

HYPNOSIS IN THE TREATMENT OF REPETITIVE STRAIN INJURY

Margaret Nicol

Clinical Psychologist

This case study describes the use of hypnotherapy with Anne, who was suffering repetitive strain injury. The treatment integrated a broad range of interventions including pain inventory, relaxation, and guided imagery techniques, plus a colour coding method to reduce pain intensity. Addressing issues of stress in her present life enabled an exploration of her childhood and unresolved grief related to the death of her father. It also provided a deeper understanding of her approach to work. Age regression assisted in re-linking her to the inner strength and support she had experienced with her father. Throughout treatment, Anne's GP and therapist worked in unison, which was a significant factor in the successful outcome.

INITIAL SESSION

Anne was employed as a secretary to the head of a university department. She had worked in this position for seven years. Five months before consultation she had begun to be aware of pains in her arms and wrists when she came home from work. This pain gradually increased so that she was often in pain during her working day. However, she did not seek help for three months, for fear of losing her job. Eventually she went to the university counselling service because she heard they had helped another staff member with a similar complaint. The counselling service referred her to a general practitioner, who immediately withdrew her from work. She was also referred to a rheumatologist and was seeing each of these on a weekly basis. She had been given analgesics and anti-inflammatory drugs and was expected to rest at home, keeping the use of her hands and arms to a minimum. Thus Anne had been off work for two months at the time of referral to me by her GP and the counselling service. In the three months of therapy I worked closely with her doctor,

so our approaches were consistent with each other and I had ongoing feedback about the extent of the physiological problem of repetitive strain injury (RSI).

Background

Anne was the elder of two daughters and grew up in a small village in England, where her father was a doctor. When she was seven, her father died of a heart attack. The family went from a secure and well-off lifestyle to one which was stressful and insecure. Her mother had to go to work in an unskilled position to support her children and they had to leave the family home — making several transitions during the period of her childhood.

There was a dramatic shift in Anne's memories of her childhood at the time of her father's death — going from describing a very happy, loving family to one in which her mother was very depressed and grief-stricken and the environment quite bleak.

When Anne graduated from secondary school, she completed a secretarial course and worked in London until she married at the age of 22. She came to Australia at the age of 30 with her husband and two sons, aged six and three years. She was here only six months when her husband left her and returned to England and she had never seen him since that time. Thus she brought up her two children on her own with no financial assistance.

Initially she worked as a legal secretary; however, after eight years, she looked for a different job as she was finding it very stressful. She then commenced her work in the university department. She reported that she enjoyed her work and found it very rewarding. However, when questioned about her hours and what her work entailed, it was apparent that she worked exceptionally long hours each day — often taking work home at night and on the weekends. It also seemed that she actually did most of the organisational work in the department, far beyond her actual role definition. In addition, she had eight secretaries under her charge.

In hearing her talk about her work, I was acutely aware of the enormous stress and responsibility involved in it, although she did not initially acknowledge the pressure. It also became clear that she was extremely worried that she might be so incapacitated that she might not be able to return to work and feared she would lose her home — which still had a significant mortgage. She was also worried about her two sons: one was completing the HSC and, she felt, needed a great deal of emotional support and later financial support to go to university; the other was in second year engineering and also needed financial support for his studies.

In the years since her husband left her she had had one relationship which had lasted five years and had ended in the past 12 months.

In the initial session, Anne was in a great deal of pain in her hands, radiating up her arms to her neck and shoulders. At that point she was unable to hold or grasp anything in either hand. Thus she was unable to drive her car, write, comb her hair, or perform any of a myriad of mundane tasks.

She was extremely anxious and had a sense of hopelessness in her view of the future. As she said: "My life is just crumbling and I can't do anything to stop it."

In this session I explored her ideas of hypnosis and discussed any concerns. Her main fear was of losing control, which I allayed, conveying to her that hypnosis is the one therapy in which one can gain control over one's pain.

While a formal assessment of her hypnotisability was not conducted, I explored her imaginative ability — finding she had a vivid imagination, particularly in the visual modality. Anne also seemed highly motivated to try hypnosis and therapy, even though it was as her last hope.

In the first session, I asked Anne to keep two forms of records related to her pain — a pain intensity hourly record and a pain diary noting the antecedent factors around pain arousal and steps taken to reduce pain (Turk, Meichenbaum, & Genest, 1983). Because of her difficulty writing, I suggested she used a tape recorder, which was quite effective.

SESSION 2

his session focused on the information she had collected regarding her daily pain levels. She was amazed to see the consistent pattern in her levels on a daily basis. The crucial times were in the morning, trying to prepare breakfast and lunch for her son and trying to do some chores (e.g., dishes, washing). It then subsided until lunchtime, when again she was working with her hands and also preparing to go to her physiotherapist. The other peaks were when her son came home and played loud music and in the evening, and preparation of dinner. It was also high when she went to bed, for she then began to worry about her future. Visits from certain people also resulted in her pain level soaring. Her action in each case was to take analgesics.

In this session, as in most that followed, we looked at Anne's beliefs and assumptions with regard to taking care of others at the expense of her own needs. Eventually she was able to talk to her son about contributing to the household chores and the preparation of meals. This resulted in a lowering of pain at those times of day. However, it became clear that as soon as her pain was reduced she immediately took on unnecessary household tasks. Thus the continuation of the diary was seen as an essential part of her treatment, for in most cases she was not aware of how much work she actually did — nor was her doctor.

The other aspect of this session was the hypnotherapy. Initially a progressive relaxation was used then, because of Anne's love of gardens and her high imagery, I chose the descending steps method outlined in Clarke and Jackson (1983). A simple eye roll was used for induction and the air balloon, where one places all one's worries into the basket and it is carried off, was also used as a deepening technique.

Due to Anne's level of anxiety and tension, I decided to focus firstly on relaxation, also providing her with post-hypnotic suggestions that each day

she would be more relaxed and enjoy her life, finding the work around her house of less and less importance.

Anne responded particularly well to the garden scene and in it imagined her father with her. Thus she was able to develop some of the inner sense of support and love she was feeling absent in her outer life. I asked Anne to use these relaxation techniques for 15 minutes, six times per day, which she did throughout the treatment with the exception of one week. I also taped the guided imagery for her.

SESSION 3

In this session the enormous grief began to surface, relating to the losses in her life. It was the first time she felt she was able to express her feeling about the death of her father and its effects on her life. She began to see that she had become a very hard worker and tried to care for her younger sister and her grief-stricken mother after her father's death. She realised that there had been much work and little time for fun or relaxation throughout her life and also sensed how exhausted she was.

Also in this session I worked with Anne to develop a colour coding for the range of her pain and we used that in trance to reduce her pain. She would report the colour level, seeing it on a television screen and then, by changing channels, turning it down to the colour of lower intensity pain (Barber & Adrian, 1982). She continued to use this method, linked with the relaxation and guided imagery, at times of intense pain.

SESSION 4

Continuation of relaxation, guided imagery, plus further inclusions of post-hypnotic suggestions regarding an increased sense of self-esteem, security, and growing reassurance that her pain will reduce more and more each day.

Again in this session the discussion focused on her losses — her father, her husband and, more recently, the break-up of a long-standing relationship.

Anne's diary was now showing significant reduction in the intensity, duration, and frequency of pain; she had also begun driving her car again. We discussed the possibility of her choosing to reduce her medication, following the discussion with her doctor.

SESSIONS 5 AND 6

Prior to the fifth session, I spoke to Anne's doctor, who agreed that Anne should reduce the analgesics gradually.

These two sessions revolved mainly around Anne's concern about work. Although her pain was significantly reduced, she realised that the idea of returning to work, which normally entailed approximately five hours typing on the computer, just seemed impossible. Her concerns regarding her home

and finances seemed to be causing a great deal of worry. It also seemed that, to some extent, Anne had no sense of power and was helpless in this situation.

We then explored her options and she was able to later investigate her position and rights through the union and her bank manager. Both of these contacts reassured her that she was not under any threat and should not be concerned about her financial security.

The remainder of each of these sessions was devoted to hypnotherapy, as previously outlined.

