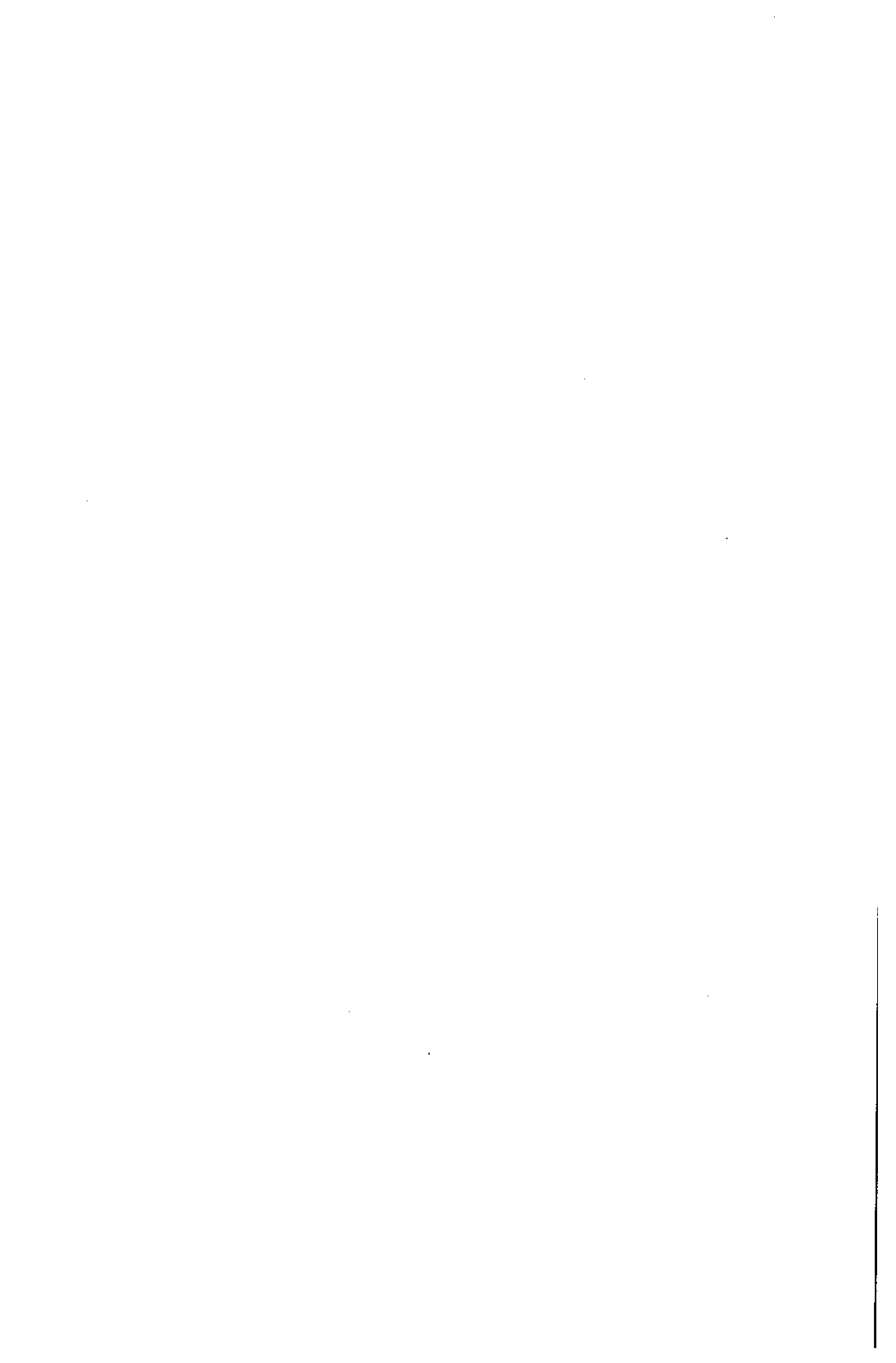
COMMENTS IN RETROSPECT

My dissatisfaction with the hypnosis rests with what I experienced as fairly clumsy technique. I would not have proceeded but for my strong connection with the client and my confidence in dealing with whatever material emerged. Ms A was also a very willing participant and, given her level of need, in retrospect I feel I made the right decision.

From a broader perspective, this was a critical step for Ms A to undertake, in that being able to validate her unexplained feelings helped her to move forward in therapy. It provided more evidence to her that she could trust her own responses, and in this way the results of the hypnosis empowered and affirmed her.

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THE CASE OF MR C

Darryl Menaglio

Clinical Psychologist

This case study focuses on the use of hypnosis in the treatment of a Sicilian patient referred to a community mental health clinic because of poor sleep and pain. The process of learning about the problems and their origins led to three major uses of hypnosis, for the treatment of pain, of sleep disturbances and as a way to allow the patient to move beyond his defences. Hypnotic techniques woven into the therapy included self-hypnosis, ideomotor signalling, sensory imagery to promote pain control, and a variety of techniques to modify defensive personality functioning and produce integration and positive motivation. Six-month follow-up revealed that further progress had taken place.

PRESENTING PROBLEM

Mr C was a 40-year-old Sicilian man who was referred by his GP to a community mental health clinic because of poor sleep and pain.

He was sleeping for approximately two hours each night and was in pain following a whiplash injury from a motor vehicle accident (MVA). He had recently left his wife and children for another woman. Also, according to the referring GP, he had made some unwise business decisions, including selling a profitable business.

Mr C believed his problems began about six weeks previously. It was at this time he began to have trouble remaining asleep. He found it easy to go to sleep, but would wake after two hours. He could not go back to sleep because he thought of the things he had lost in his move away from his family home. These losses included his workshop and swimming pool. He felt frustrated at his girlfriend's house because it was new and he had no money to buy the things he wanted.

He made no mention of his feelings toward the loss of relationship with his wife or two sons, aged 15 and seven years.

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Requests for reprints should be sent to Darryl Menaglio, 1/6 Abbotsford Street, Leederville, W.A. 6007.

Mr C said he had been “depressed” like this before. Past depressions were usually associated with the need to make important decisions. He had coped with these decisions by smoking marijuana and going out and having a good time.

On presentation Mr C was a fit-looking man, well-groomed, smiling, and affable. He had a stiff gait and walked with his head cocked to the right side. He sat in the chair and maintained a stiff posture. He said he had to remain like this because it was the most comfortable position. Any other position brought on a headache, tingling, and pain in his arms.

RELEVANT PSYCHOLOGICAL, SOCIAL, MEDICAL AND LEGAL HISTORY

Mr C was born in Sicily and migrated with his family when he was four. He had a sister with whom he was not particularly close. The part of Sicily his family came from was one that had seen many wars. The village comprised basically Mr C’s extended family. Each time a battle had occurred the whole village moved into the surrounding caves. The village and countryside had to be rebuilt many times. Life for his parents and grandparents had been a constant struggle.

In Perth his father managed to build a thriving business with two petrol stations.

Mr C was not particularly close to his father. He remembered him as harsh, overbearing, and as having little time for him. It was not until recently that he realised his father could make mistakes. His father’s harshness was evident to Mr C when, in his early teens, his father sent him to the Perth Boys’ Town. This was a boarding school on a farm in the country run by priests for uncontrollable children. Mr C’s father had heard from a friend that it was a good school. Instead of finding out for himself he assumed his friend’s advice was sound and sent his son there.

Following this experience, which he hated, Mr C lost interest in schoolwork and began to work in his father’s business. At 16 he was running the business so successfully that his parents left him in charge while they went to Italy for a holiday. On their return his father made Mr C promise to find an apprenticeship. Mr C complied, but always had it in mind to go into business himself.

On finishing the apprenticeship in the electrical trade, Mr C left to work in an electrical retail store. Eventually he left the store and bought a run-down motorbike repair business. To survive, Mr C had to expand this business. He purchased a franchise to sell motorbikes and slowly the business began to prosper.

Things were going well until his MVA, which occurred while he was a pillion passenger demonstrating a motorbike to a customer. The MVA had left Mr C with damage to the vertebrae and discs in his neck. He seemed in constant pain and required regular physiotherapy treatment. His injuries left him unable to lift or stand for any length of time. He found he could no longer run his business. He brought in a partner, then eventually sold out. This happened about five years before seeing me.

The court case for compensation had been ongoing during those years. On the surface Mr C felt that it was a battle that he would have to fight. He seemed resigned to waiting and doing whatever the insurance company wanted. He had no intention of giving up. In other words he was waiting passively for settlement while maintaining inactivity in case he might prejudice his case. He had no hobbies or interests, preferring to spend his day either in front of the TV or visiting physiotherapists, doctors, and his lawyer.

Apart from Mr C's fear of the insurance company, he was also frightened to attempt activity through concern that he would further damage his neck.

While Mr C gave details about his relationship with his father, he mentioned very little about his mother. When he did mention her it was always in passing and as if he didn't really know her.

Prior to the accident, Mr C had had many extramarital affairs. According to Mr C, his wife was aware of his philandering and had given tacit approval. He always returned to her. The recent move to another woman was the first time Mr C had actually left his marriage. Other relationships lasted a few weeks, then ended. On this occasion, however, Mr C had planned right from the beginning to have a long-term relationship. He said it was because of his fear of AIDS that he had decided to have a long-term extramarital relationship. Rather than move from partner to partner, he thought it would be better to have a single lover.

When Mr C discussed his feelings for the other woman with his wife, she suggested that he perhaps needed to move out and live with this other woman to see what it was like to be with her. Mr C maintained, throughout the therapy, that he would eventually return to his wife. He had difficulty identifying the differences between the two women. To him they seemed similar in all respects. He maintained good relationships with both of them.

INQUIRY FOR MAJOR DEPRESSION

Apart from sleeping problems, no other major physiological shift symptoms could be elicited. He did not want to be treated via medication. Indeed there seemed no place for this.¹

INQUIRY FOR DRUG ABUSE

From Mr C's reports he did not abuse alcohol, caffeine, or illicit substances. His marijuana ingestion had occurred in the past and he had ceased using this drug.

Although he presented with a clear problem — difficulty remaining asleep and returning to sleep once awake — there seemed many other issues in his life that were affecting him. He complained of depression, yet on specific inquiry presented without symptoms of a depressive illness.

Despite his complaints, there was a blasé air and bravado about Mr C that gave an impression that all was well. On deeper examination there was

a pathetic loneliness. He had been abandoned by his father to the boys' school and, despite having multiple relationships, he had never formed one that could satisfy his aloneness.

Women seemed to be objects that could be discarded. He was not attracted to them for the need of a sexual relationship. The attraction seemed more based on conquest, but always from the secure base of his marriage. With his change of plan to having long-term extramarital relationships, he had to leave the safety and security of his marriage.

Mr C did seem in a great deal of pain, his relationships were in chaos, and he was stuck in what might be called a "compensation limbo" — that is, his life seemed organised around a compensation payout while his life stagnated.²

His stoic front and resignation seemed characteristic of his family background and childhood. The many wars the family had been involved in meant they had to put on a stoic front and, because of their helplessness, to prevent conflict around them they were forced into resignation.

Although poor sleep and pain seemed to be the presenting symptoms, there appeared to be many problems which contributed to Mr C's inability to get a good night's sleep.

TREATMENT APPROACHES — ROLE FOR HYPNOSIS IN THIS CASE

Hypnosis appeared to have a role in three areas: as a method of pain control, as a way to uncover intrapsychic conflicts, and as a treatment for the sleep problem.

HYPNOSIS IN THE TREATMENT OF PAIN

The use of hypnosis in pain control has a long history (Hartland, 1971; Bassman & Wester, 1984; Wright & Wright, 1987).

From the literature, what has been noted is the difficulty establishing a therapeutic alliance with people suffering pain. In particular, presenting for psychological treatment is usually the last course of action. By this time the patient has been through a number of treatments, all of which have been more or less unsuccessful.

Psychological treatment, to the patient, may represent admitting that "pain is all in the head." The therapist is warned by the literature (Brown & Fromm, 1987; Wright & Wright, 1987) to proceed cautiously with acknowledgment of the person's pain experience and development of rapport before the initiation of treatment.

Miller (1984) has suggested that pain-prone people can justify their affect. They have reason, that is their pain, to feel the way they do. Not only does this make treatment more difficult, but it also often masks serious depression. This position is supported by projective and self-report inventories. Rorschach testing reveals 83% of pain-prone patients having definite depression; however, assessment by the MMPI shows that the depression is not over (Miller, 1984).

The findings of the Rorschach and MMPI studies go some way to explaining Mr C's apparent lack of symptomatic depressive behaviour, but complaints of depression.

Consideration of other factors apart from the pain experience are also recommended (Brown & Fromm, 1987). These include cultural, environmental, social, and interpersonal factors (Wright & Wright, 1987). Family interactions are also important as spouses may inadvertently reinforce pain behaviour via comfort and support.

HYPNOSIS AND THE TREATMENT OF SLEEP DISTURBANCES

Hypnosis has also been used with sleep disturbances (Brown & Fromm, 1986). As with pain, a multidimensional approach is advocated with consideration of the person's daily lifestyle, stimuli at bedtime and in the bedroom which may maintain the sleep disturbances, drug and alcohol intake, psychological conflict, cognitive hyperactivity, and sleep performance anxiety.

As Mr C's sleep problems seem to have started about the time he moved away from his wife, and he had every intention of moving back, I wondered in what way his complaints of depression and sleep problems were tied in with the two women in his life and why he had needed to have multiple partners.

HYPNOSIS AS A WAY TO MOVE BEYOND MR C'S DEFENCES

I considered using hypnosis as a way of uncovering what was behind Mr C's need for two women and his complaints of depression. However, I was concerned that utilising hypnosis to go beyond his defences might result in a deepening of depression. Also, Mr C did have a history of self-destructive behaviour (e.g., drug abuse and promiscuity) which might have also emerged if unconscious material which Mr C could not handle were to come into awareness.