SESSIONS 7 AND 8

These two weeks were very difficult for Anne, with her pain levels returning on the first week to baseline recordings. Her sister had arrived from England and, although she was looking forward to her visit, Anne spent a great deal of time cleaning the house and, on her arrival, catered for her sister's needs, disregarding her own. She did not practise her relaxation during this week.

The discussion of the family dynamics which resulted from this visit were, however, most illuminating for Anne and she made alternative plans for her sister's second week — which allowed Anne to maintain her times of relaxation and not to over-stress herself.

Continuation of the relaxation and post-hypnotic suggestions of placing her own needs as a top priority were included in these sessions.

SESSIONS 9 AND 10

Anne was now back to her lowered levels of pain and, under her doctor's suggestion, was commencing hydrotherapy to regain the muscle strength in her arms lost over the many months of inactivity.

In these sessions Anne referred more to her father and to the times before he died. Thus I decided to use an age regression, as suggested by Barber and Adrian (1982). Although they suggest going back to the time prior to the injury, it seemed that Anne was speaking at two levels of two injuries — one her recent physical pain, the other the psychological pain of her father's death. Thus we went back to a time prior to his death and she reported feelings of joy, security, and love which I suggested she might bring back to the present. The visual and verbal images in her memories with her father seemed to give her an enormous sense of confidence, self-esteem and hope for the future.

This was probably the most significant turning-point in the therapy. In the tenth session we discussed termination, with a plan for two more sessions.

SESSIONS 11 AND 12

These two sessions were an integration of the work we had done. The main issues dealt with were far-reaching problems Anne may face in the future

and how she may rely on her own resources to deal with her pain and the stresses related to it.

In hypnotherapy, while still using the garden as the central imagery, we added the dimension of imagining her own therapist, whom she may call on at any time to come to the garden and help her solve problems. She felt quite reassured with this addition to her inner sanctuary.

Another aspect of Anne's development was her decision, based on discussions with the university counselling service, her department head, and doctor, to take the three months leave owing to her and to decide at the end of that time what her next step would be.

By the last session, Anne was reporting approximately three to four days per week as totally pain-free, with incidents of pain of durations of one to two hours when she became tense or overdid activities.

FOLLOW-UP

At one month Anne was progressing well and seemed much more positive in her approach to life. She felt having transferred from worker's compensation to holiday pay was important for her sense of self-esteem. She had also reinstated many of her past social activities and hobbies. She had maintained her relaxation times at three times per day.

When I saw Anne at six months, she was like a new person. She had resigned from the university and taken a half-time position, with no typing, in a doctor's surgery. Her youngest son had graduated from high school and entered medicine, of which she was extremely proud, and her other son had done well in his exams and was going into his final year of engineering. She had also reinstated the relationship with the man she had been seeing for five years and was delighted to tell me of her forthcoming marriage.

She reported virtually months of pain-free days, with very minor pain when she used her hands for extended periods. However, she also noted that in each case she was able to pick up the pain signals early, cease her activity and use the relaxation and pain reduction method learnt in therapy.

REFERENCES

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THE CASE OF MS L

Norman Shum

Psychiatrist

This case study presents a number of uses of hypnosis with a woman in the treatment of anxiety with secondary depression, obesity, and smoking. While hypnosis was not considered a therapy in its own right, the hypnotic components of therapy seemed to contribute to the overall success of therapy.

Ms L, a 30-year-old registered nurse and midwife, was referred by her general practitioner and seen for the first time in mid-1988. The accompanying note read: "Ms L has had problems with chronic anxiety and depression and was contemplating the benefits of her present existence." I took this to mean that Ms L was wondering if life was worth continuing and that she might be seriously considering suicide. Accepting the possible urgency of the matter, I arranged to see Ms L the day after she had attended her GP.

The presenting complaints were summarised in her own statements: "I've been anxious and out of control for about three to four months." "I have this fear, an uncontrollable panic. I'm frightened I'm going to die. I'm frightened I've got heart disease." "I don't want to be left alone."

HISTORY

A history was obtained at the first interview. Ms L said she had had these attacks of panic on and off for about 10 years. There had been no obvious precipitant. When they came on Ms L hyperventilated, she felt tight in the chest, her heart raced, she developed numbness and tingling in her hands, and she became acutely aware of every ache or pain in her body. Asked if she had thought of any explanation for these attacks, Ms L said she did not know and started to cry.

She went on to say she had been seeing a psychiatrist for about two years and had been told her condition was probably hereditary, as Ms L's father had suffered from depression. Appointments with that psychiatrist were rather infrequent. She only attended every other month and the appointments were

very short. This was the reason Ms L asked to be referred for a second opinion, probably with the intention of transferring to the care of that other specialist if she felt comfortable with the introductory interview.

Her treatment from the former psychiatrist consisted of the drug Trimipramine, 75 mg daily for the three months prior to coming to see me. Ms L said she had been on this medication before, as well as Alprazolam and Bupirone at different times. These drugs being, respectively, a tricyclic antidepressant, a benzodiazepine, and a non-benzodiazepine anxiolytic drug.

Ms L had also been to see another member of the Australian Society of Hypnosis for hypnotherapy approximately 10 years ago. She attended about six sessions, did not notice any great improvement, and ceased appointments.

PAST MEDICAL HISTORY

Ms L has a hiatus hernia, proven by endoscopy, which is periodically symptomatic. At these times she attends a gastroenterologist for review. She takes no regular medication for this condition. She also suffers from hypercholesterolaemia. Ms L had a reduction mammoplasty in 1984.

She does smoke cigarettes, approximately 20-plus a day. She does not drink alcohol.

FAMILY AND PERSONAL BACKGROUND

Ms L is the second eldest of four siblings. She has an older married sister, also a nurse, and two younger brothers, both single and both working as fitters and turners. Her father is a research and development engineer with a diesel company. Mother is a housewife.

Her father had a single episode of depression about seven years ago. He recovered following antidepressant medication under the supervision of a psychiatrist.

Ms L was born in Glasgow, Scotland, and came to Australia with her parents at the age of eight years. She went to school in Adelaide, left at the end of fourth year to enter nursing, and subsequently gained her general and midwifery certificates. She said her childhood was unremarkable, being neither particularly good nor bad, overall quite happy. In her teens, however, she began getting into conflicts with her father. At that time he had his own business and was little seen by Ms L. When she did see him, as at weekends, she said they often argued. And it was usually over Ms L's excessive weight. Father apparently believed Ms L's obesity would diminish her job prospects. He was proved wrong when Ms L completed her training and easily got a job as a registered nurse. Father was seen as rather strict but caring.

Mother was described as "nervy" and in latter years "irritable." Ms L says her mother suffers from rheumatoid arthritis with at times considerable pain, which may account for her irritability. She is also menopausal.

Ms L relates well to her sister and two brothers.

RELATIONSHIPS AND MARRIAGE

Ms L said she had only one serious relationship before she met and married her husband, A, at the age of 25 in 1985. She did not go into details about this period of her life although experiences during this time do have significance, as emerges later in Ms L's history. A is 29 and works as a farm manager. Ms L said she and her husband "get on very well, he's easy going. The only complaint I have is that he sleeps too much!" Similarly, the marital relationship changed its descriptive character in later sessions with Ms L.

To date the couple have chosen not to have children.

PERSONALITY

Ms L said she used to be cheerful, optimistic, and not a stupid person. She enjoyed being with friends, doing her nursing job, reading virtually anything, doing craft work, and planning for the house she and A intended to build. But since the exacerbation of her symptoms, she now felt disinterested in things, withdrawn, and could not look forward to anything enjoyable.

GENERAL INQUIRY AND MENTAL STATUS EXAMINATION

Ms L said her appetite was unchanged, although she had been dieting. This had resulted in a weight reduction of 18 kg over the past year. Presenting weight was 88 kg. There had been both bowel and urinary frequency over the recent months corresponding with her increased anxiety symptoms. Her periods had been irregular for more than 12 months but seemed to be returning to normal.

Ms L's sleep pattern was quite disturbed because she feared the onset of darkness. She said that as soon as it became night, everything became quieter, there were no distractions, and she began to dwell on all the things that frightened her. This led to difficulty initiating sleep, but once she fell asleep she was all right.