Brown and Fromm (1986) warn against uncovering unconscious material too quickly using hypnosis. They argue that the therapist is in a perilous position because material can be uncovered under hypnosis more easily than in waking therapy. This can lead to the patient being confronted with material he is not ready to deal with. Brown and Fromm suggest the therapist respect the patient's defences by bringing into awareness, as the person returns to the waking state, only those things he/she is ready to face.

An alternative to Brown and Fromm's suggestion is to inquire of the patients, before entering trance, how much of the problem under consideration they believe could be solved (or dealt with) in the hypnotic session. With this approach the patients then are in a situation of facing as much as they wish when in trance. The therapist also has some control over how much is uncovered. For example, if the patient says 100% of the problem could be dealt with but the therapist believes the material that could be uncovered might overwhelm him, a more realistic figure could be discussed in order to protect the patient.

TREATMENT GOALS

At the outset of therapy the main treatment goal was to help Mr C improve his sleeping. In the history-taking and the course of therapy a number of issues emerged. These included:

1. The accident and its associated effects on: (a) pain; (b) loss in Mr C's life; and (c) challenge to his masculinity as a provider — family-of-origin values had been that the man provided for his family — if he could not he was less of a man.
2. Relationship with his father: (a) father's stoic beliefs (father maintained belief in the family values — refused to accept Mr C was in pain and suffering — Mr C felt upset about this); and (b) demand to be self-sufficient — (helping Mr C to understand the historical antecedents to this belief).
3. Relationship with his wife, girlfriend, and children: (a) choosing between wife and girlfriend; and (b) being a father to his children in a way that met their needs and within the limitations of his injury.
4. Re-involving himself in life: (a) finding a job/interest that would not aggravate his injuries nor affect his compensation claim; and (b) increased exercise and activity.
5. Pain management: hypnosis and relaxation techniques.

ASSESSMENT FOR SUITABILITY FOR PSYCHOTHERAPY

Given Mr C had linked his sleeping problems and complaints of depression with his relationship with the two women, therapy was started at this point. This also seemed a way to respect what Mr C had presented as his main problem and to develop rapport.

For his sleep problem Mr C was asked to keep a record. This sleep record was adapted from Brown and Fromm (1987).

At the same time in the sessions we began to discuss his relationship with the two women.

Mr C failed to keep a record of his sleep. This was despite protests by me that this was essential. I was not sure what was behind his decision not to keep the records. Perhaps he realised the focus of his problems was not purely sleep.

There was, however, no need to terminate the therapy, because Mr C seemed to spend considerable time outside the session thinking about the conflicts associated with his sleep disturbances. By the second session Mr C had started to consider that a feeling of insecurity was behind his need for two women. He realised he had spares for most things in his life. For example he had two cars — one permanently garaged in case one broke down — and a duplicate set of mechanic's tools in case he lost his everyday set. Both sets would be taken on country trips just to be sure that he had not left any behind.

His father also duplicated most things. For example, he had a beach shack which had its own generating plant, but the father had a second spare and always brought another with him just in case the two spares broke down. When the original went in for service, the father bought another as a third back-up unit. In the end the father had four generating plants.

Mr C had linked his feeling of insecurity to leaving Sicily and his grandmother. In Sicily, before he turned four, his mother and father left him for long periods of time to go working in other parts of the country. His grandmother had to take care of him in their absence. Mr C recalled when he was four years old saying goodbye to his grandmother to leave for Australia. Although loving her very much, he remembered thinking how dirty it was to kiss his grandmother. He also felt a great deal of guilt, but was unable to understand why he should feel this way.

I wondered, with the need to have at least two of everything and Mr C's recall of dirty and guilt feelings concerning his grandmother, whether issues of castration anxiety and Oedipal conflicts were present.

Given the long absence of his parents during his early developmental years, there also seemed the possibility more serious issues of separation anxiety and abandonment fears were also operating.

At the same time as Mr C was raising issues concerning the absence of his father and mother and feelings towards his grandmother, he reported that his sleep improved from two hours per night to four.

Although Mr C had not kept the sleep records he was demonstrating a willingness to explore his problems in depth. His insight indicated a reasonable level of intelligence. These were indicators that Mr C was a candidate suitable for psychotherapy.

SUITABILITY OF MR C FOR HYPNOTIC PROCEDURES

The idea of using hypnosis in the treatment of pain was not introduced until the fourth session, its use being postponed until I considered I had established adequate rapport. Mr C was motivated to try hypnosis for his pain control. He wished to treat himself without medication and had been looking for alternatives.

In view of Brown and Fromm's (1987) warning to try to give an initial positive experience of hypnosis in pain management, I was reluctant to try the hypnotic susceptibility scales of Hilgard and Hilgard (1979) or Shor and Orne (1962), since these scales have difficult items which could have fostered a sense of failure in Mr C.³

To establish Mr C's hypnotic susceptibility, give him a positive experience, and encourage him to use hypnosis I chose an arm-weight exercise (Wright & Wright, 1987) and focusing exercise (Gendlin, 1978). These exercises are similar to the easier exercises in the standard hypnotic susceptibility scales and therefore ones that most people should have little difficulty with.

The arm-weight exercise involved visualising bricks tied to each wrist. The person has his eyes closed as he imagines one brick weighing his arm down. Attached to the second arm is not only a brick but also a balloon. This balloon counters the weight of the brick and gently pulls the arm up.

Mr C was able to achieve approximately a 25-cm difference between each arm. Because of the pain in his neck he could not hold this position for long.

The second susceptibility test also involved visualisation. This time I asked Mr C to focus on a phrase he had used several times during previous sessions — “feeling trapped.” Mr C closed his eyes and repeated this phrase over and over, allowing any images that he had to develop and take form. He visualised himself behind bars and indicated he felt secure and comfortable behind these bars, but always looking to the outside to see what was going on.

The exercise demonstrated that Mr C could narrow his attention and be willing to go beyond what was conscious to him. The focusing technique was used several times during therapy.

PREPARATION FOR HYPNOSIS

Before the first hypnosis session Mr C and I discussed what hypnosis was, how it might help him, and general fears that people have. Mr C did have some performance anxiety. I assured him that in time this would pass. I tried to convey the message that I would not abandon him in his attempts at hypnosis, even if at first he was not successful.

Mr C feared that he might look silly, particularly if he asked for help. In part, these were the feelings he had when he was unable to achieve the tasks set by his father. He was made to feel silly and useless. His reaction to this was to put on a stoic front, that everything was all right when it was not.

Melzack and Wall's (1965) gate-control theory was introduced to explain the perception of pain to Mr C. The theory proposed that a neural mechanism in the spinal cord acts like a “gate” that can control the flow of nerve impulses along the nervous system. The perception of pain is the result of complex phenomena, resulting from the interaction of sensory–discriminative, motivational–affective, and cognitive–evaluative components (Turk, Meichenbaum, & Genest, 1983).

The gate-control theory offered the opportunity for many visualisations. These include pain being blocked at various levels in the nervous system, controlling pain via change in perception of incoming signals from the nervous system, or visualisations that change the nature of the pain.

I explained to Mr C that, when he was tense, his muscles actually made pain worse. Relaxation, the opposite, relaxed muscle and eased pain. I further explained that when he noticed pain, it required his full attention. If he could find some way of distracting himself from the pain signals, he would learn to pay less attention to the pain and it would not bother him as much.

It was also important to be aware of the meaning he attached to his pain. If he saw his pain as an enemy or something that was making him miserable,

he would compound his problem by being miserable, upset, and locked into a way of life which would not make him happy.⁴

Mr C seemed to understand the theory and was keen to try the imagery.

SELF-HYPNOSIS IN THE TREATMENT OF MR C

Because of Mr C's injuries he could not use a progressive muscle relaxation technique for hypnotic induction. After some discussion of the various techniques available we settled on a breath-focusing technique (Stanton, 1988 and personal communication). This procedure is one in which the patient focuses on his breathing while suggestions are given that, with each breath, he will become more and more relaxed.

The first session was audiotaped and Mr C went away to practise at least once a day for a week.

During the week Mr C found that about 40% of the time he was easily distracted by outside noises. The rest of the time he found himself "relaxing" very deeply and enjoying the peace and quiet.

IDEOMOTOR SIGNALLING IN THE TREATMENT OF MR C

I introduced the idea of ideomotor signalling. There were two reasons for introducing this. I wanted to use the motor signals as a way to indicate how deeply Mr C was in trance. If his fingers moved slowly and with hesitation I assumed he was in a reasonably deep trance. If on the other hand the movements were quick and smooth I assumed a light trance had been induced.

The second reason was an indication to me that Mr C was ready to proceed with the various stages of the hypnosis. This promoted a spirit of cooperation and co-management (Wright & Wright, 1987). In view of Mr C's opposition to keeping records, this co-manager role seemed important.

In the main, Mr C's finger movements were quick and smooth. He seemed to achieve a light trance.

HYPNOSIS IN THE TREATMENT OF MR C'S PAIN

The hypnosis was targeted at Mr C gaining control over his pain through using imagery, finding meaning attached to his pain, and consolidation of gains. In all sessions, six altogether, the suggestion was given that his "pain would gradually disappear as he became more and more relaxed."

Imagery entailing warmth, colour, feeling, smell, and taste was used to promote the control of the pain. In the first, third, and final sessions, Mr C visualised the pain, increased it, then controlled it with his imagery. Images such as untwisting tight ropes, mending broken twigs with glue, reducing the pain to a particular area, moving the pain around the body, and relaxing muscles around the pain area were also used.

In discovering meaning behind the pain we used a theatre technique in which the pain had a life of its own and Mr C, as an audience, could ask

it questions. In one session Mr C visualised a man on stage who was wandering in a fog. When he asked the man what he was doing, Mr C received no reply. As he watched, Mr C imagined himself becoming the man. As the man he wandered in the fog which then turned to hailstones and rain. As he walked a blue car kept passing him and splashing water over him.

Out of trance, Mr C was able to associate the blue car with his MVA and how he was frightened to leave the sanctuary of the lifestyle he had created for himself, even though it was like being in gaol. To this time in his therapy Mr C had been putting on a brave front telling me that he had overcome his feelings towards the MVA.

Mr C also learned that he could use his spine as a barometer to control his pain. This procedure was as part of a way to move the pain experience around his body. He visualised the pain as if it was the fluid in a barometer. The containment for the fluid (pain) was in his spine. The base of his spine was the top of the barometer and the base of his neck the bulb. By visualising "hot" or "cold" colours — that is red for hot, green for cold — Mr C was able to change the colour of the liquid and move his pain up and down his back.

Thinking of the pain as green helped him to concentrate it at a small part in the back of his neck. This concentration of his pain helped him to cope with it better. It did not seem as if it was so large and consuming.

That Mr C had been successful was evident on observation. To enter the treatment room he had to climb a flight of steps. At the beginning of the session he climbed the steps with difficulty. He descended at the end of the session with freer movement.

As Mr C became better at moving his pain around his body, he introduced other imagery such as being under the sea. This imagery gave him a sense of weightlessness with a consequence of easing tension and pain.

HYPNOSIS AS A WAY TO UNCOVER INTRAPSYCHIC CONFLICT IN MR C

Mr C was able to use the relaxation procedures in the self-hypnosis and apply these procedures to help him to get to sleep. However, the application of these procedures to improve his sleep seemed to be a part of Mr C dealing with intrapsychic conflict.

Depression did emerge during treatment. It occurred after Mr C began to question the meaning of his pain. He found himself to be impotent and out of control of his life.

His sense of impotence began during a session where he felt depressed but could not say why. As he spoke he used the phrase "nothing coming." In trance he focused on this phrase, repeating it over and over to himself. When I asked him what was worrying him, he revealed that he had spent the weekend with his children and how he felt inadequate and frustrated at not being able to do the things his sons wanted him to do.

During the trance his father's image appeared to him. At first he could not understand why this should be. However, in the following sessions Mr C began to talk about how his father failed to acknowledge his son's pain. The failure of his father to acknowledge this pain was discussed in the historical context of the family's Sicilian background. This included the stoic beliefs of putting on a brave front in the face of adversity and hardship.

Encouragement was given to Mr C to say what he felt, rather than present his symptoms, as he often presented a symptom, pain or depression as a cover for other things that were bothering him. This "cover" was again something he discovered had been learnt as a way to protect himself against his father's jibes and criticisms when he was younger. As an adult, this protection was inappropriate.

Mr C started to see his need to improve beyond what his father had achieved. While the accident had impeded this, it was in his relationship with his father that Mr C felt most threatened if he did do better. He feared his father would refuse to see him. Mr C eventually realised that this was unrealistic. His father was old and depended on his son for company and support.

When Mr C realised how dependent his father was on him he became sad. The therapy moved to discussing how sons gradually move to taking care of fathers. About this time in the therapy Mr C began to take more interest in his father. They spent time together in a beach shack they had bought together. Mr C was able to tolerate his father's jibes and comments. He was also able to say no to his father's demands, especially those associated with doing heavy physical work that resulted in aggravation of Mr C's pain.

Mr C noticed during this time his father's tendency to have at least two of everything. Mr C likened this to himself. Both men's need for at least two of everything seemed to be part of the family's sense of being self-sufficient, not reliant on anyone — as if they were still in Sicily, caught between warring armies.

In part, Mr C's need for two women reflected his family's value to be self-sufficient and protect against major loss. He had two women to take care of him in case one was unavailable. Mr C had experienced abandonment when he was younger and his mother had left him with his grandmother.

As Mr C talked about his relationship with his father he began to discover ways to join in with his children's activities. He introduced his younger son to aircraft modelling. He went as a spectator to his elder son's soccer matches and was considering a coaching or assistant coach position with the team.