Her prevailing mood was that of anxiety and fear. Unable to relax because of her preoccupation, she denied any disturbance in cognitive function but admitted to an almost total loss of sex drive and interest.

On examination, Ms L presented as an attractively featured, carefully made-up, young, blonde-haired, grey-eyed woman who, although obese, carried her excess weight well. She was fluent and well-spoken, with a good command of English. Her language and history-giving were not excessively detailed or exaggerated. She did not appear overtly depressed or anxious. There was no disorder of perception or cognition evident.

A physical examination was not done as Ms L had been examined recently at the hospital at which she worked.

DIAGNOSTIC FORMULATION

Ms L satisfied the DSM-III (American Psychiatric Association, 1980) criteria for Panic Disorder.

She had also, secondarily, become quite severely depressed with suicidal thoughts. This depression had the features of a reaction to her intense panic state. It was thus not a primary diagnosis, although Ms L probably has the genetic predisposition to develop a depressive disorder herself, as witnessed by her father's illness. However, the pattern described by Ms L was more consistent with a neurotic/reactive type than an endogenous/biological depression and it followed in time the worsening of her panic symptoms. The depression did not arise *de novo*.

Ms L's fear of death or dying of a heart attack may have been part of her panic disorder or may have its own separate existence as a phobia. In her work as a nurse, Ms L described once having a patient suffer a cardiac arrest and die in her arms as resuscitation arrived too late. This certainly would represent a sufficiently sensitising (reinforcing, precipitating, or perpetuating) event to condition Ms L into having a phobia about her heart and its functioning.

However, any working diagnosis reached must always be consistent with the observations and results of confirmatory investigations, if any, that were done. Ms L's history leads most logically to the diagnosis as given above.

Ms L's other problems were (a) obesity, (b) hypercholesterolaemia, and (c) cigarette smoking.

DIFFERENTIAL DIAGNOSES

Anxiety occurs in many other psychological disorders, including depressive illness, obsessive compulsive disorder, pure phobic states, and the psychoses. It also occurs in many medical conditions such as acute toxic confusion states, and dementias. In fact, disturbance in any of the body's organ systems can give rise to anxiety. For example, the cardiovascular, which may be comprised in various ways ranging from cardiac infarction to heart failure. Mention must be made of the mitral valve prolapse syndrome because there is a significant association in occurrence together, although the precise link is unclear. Thyroid disease is another relatively common condition in which anxiety may be a prominent symptom. However, from the history and examination, none of these alternative diagnoses could be sustained, especially as Ms L had been examined and investigated with negative findings by at least two specialist physicians.

MANAGEMENT

It is well known that medication alone is not a complete answer, but the first step in the short term was to get Ms L's disabling symptoms under better control using medication — that is, a physical therapy. Although I do not

normally use Trimipramine for panic disorder, it seemed expedient to continue it as the patient already had a loading dose in her body. I therefore instructed Ms L to increase her Trimipramine immediately to 100 mg nightly. Six days later, during the evening, Ms L phoned me at home and reported that she had been very distressed at work during that day and had felt more panicky than at any other time in the previous 10 years! Obviously the increase of Trimipramine to 100 mg had been inadequate and I advised Ms L to go up to 125 or even 150 mg, if she felt a need, before I was next able to see her.

Two days later, Ms L attended at Fullarton Private Hosital (FPH) and reported: "I seem to be getting worse . . . I collapsed at work . . . I thought I was going to die . . . I was put into coronary care, had an IV drip in me and was monitored. I was seen by Dr H [a specialist physician] before being discharged." I gave Ms L a definite instruction to increase her Trimipramine to 150 mg nightly and began teaching her the first steps in correct breathing, concentrating on the exhalation phase, as a forerunner to formal hypnotic induction. Three days later, on 25 July 1988, I admitted Ms L to FPH as she was "just not coping!"

With Ms L in FPH, I was able to proceed with the use of hypnosis much more quickly than if she had remained an outpatient. I also prescribed the benzodiazepine, anti-anxiety drug Diazepam. This was added when it became apparent Ms L was not being controlled by Trimipramine.

As it happened, I was not convinced at all about the effectiveness of Trimipramine for Ms L and weaned her off it. At the same time she asked to stop the Diazepam as she felt, non-specifically, uncomfortable on it. I substituted Buspirone, a non-benzodiazepine anti-anxiety drug, and at the same time continued hypnotic sessions.

In as far as Ms L also had the medical problems of obesity, hypercholesterolaemia, and smoking, it seemed opportune to make use of Ms L's time in FPH to review at least the first two of these three health risk factors.

Ms L was reviewed by the visiting dietitian and counselled about the most appropriate diet to reduce weight and lower cholesterol. The hospital provided the modified diet while advice was obtained from the clinical chemists at the Institute of Medical and Veterinary Science, where my pathology investigations are done. They commented on Ms L's cholesterol levels and, at their suggestion, Ms L began the cholesterol-lowering drug, Cholestyramine.

As an adjunct to my own psychotherapy with Ms L, the "therapeutic alliance" having been rapidly developed, she was referred to the cognitive restructuring program run within FPH by a nurse therapist. This program follows the cognitive behavioural/rational emotive tenets of Drs Aaron Beck (1976) and Albert Ellis (1962) and takes place in a group setting.

HYPNOTIC PROCEDURE

The following section is given in moderate outline only.

Ms L was not formally tested for hypnotisability as she more than satisfied the clinical requirements as being suitable for a hypnotic approach: there was good rapport between her and myself and she expressed trust; she was highly motivated; had an expectant positive attitude towards hypnosis; and prior to presentation with her panic symptoms, had displayed very adequate ego strengths in her personality to deal with the hypnotic process.

As part of her preparation for hypnosis I asked Ms L what she remembered of her previous experience of hypnosis with the other member of ASH whom she had seen. Ms L could not remember any specific reason why she did not benefit very much from therapy. She simply said she did not notice any change in the level of her anxiety.

I then took Ms L through an induction following a protocol devised by Dr David A. Soskis (1986). Called the "Brief Hypnotic Experience," the script as used incorporates transferring control of the induction process from the therapist in the heterohypnotic situation to the patient, so it can be used in the self-hypnotic setting.

The actual induction sequence consisted of brief eye fixation, eye closure, arm levitation, progressive muscle relaxation, evoking imaginal tranquil place (either real or potentially real), establishing coding or cue (words) for rapid entry into trance and/or deeply relaxed state, termination and exit from trance.

Ms L proved to have good hypnotic capacity and after only a few inductions following my suggestions, was able to enter trance rapidly on her own. On reaching what she regarded as a working depth of trance, Ms L would use an ideomotor finger signal to tell me she was ready. Her special place was a beautiful garden, her code words were "safe and well."

The earlier sessions were mainly aimed at ego-strengthening, to reinforce her normal defence mechanisms so that the intense anxiety lessened. Ms L particularly enjoyed (her actual word) the script from John Hartland's book *Medical and Dental Hypnosis*, as quoted in the American Society of Clinical Hypnosis' *Syllabus on Hypnosis and Handbook of Therapeutic Sessions* (1973). This script was so effective that Ms L requested that I make an audiotape of one of our sessions with the ego-strengthening suggestions given verbatim. This we did.

Some sessions were used to deal with the physical manifestations of her anxiety, such as her rapidly palpitating heart. For instance, while in trance, Ms L was instructed to take control of her own heart rate, first increasing it and decreasing a few beats at a time using her trance to access her autonomic nervous system. This control was then linked to normal responses to exercise and other strenuous activities, and then given a simple reframe. Ms L was told to regard her heart beating strongly as indicating her increasing fitness and health.

Other sessions were used to explore in an analytic sense the possible origins of Ms L's anxiety. In these sessions Ms L was given the suggestion that she could verbalise rather than use finger signals. Using the affect bridge technique

Ms L only needed to travel back as far as the age of 18 years. Ms L recalled having been in a motor car accident in which she was badly frightened, although not injured. She recovered from that death-threatening experience but then developed severe pneumonia, and once again recovered and survived.

Also around this time, Ms L was under some sexual pressure from a boyfriend. She refused to acquiesce and later split up with him.