The MVA claim also became less important to him. He started to think of opportunities for himself. He developed an interest in electronics, particularly the maintenance and repair of CB radios. Mr C found old wirelenses and CBs and began to experiment with different circuits. He approached local technical schools in search of courses in electronics. Finally he went into partnership with another man selling and repairing CB radios.

As he became more interested and active, Mr C's sleep improved. At the end of the therapy sessions he was sleeping six hours a night. Although the pain remained, he found some relief through self-hypnosis.

On his own Mr C discovered that he could use the relaxation techniques he learned to enter trance to help him sleep at night. If he woke he would also apply these relaxation techniques.

At the time of termination Mr C was planning to return to his wife. He was trying to work out a way to gently tell his lover that he would be leaving.

While Mr C's individual sessions had finished, he planned to return to groups and workshops I run from time to time, in order to examine other aspects of his life which were not covered in his individual therapy.

FOLLOW-UP

Mr C returned to the clinic six months after the end of his treatment. His partnership was working out and he had just obtained a contract to build special transformers for truck radios.

He had moved from his girlfriend's place, was living with his parents, and had started to develop the relationship with his wife.

Although his pain was still present, it had not greatly interfered with his work.

COMMENTS IN RETROSPECT

While what is presented here seems clear-cut, the process of the therapy was more meandering. We often started on a topic only to change the next week and return to it again at a later date.

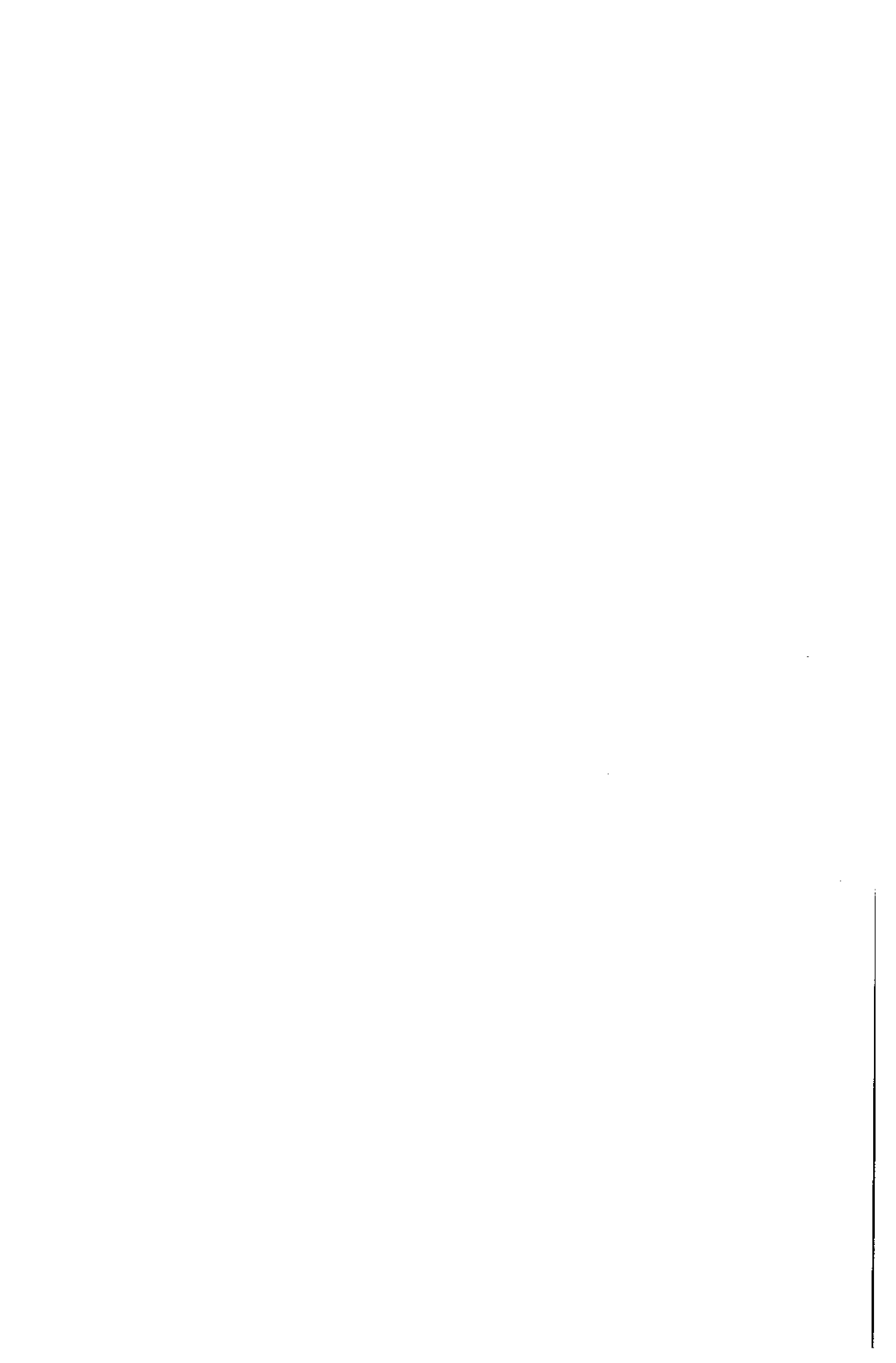
At first I felt uncomfortable with this. There seemed no flow or direction. However, after our initial six-week contract period some direction had started to emerge. In discussion with Mr C, both of us became more comfortable with the process.

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- ¹ Opinion of consultant psychiatrist attached to the clinic.
- ² In reality, while the payouts seem large they are one-off and it has been argued do not in fact cover financial losses. Nor does the payment encourage rehabilitation — Australian and New Zealand Association of Psychiatrists, Psychologists and Lawyers (1990).
- ³ It could be argued that giving these scales would avoid failure because it would alert the therapist to those who are not good hypnosis candidates. On the other hand, most people are susceptible to some degree of hypnotic suggestion (Bowers, 1976). It seems therapeutically more viable to build on what abilities people have, rather than confront them initially with difficult tasks they may not be able to complete and consequently lose faith in their therapy.
- ⁴ I used Beecher's (1946, 1959) studies of soldiers, who had experienced serious wounds but who felt little or no pain, as a way to reinforce that it was the meaning that was put on pain that determined its effects on mental state.



THE CASE OF MRS S

Darryl Menaglio

Clinical Psychologist

This case study reports the successful treatment of Mrs S, a 37-year-old married nurse, for compulsive smoking behaviour. A simplistic concept of smoking was avoided, and treatment planned from a multi-modal view, considering cognitive, systematic, intrapsychic, and interpersonal variables, since S had been unsuccessful in quitting on several occasions. The author and patient worked as co-managers of therapy, avoiding negative transference effects, and her tasks in self-hypnosis were tailored to her needs and expectancies. She had not resumed smoking at six-month follow-up and had reversed the weight gain of the early weeks after quitting.

PRESENTING PROBLEM

Mrs S was a 37-year-old who sought help to quit a 20-year compulsive smoking habit. She was smoking up to 20 a day, with an average of 15.

She was self-referred and specifically requested hypnosis to help her quit. Mrs S believed hypnosis was a last solution to the smoking habit as she had tried other ways of stopping, such as nicorettes, gradual withdrawal, and "cold turkey." She had once managed to quit for several months, but found the craving too much for her. On each occasion that she had been unsuccessful she had become derogatory of herself. During these times she thought of herself as a wimp, a failure, and as useless. She rationalised her return to smoking by thinking that, as she was such a wimp, she deserved to do harm to herself.

CONTRACT WITH MRS S

Mrs S occupied a senior position with supervisory responsibility in a large hospital. I had occasion to work with her, but as I was leaving the hospital I decided to treat her. Before embarking on treatment I discussed with her

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Requests for reprints should be sent to Darryl Menaglio, 1/6 Abbotsford Street, Leederville, W.A. 6007.

the fact that she was known to me and offered her the names of three other therapists whom she could see. She declined this offer and requested to be seen by me.

Our contract was for six sessions, then review. Therapy was to be conducted in private professional offices away from the hospital. Mrs S was to keep a record for one week of her smoking. The record included the time, activity, and need for the cigarette. I undertook not to give information to anyone she worked with that would indicate Mrs S had seen me. She agreed in writing that her treatment could be used for the ASH case study and also that it could be audiotaped and videotaped.

REASONS FOR STOPPING SMOKING

At the time of Mrs S's approach she was under considerable stress. Her smoking had increased to levels with which she was unhappy. She was planning a six-week holiday and felt that, as her daily routine would be disrupted by the holiday, it would be an ideal opportunity for her to give up smoking.

Her plan to give up smoking was also part of an overall review of her lifestyle. It was not uncommon for her to work up to 20 hours' unpaid overtime per week. This was on top of 15-20 hours a week correspondence studies. Mrs S often took work home. She was having difficulty getting to and remaining asleep. Her tossing and turning forced her to sleep apart from her husband. Her commitment to work was putting a strain on her marriage and her health. Her husband, while supportive, could not understand why she worked so hard.

Mrs S had developed palpitations, tachycardia, sweats, had nightmares, and woke in cold shivers. She attended her GP who asked what was stressing her. Mrs S refused to tell him because she felt embarrassed. As a nurse, she considered that she should be able to recognise and deal with her symptoms. She refused to take minor tranquillisers to alleviate her sleeping problem and anxiety, but was very frightened that her smoking and lifestyle would lead to a heart attack. She realised she needed to be less demanding on herself.

THE SMOKING HABIT

Mrs S began smoking when she was 17. She said it was because of peer pressure and as a way to join in and be part of the group.

In a "dialogue as a cigarette", a technique used in Gestalt therapy to elicit those factors that prevent and encourage a person to give up problematic behaviour, I asked Mrs S to pretend she was a cigarette and describe what needs it fulfilled in her. She used words such as "support, confidence," "social acceptance," "makes me feel alert," "part of a group," and "helps me to sleep." The dialogue seemed to centre around dependency and self-esteem needs. Mrs S did not feel supported from within herself in a way that she could join others on her own merits. It had to be what the group demanded. Her willingness

to meet the demand of the group went as far as knowingly to risk physical harm through smoking in order to be part of the group.

In telling the cigarette why she should give it up (a situation in which she pretended to speak to a cigarette about giving up smoking), Mrs S talked mainly of how it harmed her. She used words and phrases such as "bad influence," "resent what you do to me," "makes me feel tired, hate the taste," "not good for my health," "a habit that makes me dependent," "dislike the burn of the smoke," "makes me more tense," "feel sick," "don't like the taste," "foul breath and damage to my lungs." Frightened that her smoking could lead to cancer, Mrs S also felt a certain amount of social pressure as the hospital had introduced a smoke-free environment policy. After the introduction of this policy, many nurses gave up smoking. Mrs S felt she was becoming an outcast because of the increasing number of non-smokers.

She also realised during her dialogue that she often visited a close friend where she found herself craving a cigarette and smoking heavily. As she talked Mrs S used the work "smokescreen" several times. When I wondered what she meant by this, she admitted to becoming anxious with her friend because of a number of "unsaid things."

It seemed Mrs S also used smoking as a way to hide her feelings rather than deal with what was worrying her. The cigarettes were a way to cover her anxiety in social situations.

RELEVANT PSYCHOLOGICAL AND SOCIAL HISTORY

Mrs S's psychological and social history confirmed the dependency needs and her need to hide her feelings. The history also revealed a rebellious side to her.

Born in England to wealthy parents, Mrs S was the eldest of three siblings (two girls and a boy). The family environment was one of high expectations, particularly academic achievement. She attempted to meet these expectations and in her early teens was boarded to an expensive private school. At 15, she rebelled against the family expectations and deliberately set about getting expelled from school by forging her mother's signature on a letter to the school stating that she was withdrawing. Although she was remorseful and despite apologies, the school refused to allow her to re-enrol. She was forced to complete her studies at night school. Mrs S's parents were not at all happy.

The rebellious act was the beginning of further behaviour which was consciously directed at "being different." However, this being different also required her to belong to a group in order to feel supported. She became involved in the hippie movement in England. During this time Mrs S went out of her way to draw attention to herself. She remembered enjoying the startled responses of people at her dress when she went in public.

The mixture of dependency and rebelliousness was also evident in her work. She saw herself as a hardworking and conscientious nurse. She planned to become a nurse therapist and was enrolled in the first bachelor of arts course at university for nursing.

At the same time Mrs S saw herself as ambitious and independent, with a desire to reform the nursing practices in hospital. She was critical of her superiors, calling them incompetent, though never in open conflict with them. At the same time she wanted their sanction and support for what she was trying to achieve.

CLINICAL IMPRESSIONS OF MRS S

The need for approval seemed to permeate a number of areas of Mrs S's life. It surfaced in the *way* she took up smoking. Though disliking smoking, she began in order to be part of a group, to have its approval. This continued into the present, with her use of smoking as a way to maintain her relationship with her peers (i.e., talking with them over a cigarette and cup of coffee). Even her decision to give up smoking was in part motivated by a desire for approval. Smokers in the hospital were becoming a minority and Mrs S wanted to be accepted by the non-smoking majority.

My observations of her smoking behaviour in the hospital seemed to confirm much of what Mrs S had said about using smoking to join with others. I often noticed her in groups smoking, sitting with her legs crossed tightly and her upper body doubled over as if she had stomach pains. I wondered at these times if the cigarette was a way she calmed and soothed herself in an anxiety-provoking situation. This calming and soothing seemed evident in her behaviour whilst she was with the friend with whom there were unsaid painful issues between them.

SUITABILITY OF MRS S FOR HYPNOTIC TREATMENT — IMPRESSIONS

From her history and motivation, Mrs S seemed an ideal candidate for hypnosis to help her quit smoking. She had reasonable knowledge of hypnotic procedures and knew what to expect. As a nurse in England she had "chaperoned" a male clinical psychologist while he used hypnosis in his therapy with women.