And finally, only 18 months ago, Ms L fell off a horse. She was badly shaken but again not physically hurt.

It seems quite logical that this series of events was probably, to a considerable degree, the sensitiser, the reinforcer and the precipitant to Ms L's anxiety/panic disorder. The pressure from the boyfriend provided the stress factor increasing Ms L's vulnerability at that time.

After this particular session in which all this explanatory information was revealed, and after trance had been ended and we were debriefing, Ms L said she felt that she was now "past the change point," and could now believe that she would get better.

PROGRESS IN HOSPITAL

Following the session just described, Ms L made slow but steady progress. She attended the cognitive restructuring program along with other day-patients and in-patients of the hospital but found many of the topics being covered were already familiar to her from her individual work with me. But being in a group had other advantages for Ms L, such as discovering that there were many patients with symptoms almost identical to her own and that they were struggling, just like her, to master and control them.

Ms L was surprised to find that hypnotic techniques were not being used by any other patients except those who were attending the pain management unit. The psychiatrist in charge does occasionally employ hypnosis in a group educative setting, but in private conversation with me said he did not call it "hypnosis" so as to avoid any patient or group resistance to the method.

Medication was playing a rather secondary role to the psychotherapy and hypnotherapy in Ms L's slow improvement. The anxiolytic Buspirone, a non-BZD, was stopped when Ms L started getting adverse reactions/side-effects in the form of dry skin and falling hair. But the main reason for ceasing this drug was her self-perceived lack of response to its expected action in modifying her anxiety level. Alprazolam, yet another benzodiazepine, was started in place of Buspirone. Ms L had taken this before but the dose had never been pushed very vigorously.

Ms L continued her diet and cholesterol-lowering medication. The total weight reduction achieved from the time Ms L started her weight/diet/exercise regime was 29 kg. Some hypnotic sessions were used to promote balanced eating, an addition to her other therapy which Ms L found useful.

As preparation for discharge, Ms L started having weekend leave from the hospital and spent those days in her own home. When reviewed, Ms L

reported disappointment in not achieving as much as she had hoped, that is, she had hoped to be able to spend time alone but people would keep "dropping in."

Ms L was finally discharged after nine weeks as an in-patient.

OUTPATIENT FOLLOW-UP

Ms L was now being seen at my rooms. The overall therapy approach at these appointments did not change, but Ms L was now practising her self-hypnotic relaxation skills. Simply coming to my rooms, which had been a huge effort before the period of hospitalisation, was something Ms L could now handle more comfortably.

She was quite honest in admitting that she still got apprehensive and still wondered when her residual anxiety would go completely. She had, at least, not had any more full-blown panic attacks since being in hospital. As a measure of her recovery, Ms L said she could now watch TV movies in which an actor supposedly died of a heart attack. She did experience some rise in anxiety but controlled this using the self-hypnosis exercise. Previously the mere suggestion of a heart problem — even though Ms L knew it was only a film — would end with Ms L leaving the room in a state of agitation and dread.

Once she was an outpatient, Ms L's cholesterol status was checked and this proved a considerable disappointment. The level had not dropped and her ratio of high to low density lipoproteins had shifted slightly in the wrong direction. An expectable reactive depression followed this finding. Further advice was received from the clinical chemistry division of the IMVS to the effect that this phenomenon does occasionally happen and the reason is unknown. However, the cholesterol-lowering drug could be increased and Ms L followed this suggestion. After spending time discussing this issue in therapy Ms L showed another aspect of her newly learned cognitive methods. She gave herself coping instructions to the effect that she would continue to do all the right things, and ignore the plateau that her blood had apparently reached. By way of doing something else actively towards becoming healthier, Ms L requested hypnosis to help stop smoking. Of course I agreed.

With Ms L being well versed in self-hypnosis, no further preparation was necessary. After she had entered a trance state, I gave Ms L the Spiegel (1978) "Three Point" smoking cessation suggestions. As described by Spiegel, the whole session was used to really implant the technique so that they became, in essence, post-hypnotic suggestions. Ms L was told to practise the exercise often. Only one session was spent on teaching this technique.

At her next appointment, Ms L reported a small decrease in her urge to smoke and a slight reduction in the actual number smoked in a day. She asked if we could use another technique to "reinforce" the Spiegel we had already done. I chose another script from the American Society's *Handbook* (1973), devised by Cooke and Van Vogt. The suggestions are framed around the idea that the person will smoke less because each cigarette that is smoked

will be enjoyed more. Eventually the person will decrease to smoking only once a day. I have noticed in passing that there is a plethora of "stop smoking" scripts, indicating clearly that no one version seems to be more effective than the next.

The next appointment demonstrated how chronic habit disorders really are. Ms L reported another slight decrease in her smoking but admitted that she needed really powerful suggestions if she was going to get close to zero. She asked if I could make up and use a script which had aversive suggestions as she believed this might be the most effective. She said one of the physical events she found most aversive was to be nauseated and/or vomiting. Since nicotine poisoning does cause both of these, it was not hard to devise a script with the aversiveness requested. This was presented to Ms L in trance during the remainder of the session. The next time I saw Ms L she said she had reduced her smoking to an acceptable level for her.

Ms L's return to health and competence continued quietly and was marked by her return to work on 28 December 1988, five months after she was admitted to Fullarton Private Hospital.

FINAL WORD AND COMMENTS

Contact with Ms L continues. Since she went back to work she only comes once a month. She still takes Alprazolam. A switch to the tricyclic drug Imipramine was attempted, but it failed. She still smokes a few cigarettes. She has not checked on her cholesterol level and has not asked me to do so either. Her weight seems to have settled at the 78 kg mark.

Further appointments are likely as another issue arose just before Ms L restarted work. This was a marital dissatisfaction and relationship problem. Ms L had hinted at this in some of her earlier psychotherapy sessions but clear information only emerged recently. Therapy for this is continuing and will not be discussed as part of this case.

Ms L had three medical problems and one psychological problem when she first presented. Of these, only the hypercholesterolaemia has not improved, but then, no hypnotic technique was specifically directed at it. As Ms L got rid of excess weight, her cholesterol level should have begun falling. It did not and the experts are somewhat mystified. They have no explanation other than to say that cholesterol levels have been known to go the wrong way despite every best effort on the part of the patient. The substantial weight loss and the smoking decrease would have to be regarded as successful outcomes to therapy and hypnosis. Both are conditions well described as being amenable to hypnotherapy, although success can be variable. Longer term follow-up with Ms L will tell how permanent the changes are, using the techniques she has learned.

A reduction in panic attacks to nil and a lowering of her general anxiety level such that she could return to work have to be seen as very good results and as attainment of the goals of management.

The hypnotic techniques used with Ms L were standard formats except for the last stop-smoking script. This incorporated, at Ms L's request, aversive suggestions which on the whole are thought not usually to be as effective as positive suggestions. But when the patient is improving, wants even more, and supplies the therapist with the necessary tools, it would be wasteful, if not irresponsible, not to make use of the opportunity. The facts that Ms L had a good hypnotic capacity and a likeable personality made her easy to work with. She needed little encouragement or prompting and achieved much of what she had wanted, a reflection of how powerfully motivation contributes to the satisfactory and satisfying practice of hypnosis and therapy.

IN RETROSPECT

Even though this case has not yet concluded, the one thing which became obvious was the need for the therapist to be patient. Whether one used hypnosis or not, it would have been easy to have fallen into the trap of trying too hard to bring about too rapid results. The fact that Ms L was a medically associated person, a nurse by training, may have affected the efforts a therapist made. It has often been said that a doctor's family receives the worst medical care. Nurses have almost the same risk because of the assumption that they can or should be able to "care" for themselves.

As Martin Orne and David Dinges (1989) say: "Although it can provide therapeutic advantages, hypnosis should never be used in the treatment of a condition that the therapist is unprepared to treat without it" (p. 1502). I believe I could have treated Ms L without hypnosis, but I might not have been as successful.

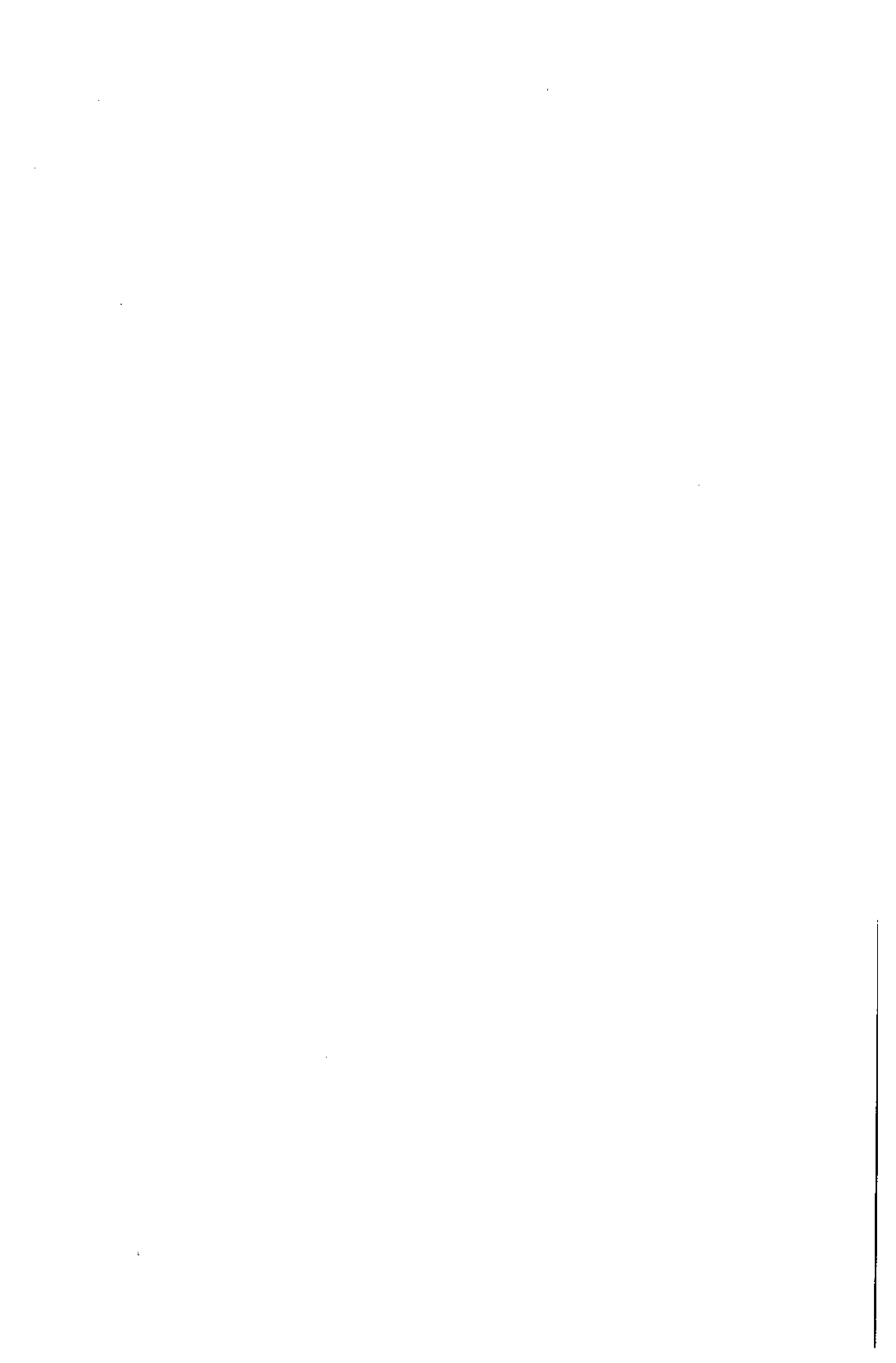
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THE CASE OF MR D

Norman Shum

Psychiatrist

Shyness is common, but when unassertiveness reaches almost total (self) effacement, the sufferer has a distinct psychological problem. Mr D's first shyness interfered with two of his basic human functions, namely, eating and elimination. The second interfered with virtually all other social interactions. The usual emotion underlying shyness is anxiety which may or may not develop into panic and then cause phobic behaviour. Mr D's case illustrates this progression. Standard therapy was enhanced by using hypnosis.

INTRODUCTORY DATA

Mr D, a 47-year-old unemployed self-taught mechanic from South Australia, was referred by his GP and first seen on 16 November 1988. The accompanying note read: "Mr D suffers symptoms suggestive of agoraphobia. He also suffers from reactive depression due to being unemployed. Past history of back injury with worker's compensation. I would appreciate your assessment and advice."

HISTORY

Asked to describe the problem in his own words, Mr D told me the following:

It's my attitude to life. Not one thing, lots of things. I can't handle "niceness." Any situation I can't handle I turn to anger. For example, Christmas, you can have it. I can't handle places where there are lots of people. I feel depressed. I've got to get away out of it. I want to get away most of the time. Over to the solitude of the West Coast [a remote region of South Australia].

I've felt this way most of my life, but it seems to have gotten worse in the last two years. I can't think of any reason why this happened. [That is, there was no precipitant.]

Asked to expand on what he meant by “depressed,” Mr D said:

I feel threatened in public places. It's okay if it's children or old folks but if it's teenagers up to people my age, I feel wary, cautious and go out of my way not to upset anyone. It's happened quite a lot in the last 5 to 10 years. I start to sweat, get a funny feeling, as if I have to get out there and then. The noise gets unbearable.

Past History/Social History

Mr D suffered leg and knee aches and pains, which had resulted in many negative tests with no physical diagnosis. At night in bed, he said, he often could not find a position for his legs which was comfortable. These symptoms had been present 5–6 years. He had been assessed by a physician and a psychiatrist.

In the past, he had received surgery for removal of tonsils, left testicular cyst, and vasectomy. He had suffered a crowbar injury to his foot 16 years ago, for which he received compensation. In May 1988 surgery to a bunion on the left side of his left foot led to complications with a bad surgical result. He was seeking/awaiting final corrective surgery or other treatment.

Mr D said he had taken the hypnotic Temazepam regularly over the past three years because of persistent initial insomnia at that time. He took Diclofenac (Voltaren, non-steroid anti-inflammatory, analgesic) irregularly.

Mr D stopped smoking 11 years ago; drank alcohol socially most Friday nights, preferring spirits; and professed no religion.

Family and Personal Background

Mr D was born illegitimately in Southampton, U.K., and never knew his natural father. He was told various stories about this unknown person, most of which revolved around his progenitor being in the armed services during World War II, and being killed; or he was none of these and was still alive.

Mr D was raised by his maternal grandmother in a country village until he was nine, even though his mother, M, now 69, had married when Mr D was six.

M was working in a Spitfire factory when she married her husband, N. Once back with his mother and stepfather, Mr D travelled to Pakistan for two years where N was assigned. After one year back in England, the family migrated to Australia. Mr D was 12.

He attended a local primary school for one year and high school for two years before leaving at 15 years of age. He got a job in a radio-electrical shop but stole small bits of equipment. His mother reported him and Mr D was sent, via the courts, to a remand home. On his release, his mother had moved, so Mr D went boarding.

Various jobs followed, interspersed with jaunts around Australia with a friend. Mr D's two longest jobs were of four years each in motor firms where he learned about engines but did not qualify as a tradesman mechanic.

Mr D's last job finished in 1980. For the next four years he was on a supporting parent's benefit looking after his son D (24) and daughter W (21). Son and father were living together. D was employed in an engineering firm as a production manager. W was a single mother with two children and lived in New South Wales.

Personality

Mr D offered the following description of himself: "I'm introverted, I don't like myself very much, I feel something is wrong with me. I'm frightened of failure, not of losing but of not knowing what to say to winners. I can't handle people saying how good they are and so I don't like meeting or mixing with people."

Marriage and Relationships

Mr D was first married at age 20. The marriage lasted 13 years and ended 13 years ago when Mr D became interested in another woman. This relationship ended when, as Mr D said, "It went nowhere. The grass wasn't greener and we parted."

Mr D's wife H (42) now lives in New South Wales and there is no contact. As noted above there are two offspring to that union.