Mrs S had used transcendental meditation during her days as a hippie. Her experience with transcendental meditation suggested she had experience with altered states of consciousness.

Brown and Fromm (1987) note that "concern with specific existing health problems and a high degree of personal responsibility for quitting are most likely to alter smoking behaviour" (p. 151). Mrs S seemed to fit this description. She was concerned about the effects of smoking on other concurrent health problems such as her tachycardia, high blood pressure, sleep disturbances, and fears of cancer. She felt a high degree of personal responsibility, as demonstrated by her motivation not to take minor tranquillisers but to seek some other form of help for herself.

Mrs S also indicated she had the support of her husband.

ASSESSMENT OF HYPNOTIC SUITABILITY

Hypnotic susceptibility was assessed via Wright and Wright's (1987) arm-weight and umbrella exercises. Before both exercises, Mrs S made herself comfortable and suggestions were given to make her as relaxed as possible.

The arm-weight exercise is similar to the hand- and arm-lowering tests on the Shor and Orne (1962) Harvard Group Scale of Hypnotic Susceptibility and Barber Suggestibility Scale (Barber & Wilson, 1978). The advantage of the Wright and Wright arm-weight exercise is that the subjects are allowed to open their eyes and see for themselves the results of their visualisations. This would seem to encourage a deepening of the belief in the power of visualisation and consequently hypnosis to influence behaviour.

Wright and Wright's arm-weight exercise involved Mrs S closing her eyes with both arms extended as far forward as possible. She was asked to imagine a canvas bag slipped over the wrist of her right hand. Suggestions were then given to visualise two heavy red bricks in the canvas bag. Mrs S was asked to feel the weight of these bricks in the bag. At the same time Mrs S was asked to imagine a balloon filled with helium tied to her left wrist, gently tugging her arm upward.

On being asked to open her eyes, Mrs S found her arms about 18 inches apart in the vertical plane. She indicated surprise at what had happened.

In the next exercise, after Mrs S had let the tension out of her arms from the arm-weight exercise, she was asked to imagine she was walking in a light rain, happy and cheerful, with a large black umbrella opened to protect her from getting wet. As she was walking, a suggestion was given that the wind was increasing and tugging at the umbrella. As the wind increased, it was suggested that she could feel the open umbrella being pulled higher and higher with her being pulled off the ground. Eventually the wind is so strong that she has to let go of the umbrella.

During this exercise Mrs S's right arm raised as if she were holding onto the umbrella. As suggestions for the wind to become stronger were given, her arm moved as if something were tugging at it. She began to frown. Prior to the frowning and in response to the suggestion of being happy and cheerful, she displayed a smile. The smiling and frowning suggested Mrs S was involved in the imagery. She confirmed her involvement when, after trance, she spoke of her concern in letting the umbrella go and how she recalled an experience in a storm in England.

It seemed from the two susceptibility tests that Mrs S could use visualisation to involve herself and enter an altered state of consciousness.

THE USE OF HYPNOSIS TO TREAT THE SMOKING HABIT

Although Wester and Smith (1984) state that "hypnosis has emerged as a significant and effective form of treatment for cigarette smoking" (p. 312), there seem wide and varying reports in the research literature on its effectiveness.

Holroyd (1980), in a review of outcome studies using hypnosis, reported success rates ranging from 4% to 88%.

Apart from the methodological flaws evident in many outcome studies of the use of hypnosis in the treatment of smoking, what emerges are two important concerns. The first involves relapse rates and the second is the tailoring of a treatment program to suit the client rather than applying a generic treatment program.

Hunt, Barnett, and Branch (1971) and Hunt and Bospalec (1974) reviewed studies on smoking cessation which involved the use of a number of treatments. They found that there were initial high success rates (75%) with subsequent high relapse rates. At a one-year follow-up, only about 20–25% of patients maintained abstinence. These results suggest the clinician should build in relapse-prevention strategies in treatment.

These strategies may only be part of relapse prevention. Many of the early outcome studies used specific treatment strategies to answer specific questions, for example, does treatment X alleviate symptom Y? (Brown & Fromm, 1987).

Consideration of recent developments suggests a greater individualisation of treatment. It also opens the possibility of treatment at different levels. Thus, rather than treat the behaviour (in this case smoking) in a mechanistic fashion, variables such as transference should also be considered.

I approached Mrs S's treatment to give up smoking from a multimodal view, considering cognitive, systematic, intrapsychic, and interpersonal variables. I did this because Mrs S had tried on several occasions to give up smoking and had not succeeded. She was intelligent, knew the usual methods for giving up, but still had not succeeded. This suggested other factors were operating to maintain the smoking.

DEPENDENCY AND REBELLIOUS BEHAVIOUR — IMPLICATIONS FOR TREATMENT OF MRS S'S SMOKING

Transference issues seemed important in the treatment of Mrs S, in particular those concerning her issue with authority. In our initial discussion she had made it clear what was permissible in the therapy. She wanted a particular form of hypnotic induction; wanted to enter the trance state; did not want a Jacobson technique, nor did she want an eye-roll technique; and preferred a gentle approach that was similar to her transcendental inductions of the past.

In her demand for a particular form of induction, she had established the rules for her therapy and direct challenge of this controlling behaviour might have precipitated a rebellion against the therapy.

To work around this possible negative transference I decided, as early as possible in the therapy, to help Mrs S develop skills in self-hypnosis, to have her self-monitor her smoking behaviour and to establish her own pace for giving up. The therapy and hypnosis were to be undertaken in a setting where Mrs S and I co-managed her therapy (Wright & Wright, 1987). It was my hope that the co-manager role would aid Mrs S in developing a sense of having

a measure of control over her therapy and at the same time minimise her feeling as if she were in a situation where she was being told what to do.

Mrs S's transcendental meditation offered the option for her to develop self-hypnotic procedures. After discussion we decided on an induction procedure used by Stanton (1988, and personal communication). This procedure involved her focusing on her breathing while suggestions were given that with each breath she would become more and more relaxed. Mrs S also incorporated the use of a cue word to aid her to quickly achieve trance.

In the spirit of co-management, direct suggestions, such as those suggested by Hall and Crasilneck (1970), that she would not crave nor would she smoke cigarettes again, seemed out of place. I was also concerned that, if these statements were used, they might challenge Mrs S's sense of independence and result in a negative treatment effect.

SUGGESTIONS AND TECHNIQUES USED TO TREAT MRS S'S SMOKING HABIT

As I have noted, Mrs S seemed to use cigarettes for different needs. They seemed to comfort her, nurture her, act as a protection for her against anxiety-producing events, and bolster her ability to make contact with people. In short, they seemed to act as a substitute for ego strengths that were not available to her.

These "ego weaknesses" formed the basis for the suggestions I used in the hypnosis. It was my hope that by using ego-strengthening suggestions, she would have other ways of coping with anxiety-provoking situations.