When Mr D was first referred he was keeping company with L (40), a lady he had known since she was 13 years old. She had been Mr D's girlfriend while she was still in school and he had been in his first job. They went their separate ways and L also married and separated before Mr D met her again. This relationship was not entirely satisfactory, but Mr D could not specify what it was that made it so.

GENERAL INQUIRY AND MENTAL STATUS EXAMINATION

Apart from the continuing problem with his foot, Mr D said his general health had been all right. He ate well, perhaps too well, and when he decided his 'pudding' (abdomen) was getting too prominent, he said he would stop eating for a week or two. His weight had been stable for years.

His bowels gave no trouble but Mr D did have a urination difficulty. He said that if he were in a public toilet and another man entered, Mr D could not initiate micturition.

The sleep difficulty was as previously noted. Mr D had quite severe initial insomnia about three years ago and had been taking a drug ever since.

Asked what he felt within himself most of the time — that is, his mood state — Mr D replied, "I'm not a happy man."

Mr D denied any problems of cognitive function.

Finally Mr D described an interference with his sex drive. He complained of having premature ejaculation almost all his (sexually active) life and it bothered him.

On examination, Mr D presented as a stocky well-built man of slightly less than average height with a mildly protuberant abdomen. He had a fair complexion with blue grey eyes and short wavy blond brown hair. (I even wondered if it were a hairpiece.) He was neatly and casually dressed.

Mr D's conversation was delivered slowly with a noticeable English accent reflecting his limited education, but his command and comprehension of language was more than adequate.

His manner and mood were appropriate. He did not appear anxious or depressed. He related well, with good eye contact. Cognitive processes were not impaired.

A physical examination was not indicated as all of Mr D's complaints were firmly of a psychological nature and there were no indicators of any organic pathology.

It was not immediately apparent what diagnosis could be applied to Mr D's problem. Although his general practitioner had wondered about an agoraphobic disorder, the overall pattern was incomplete and I was not convinced Mr D had this.

Mr D seemed to show some interpersonal problems which also did not fall easily into the more common categories.

This left the problem of finding either one diagnosis which had features embracing both areas of Mr D's difficulties, or accepting that there were two diagnoses. The dilemma was not resolved until several more sessions had passed, during which just one or two statements made by Mr D in each session started pointing to two probable and, in many respects, overlapping descriptive diagnoses. To quote:

L had a Christmas celebration coming up. It's held on the Christmas Eve because they're Europeans. There'll be lots of singing, joking, they'll be happy . . . I don't think I can go, can't join in . . . I'm self-conscious, what if I say or do the wrong thing, what if I offend someone?

I've never made it . . . I'm always on the outer. Whatever I've tried I've never gotten good at it. I can't accept praise . . . brush it aside, rather not hear it.

There's this model aeroplane club I'm in. They race . . . I was going to enter . . . but didn't . . . I withdrew. Didn't go to the BBQ either . . . couldn't stand in the queue so went hungry.

I want people to accept me . . . I'm frightened to make a fool of myself.

The two diagnostic conditions which emerged were Social Phobia and Avoidant Personality Disorder, as described in DSM III (American Psychiatric Association, 1980).

DIFFERENTIAL DIAGNOSES

The most common organic differential of phobic disorder is intoxication with hallucinogens, sympathomimetics, and other abused drugs. But most organic

disorders do not cause isolated symptoms of phobia in the absence of other psychiatric or neurological symptoms.

Mr D could almost be regarded as out of the age group likely to be abusing drugs and he was no longer even a smoker. His intake of alcohol likewise did not sound excessive. Thus the possibility that abused drugs could explain his phobia and avoidance was most unlikely.

The psychiatric/psychological differential diagnosis of social phobia includes depression, schizophrenia, and schizoid and avoidant personality disorders. There was no evidence for any of the first three of these, and the last one, avoidant personality, was accepted as a second diagnosis.

MANAGEMENT AND THERAPY

In as far as the main symptom of these two conditions tends to be anxiety, the goal of treatment was to alleviate this and enable Mr D to assume a more "normal" existence, so he could go out without the anticipation of failure, rejection or humiliation.

The therapeutic approach thus had four strands: pharmacological, insight/dynamically oriented psychotherapy, behaviour therapy, and hypnosis.

Mr D was already taking a benzodiazepine, Temazepam, as a night-time sedative. It is well recognised that these and similar drugs are recommended only for short-term use. After three years it seemed unlikely that Mr D was actually being helped to go to sleep by Temazepam, especially as the usual duration of use is only two to three weeks! However, it is possible that Mr D was deriving some daytime anxiolytic effect from the built up residua of Temazepam.

When discussed with Mr D, he expressed a wish to actually get off medication if he could, rather than add to or substitute that which he was already taking. In view of the fact that Mr D's subjective level of anxiety was not intense or totally disabling, the use of an anti-anxiety medication was postponed.

Psychotherapy was already proceeding and each session usually involved helping Mr D change his approach to life; to understand the possible origins of his phobia; and to develop more coping strategies while diminishing his defensive manoeuvres.

Coinciding with psychotherapy, Mr D was introduced to behavioural methods such as learning graded exposure to the feared situations.

Hypnosis was introduced to enhance and reinforce Mr D's acceptance of the non-threatening nature of those same social situations. I also intended to use hypnosis to explore analytically the origins of the phobia.

PROGRESS: PSYCHOTHERAPEUTIC AND HYPNOTIC

As therapy proceeded Mr D's problem crystallised into four major areas. While describing these separately, the work on them was actually done concurrently.

The social phobia was dealt with initially by cognitive disputation along lines suggested by Aaron Beck's work (1976), especially as from his history there was no doubt that Mr D experienced the "cognitive triad" the parts of which are: (a) a negative self-percept that sees oneself as defective, inadequate, deprived, worthless, and undesirable; (b) a tendency to experience the world as a negative, demanding, and self-defeating place and to expect failure and punishment; and (c) the expectation of continued hardship, suffering, deprivation, and failure.

My strategy involved explaining and educating Mr D about anxiety/depression and its expression, interaction with, and effects on his body's systems. I challenged and pointed out his faulty logic and questioned his evidence for believing all the negative features he professed to own. I asked him to review his automatic thoughts and assumptions and to test their validity. Mr D was also instructed to continue thinking about these aspects as a homework assignment between appointments.

Obviously this work took place over a number of sessions and not, as might be suggested by the above description, condensed into one. Hypnosis was used during this work for purposes of ego-strengthening, anxiety reduction and imaginal rehearsal.

In this latter work Mr D was guided through various possible social scenarios and he visualised himself being competent as a conversationalist, able to mix without embarrassment or gaucheness, and so on. I suggested Mr D imagine himself in a theatre and put all the participants on the screen or stage. He was to control the activity like the director of a play.

The first time we practised this method Mr D got quite agitated and said he had been reminded of an unpleasant real event rather than a new scene in which he was functioning well. After dealing with this bad time, using some more cognitive disputation and interpretation, Mr D changed his reaction to that incident and we were able to proceed.

Mr D's preferred method of induction was Spiegel's eye-roll technique. Mr D found the eye fixation, distraction technique too slow and tedious. During debriefing after one hypnotic session, Mr D commented that using the eye roll, he had been "quite surprised at the power of the induction. It was a bit like fainting" (i.e., the plunge; Spiegel & Spiegel, 1988).

Soon after Mr D had practised his guided imagery with successful outcomes, he was able to attend a real social function and reported that he had been "about 80% successful in handling people who were strangers to me, making conversation, etc."

The second issue which arose in psychotherapy was his relationship with L. Mr D was questioning more and more what was happening or not happening in it and was wondering why he continued with it. They had fewer and fewer common interests and their ideas in general were no longer compatible.

L seemed to treat him as a convenience. When she needed some work done, she called Mr D. To ensure his compliance, Mr D noted she would

be "all nice to him" for about a week before the request. Mr D had already revealed that the relationship was sexual but very sporadic, and inevitably, in latter years, was accompanied by an expectation of some sort, such as putting in cupboards or fixing a stove. And even when they did have sex, Mr D felt he was being used, as she issued instructions like a drill sergeant as to how the activity was to be completed. Mr D said having always had premature ejaculation, sex with L was not helping and his satisfaction was diminishing. And L had not always been faithful to him either.

In this instance psychotherapy with hypnosis helped Mr D resolve the conflict, although hypnosis for the social phobia indirectly contributed to its resolution.

Mr D had said he would never marry again, as the very thought of permanence or commitment as represented by a marriage certificate somehow frightened him. But he did feel a need for limited friendship by way of a female companion. If he and L split up, Mr D was anxious as to how he would find another girlfriend, because he lacked the confidence to attend the usual places where people meet.

As his social phobia decreased his confidence grew, and five months after he started therapy, he announced he had met someone new. The lady was a 42-year-old divorcee, called J. They met at the local club through mutual married friends and seemed to "hit it off straight away." J had invited Mr D back to her place and even initiated lovemaking. Mr D said he was surprised by her directness, how the roles seemed to be reversed, and it did not feel wrong. "I felt better with this experience than on other occasions. Am I a wimp, do I want to be dominated or looked after, or am I effeminate in some way?"

In the succeeding months the relationship with J has grown and Mr D has seen less and less of L. His delight in talking about J has been quite evident and was epitomised by his rhetorical question or statement — "I think I'm in love!" Mr D and J are currently talking about perhaps living together. Mr D's self-described premature ejaculation seems to have become irrelevant. "J's approach to sex is so different, I've never had anything like it before!"

The third issue was linked to the first. Psychodynamically, Mr D's phobia must have originated in some earlier experience and Mr D had openly questioned this himself. At one session about seven months after therapy started, Mr D arrived, sat down and said: "I wonder what I'll talk about today?" I waited silently for several minutes, and then Mr D said:

My mother. Our relationship has never been very brilliant. I last saw her about four years ago and we didn't part on very good terms. Haven't spoken to her since. She's always been tight. When mates have gotten married, their parents helped out. My mother did nothing. There was this incident over money. She said she wouldn't be buying my son any more Christmas presents because he was too old! She's already stopped on my daughter two years ago. So I let myself go, and told her how money had always meant more to her than anything else. Told her not to leave me anything in her will. I didn't want it!

Mr D was quiet for a while after this but then went on, almost talking to himself: "There's never been any affection between my mother and me . . . she's getting on. Wonder if I should extend the olive branch . . . but I know what she'll think. That I'm after her money! She's worth a few bob, but I'm not after it."

I closed this session with an offer to explore this relationship between Mr D and his mother further, in hypnosis, if he wished. He decided to do it three weeks later.

We used the Spiegel eye roll and Mr D went immediately to his "special place," his sanctuary, which was a small pool near a larger lake. He used his code words "at peace" to intensify his relaxed state. I also decided to deepen his trance because I anticipated using age regression to track back what had happened with his mother. I used a progressive muscle relaxation deepening and asked Mr D to use ideomotor signalling to tell me when he felt ready.

I suggested that 40-year-old Mr D could give 16-year-old Mr D some of his newly gained confidence and knowledge of life so that he could talk with his mother, to ask her why the relationship changed. A very definite "no" came from the finger signals! Sixteen-year-old Mr D did not want to ask mother the reason why.

When I asked what was the reason for avoiding asking mother for an answer I received a verbal reply from Mr D, still in trance: "There is no answer!"

"Your unconscious knows the answer."

"I knew she never wanted me. I was just an embarrassment."

"So you've felt rejected all your life?"

At this stage Mr D cried quite openly but silently for several moments.

"My grandmother loved me."

"Wasn't it enough?"

"When I was nine it was, but then my mother took me away from grandmother, and I knew she didn't want me, and didn't know why she had to."

"Were you able to find out?"

"No, not for sure."

"So you lost your grandmother. Did you ever see her again?"

"Yes, just for eight months and then we came to Australia."

"Would you like to see your grandmother again?"

"No."

Another quite long pause followed before Mr D continued.

"I guess I always knew it, that she didn't want me. That day I went to court, she didn't come. My stepfather, he came, and we never even got on. I knew that day she didn't want me."

I felt at this stage that Mr D had probably done as much as he could for the session and offered the suggestion that grown up Mr D could go back and comfort young Mr D on that particular day.

The fingers signalled "no."

I said a verbal reply was okay.

"There's nothing to say."

"There's no need for words, a hug, an arm around the shoulder, he'll understand."

There was silence and after a few more moments I suggested that Mr D return to his special place again by coming forward in time after saying goodbye to young Mr D. Mr D did not say much before leaving the appointment.

He took up what happened at the next appointment but without using hypnosis: "It broke my heart to leave my grandmother. To get on that bus and it drove past her doorway where she was standing. And my mother said: 'For Christ sake, shut that up or you'll upset me!'"

Mr D spent the rest of the session talking about his mother in a very cathartic way. He said he had tried to remember one good experience but there was not even one. Mr D expressed considerable feelings of deprivation and lack of affection before the session ended.

It was obvious that Mr D had not yet finished with his mother.

The fourth problem was Mr D's symptom that is an example par excellence of a social phobia, namely his inability to urinate in a public toilet.

I decided that the Bandler (1985) theatre technique was a good choice for dealing with this and we spent one session doing it. Since that one session Mr D has reported virtually no problems micturating in public urinals. He said he "forced" himself but he was actually doing it. Whatever made the change in his behaviour, Mr D is no longer quite so phobic about a natural function.

FINAL COMMENTS

Mr D was a good example of a problem which was initially difficult to diagnose, but one which became clearer after several interviews had been conducted. As it was, the diagnosis reached proved to be in two categories, although they had some common features.

The management and progress also demonstrated how psychotherapy and hypnotherapy can merge at times almost imperceptibly for the practitioner/therapist. It illustrated the importance of having the background training before embarking on a treatment program.

Mr D has still considerable therapeutic work to do before he will be rid of most if not all of his underlying conflicts. The aetiologies of phobias and avoidant personality share some common factors. Mr D has not yet reached or worked through the manifestations implied by those commonalities.

I believe his relationship with his mother is the crux of his problem(s), especially as it appears to have given rise to both of his postulated psychological difficulties and has, it seems, until very recently interfered with his relationships with the more intimate women in his life. The management goals have been more or less reached. Mr D no longer finds it impossible to relieve himself

when having to use public facilities. He is more able to enjoy himself at social functions and is less self-critical about how he appears in public. The fact that he has a new lady friend and apparently a very satisfying relationship is probably more than instrumental in his overall improvement. But then he might not have been able to find her had he not already improved with the therapy.

Pleasingly, medication was not required at all in this case.

IN RETROSPECT

When Mr D first presented, I had my doubts as to whether I had anything therapeutically useful to offer him. His complaints were so general that I at first thought he must have a personality disorder, the main feature of which was a large chip on the shoulder.

Fortunately, initial impressions can be, and often are, wrong. It is salutary to note the need to keep and maintain an open mind at all times. Sometimes making the diagnosis may be hard but, once made, it is still important not to stop thinking.

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While not specifically cited in the text of this case study, the following book was also found useful during Mr D's therapy:

- Kaplan, H. I., & Sadock, B. J. (Eds.) (1989). *Comprehensive textbook of psychiatry* (5th ed.). Baltimore: Williams & Wilkins.

CASE NOTES, TECHNIQUES, AND ANECDOTES

This section of the journal is a forum to which readers are invited to contribute brief items drawn from their own experience. These may be vignettes of case situations, unusual or ingenious devices and techniques, or simply thought-provoking experiences.

Correspondence regarding these items is also invited.

A BRIEF, UNINTENTIONAL, AND THOUGHT- PROVOKING HYPNOTIC EXPERIENCE

Thomas Paterson

One of my medical colleagues described an intriguing event that occurred to him when visiting the Rundle Mall shopping area in Adelaide.

There has been a lot of publicity in Adelaide over the past few years about the redevelopment of one of our large Australia-wide department stores. The result is an imposing modern store which has as its entrance a multi-level shopping arcade of specialty shops. These are at the periphery of the foyer, while the main area is full of walkways and interconnecting escalators and elevators providing access to the shoppers. At the top of the foyer is a fun park, the feature of which is a dazzling rollercoaster. The whole area receives piped music, as well as the overlay of noise that inevitably arises from a fun park.