The ego-strengthening suggestions included setting lower standards for herself, not overextending herself, setting more realistic standards, being more supportive and nurturing of herself, being less critical and less anxious about the way others saw her, and feeling more secure, settled and less shy. Each trance session ended with a suggestion along the lines that, "You'll begin to work through your differences, solve your difficulties and remove those things from your life which hinder you from enjoying life more fully."

As part of the relapse prevention I wanted to help Mrs S to identify themes, values, and ideals in her life which were recurring and causing her distress and conflict. This was a way to point her towards her dependency and authority issues without confronting them directly.

It seemed that without some resolution of these conflicts, her anxiety and her low self-esteem (as evident in her need to have a prop to join others) could lead to a relapse in her cigarette smoking.

I attempted to achieve this via an age-regression technique. Mrs S used an imaginary TV set to "replay" times in her life when she had set high goals for herself, was shy, etc. While watching the replay, she noted what she felt, what she told herself, and how she behaved. At the end of the scene she wrote down in an imaginary "critical diary" those negative themes she had observed recurring throughout her life. She then replayed the scene, but this time changed the way she behaved, thought, and felt. I encouraged her to

look for good qualities in herself that she could amplify in a way that changed her behaviour to what she wanted. At the end of these "good" scenes Mrs S wrote her experiences down in a comfort diary.

I suggested that she could, at any time she felt comfortable, get rid of, destroy, or throw away her critical diary. This was an attempt to further reinforce her giving up those behaviours, thoughts, and memories which were causing her distress and conflict and leading to her smoking.

To reinforce the sense of taking care of herself, the imagery was done in a suggested place that was special to her. This place was a place where nothing mattered except my voice and where she could achieve anything she wanted. It was also a place that I suggested as safe, secure, warm, and a sanctuary for her.

To reinforce the co-manager role, a suggestion from Wright and Wright (1987) was used, in which Mrs S was taught finger ideomotor signals to indicate when she had achieved her "special place" and when she was ready to proceed.

PROGRESS OF THERAPY

The first session was devoted to obtaining a history and introducing the smoking record. As agreed in the contract, Mrs S kept the smoking record for one week. The record listed the number of cigarettes she smoked, the time she smoked them, the activity or situation she was in at the time she smoked, and her need for the cigarette.

Analysis of this record showed that the number of cigarettes Mrs S smoked increased as the day progressed. She smoked mostly while she was having a cup of coffee, watching TV, or driving her car. She felt the greatest need for a cigarette after a meal and while at social functions. She had the least need for a cigarette while reading, during a break from physical exercise (e.g., gardening), or sitting with her husband.

Without prompt from me, Mrs S began to cut down on her cigarette smoking. She chose to begin with those times she felt the least need. She also realised the need to take up some form of physical activity and consequently joined an aerobics class. She also thought of alternatives to smoking while doing passive activities such as watching TV. I congratulated her on her ability and determination to stop smoking.

The next two sessions involved teaching Mrs S self-hypnosis. The self-hypnosis, based on the Stanton technique discussed above, reminded Mrs S of her transcendental meditation and she felt she did not need to use a taped recording of the session to practise at home, twice a day. At first she found it difficult. Unrelated thoughts and distractions intruded. However, in the second session she was able to put herself in trance without my help.

From the finger ideomotor signals Mrs S gave in the second session, her trance seemed reasonably deep. When I asked questions while she was in trance her finger rose slowly and unsteadily.

In the second session Mrs S began to ask what more there was. She had been trying to use her own visualisations and positive affirmations. However, the distractions and unrelated thoughts she experienced while trying this were negative (e.g., how useless she was in not being able to give up smoking). She felt unsure that she should have tried the visualisation and affirmations by herself. To reinforce her independence, I congratulated her on taking the work we were doing together seriously and on her ability to think ahead.

It was in this third session that I introduced guided imagery with the age regression centred around a particular theme. We covered three "main themes": setting high standards for herself and feeling anxious she might not meet them; shyness which included not asking for what she wants such as support, affection, attention, and love; and taking care of herself by not taking on extra demands. This included permission to say *no*.

Mrs S requested two sessions on the shyness theme.

The final (sixth) session was devoted to maintenance issues such as what to do if she felt a craving for a cigarette, and how to handle the advances of others and reinforcers for giving up. The six sessions were completed over 10 weeks.

We had three sessions together before Mrs S left for her holidays. By the third session (over a period of three weeks), she had cut down from 20-odd cigarettes a day to seven.

On her return from vacation Mrs S looked fit and healthy. She had stopped smoking altogether and was proud of her achievement. At this final session she did complain of increasing her food intake and was worried about her weight. On discussing this, Mrs S revealed she had developed a craving for foods rich in carbohydrate, such as cakes. We discussed this craving and Mrs S indicated that she was comfortable in handling the craving and did not want help.

COMMENTS ON ADDITIONAL ISSUES RAISED IN THERAPY

In the second session other issues concerning the sessions emerged. Apart from the bad images Mrs S had experienced while she was practising her self-hypnosis, she also said she felt nervous about the session. She felt that she had started something that she "could not turn back from," that there were issues and things in her life she would not tell anyone about. She also feared that I did not have enough information about her to be able to help her. Although the issue of confidentiality had been addressed during the initial contact, she seemed fearful of revealing things about herself.

We talked about issues concerning our relationship and the need for confidentiality. I reiterated that I would not under any circumstances reveal information I had about her to anyone at work or anywhere else.¹ I further explained that if we met at work, socially, or anywhere else, I would treat her as if our therapeutic work together had never happened.

Even with the guarantees I gave, Mrs S did not reveal details about her discoveries while under hypnosis. She would come out of trance, smile, and

say that there were indeed themes that ran through her life, that she had discovered things she had never thought about. Questions from me about what she had discovered were met with a smile and no further comment. I learned quickly not to press Mrs S to reveal her discoveries. Indeed this might have been intrusive and, if I persisted, could have destroyed our work together.

Intruding by asking questions seemed similar to her description of her relationship with her parents. She felt they wanted to control her by having little respect for her privacy and wishes.

By the final session Mrs S had started to talk about work and her worries. She was due to start back at work soon after our final session together. I wondered about her talk about work and concluded that she just wanted me to hear her problems. Mrs S seemed to be attempting to normalise our relationship as her way of terminating.

Certainly our goal had been achieved. Mrs S had quit her smoking and was justifiably proud of her achievement.

FOLLOW-UP

On a visit to the hospital where Mrs S worked, I made contact with her three weeks after her last session. I was surprised to see how quickly she had gained weight. We again discussed her weight and Mrs S indicated she was restricting her diet to avoid carbohydrate foods. During our discussion I attempted to reactivate suggestions that had been given during the trance (i.e., that she could remove those things from her life that hindered her). Mrs S seemed to pay little attention when I added this to our conversation.

At six months follow-up, again a visit to the hospital, Mrs S had not begun to smoke and her weight had decreased to levels of before she stopped smoking. She had restricted her diet and achieved her goal.

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¹ Mrs S still agreed for our work together to be reported as part of my ASH examination case history.