My colleague was in this entrance foyer on the third or fourth floor, accompanied by his wife. He remembers feeling irritated by the noise about him. The next thing he recalls is being in the Mall outside the building, complaining of a slight headache.

His medical history is of hypertension, which is treated by Enalapril. There is no previous history of psychiatric illness.

His wife reported that on this occasion he suddenly seemed to go blank and spontaneously, with no regard at all for her, proceeded, in a very aggressive way, to go down several flights of escalators to the ground floor part of the entrance foyer, and from there out of the building and into the Mall.

At this time he quickly seemed to regain his composure, albeit with the slight headache already mentioned. He had, however, no recollection of the events of the previous few minutes. They curtailed their shopping trip and returned home, by which time he was feeling completely well again.

After discussion with him the following day, I began to wonder about what might have happened to him.

It seems probable that he was in an altered state of consciousness and, if we use the definition which says that hypnosis is an "altered state of consciousness where sensory input is processed in a different way," then it would seem possible that he had been in a state of hypnosis.

When I visited the site of his experience, I was impressed by two separate things: First, the very high and, indeed, at times irritating, level of ambient noise; second, the extremely interesting and yet confusing light and lines and angles that are made by the crisscrossing of the escalators and structural supports of the complex.

I suggest that the combination of these two factors created a confusional state and led to an indirect and spontaneous induction into hypnosis.

This in itself would be of no more than passing interest were it not for the fact that, if this is indeed what occurred, then my colleague was an unwitting subject. It may be that he is not the only person to whom this has occurred or will occur.

Because this random, unwitting self-induction was not anticipated by my colleague, it may be possible that a person with a fragile personality, or a very depressed person, may also be susceptible to a similar hypnotic experience. If such a person were to simply duplicate the escape down the escalators, as did my colleague, then there would again be no major issue. However, this is a very highly exposed site, which provides the wherewithal for a person intent on suicidal actualisation, or for a person with paranoid or other delusional thinking with the same end-goal, to actually complete the task, with grave consequences to them and possibly to others below.

This whole direction of thinking possibly has implications for town planners and architects in the design of buildings.

It is reminiscent of the effect of strobe lights on pre-epileptic patients, where a grand mal fit can be precipitated by the effect of the lighting. The potential consequences of architecturally induced hypnosis are grave.

Perhaps, as therapists in the field of hypnosis, we should be aware of these potentials. Maybe we should bring them to the attention of those who design? It is indeed food for thought.

SAUNABULISM

David W. Henty

Does a sauna create an altered state of consciousness and hence the heightened suggestibility associated with hypnosis?

Before going too far in sharing some experiences at our local health club where I enjoy the relaxation from a swim, spa, and sauna, I need to point out that our set-up is quite legitimate. (When sharing the following with some Sydney colleagues, their thoughts were of Kings Cross type venues.)

Conversations in which I become involved in the male-only sauna tend to be often what could be called "without due professional regard." Having shed my clothes, I also like to shed my professionalism (debriefing/no briefs); thus sometimes I give voice to "psychological" comments without giving them much thought. Therefore the two cases I now share are offered "without prejudice."

Case 1

During one sauna session, a young man involved in muscle-building got around to telling me about his social anxiety, especially with the opposite sex. My personal belief was that he had realised that there was more to it than developing the body beautiful. My suggestion was that he have a couple of drinks prior to any "chatting up" opportunities.

In our next sauna session a week later he told me: "I did what you told me to do."

Questioning revealed that my suggestion had been successfully acted upon. My wonderment related to the fact that he had acted so directly, as if there had been a state of hypnosis induced from the heat of the sauna, and hence heightened suggestibility. For me the therapy was too simplistic for such not to have an explanation for its success.¹

Case 2

This case involves a man, in his early thirties perhaps, whom I had never met before. As we lay chatting he brought up the subject that he was a smoker.

This subject will usually arouse a strong negative response from me as a sauna counsellor, and as a person.

An investigation of his smoking revealed that it was the only evidence left of behaviour related to his recent marriage and divorce. Smoking had been a behaviour they both had shared. My somewhat flippant analysis of his behaviour was that, at an unconscious level, he really did not want to give up his wife. The cigarette packet would remind him of her presence, while sexually there was the cigarette in his mouth to remind him of their oral activities. The man in the sauna responded in an angry manner by leaving me in peace, alone.

A couple of weeks later I again met this man at the same location. He reported he had given up smoking as a result of thinking over what I had said about his subconscious needs for his ex-wife. In fact he strongly denied those needs!

Once again I was left to ponder over the behaviour change resulting from such a simplistic analysis. The question I therefore raise is this: do the heat and relaxation of the sauna in effect produce a trance-like state similar to hypnosis, and if so, then is that the reason why my suggestions were so acceptable?

Move aside Wendy-Louise Walker, because I may have found a rival to music as an hypnotic induction technique.

- ¹ The young man with his social anxiety ended up with two choices for a girlfriend, one pregnant from another liaison and the other not. His dilemma then became one of how to handle this situation and my counselling skills took on a more professional tone.

BOOK REVIEW

Clinical Self-Hypnosis: The Power of Words and Images. Shirley Sanders. New York/London: The Guilford Press. 1991. ix + 224. \$4.95.

This book is a must for any clinicians who wish to further their use of hypnosis in the clinical situation by the addition of a large range of self-hypnosis skills. It is also a must for anyone in the field of research in the area of hypnosis and particularly clinical self-hypnosis. The book is impeccable in a scholarly sense, yet written in a style which is entertaining and enjoyable to read.

The book is divided into four major sections. The Introduction covers a definition of clinical self-hypnosis and how it can be used in practice, plus a comprehensive historical overview of self-hypnosis and its psychological and sociocultural roots. The second section, on theory and research in self-hypnosis, is scholarly and thorough. The third part covers diagnostic evaluation of the need for self-hypnosis and applications across a wide range of clinical situations. Among these are included a variety of fresh and expanded approaches to pain management, a fascinating section on psychosomatic disorders, a section on children and self-hypnosis, and finally a section for the professional therapist describing ways of using self-hypnosis to relax, to deal with tiredness and possible burn-out, to re-energise and enhance creativity. In this section the author offers scripts for the therapist. There is even a small section on dog obedience and how self-hypnosis in the owner of the dog can be transferred by affect and tone of voice to the dog so that the two can make a more effective team in competitions of dog obedience. The book concludes with a short summary and future directions for research in this area where there is still a paucity of research.

Sanders defines clinical self-hypnosis as part of an overall treatment program rather than a simple self-help technique. She proposes that self-hypnosis is commonly first experienced as a reflexive automatic reaction to threatening situations, and that this instinctual or archetypal self-hypnosis serves as a model for further trance states that are taught, induced, or triggered by drugs. Sanders claims that the individual experiences a greater quantity of imagery and time distortion in self-hypnosis than in heterohypnosis. However, she points out that to date clinical research has tended to confound hypnosis and self-hypnosis, and for this reason it is perhaps premature to theorise about self-hypnosis as a separate entity. She uses this transformation of meaning and experience perceived by the patient and contained in his or her words or images as the major theme of her book.

Sanders gives a bird's-eye view of the work that needs to be done to clarify, understand, and use clinical self-hypnosis meaningfully. She states that most

patients learn self-hypnosis as a post-hypnotic suggestion after they have entered heterohypnosis. Vivid and absorbing case examples of the applications of self-hypnosis are offered. Sanders has an interesting approach to psychosomatic disorders. She feels that the symptoms are physical expressions where verbal language is blocked. She says therefore that frequently therapy needs to address the body language first and, after the physical symptoms have been reduced, help the patient make the translation from body language to talking about his or her feelings. Sanders structures her descriptions for various clinical applications of hypnosis in a very clear, step-wise method. As well as offering a comprehensive review of the literature on self-hypnosis, Sanders also suggests ways of conducting research into this phenomenon.

The book is to be highly recommended to all professional people interested in expanding their use of clinical hypnosis through clinical self-hypnosis, from students of hypnosis to the most experienced and seasoned of clinicians.

SUSAN BALLINGER, Randwick.



