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EDITORIAL iii

HYPNOSIS IN THE TREATMENT OF BRUXISM
Felicity Wardlaw 97

HYPNOSIS AS AN ADJUNCT THERAPY IN THE TREATMENT OF PANIC DISORDER
Anthony J. Wild 109

SPORTS IMAGERY AND HYPNOSIS: A POTENT MIX
Harry E. Stanton 119

HYPNOSIS IN THE TREATMENT OF CONVERSION HYSTERIA
Zararah Braybrooke 125

HYPNOSIS AND BREATHING TRAINING IN THE TREATMENT OF ANXIETY: THREE CASES
Tannis M. Laidlaw 137

THE RELATION OF SPONTANEOUS AMNESIA, EGO STATES, AND HIDDEN OBSERVERS TO POST-HYPNOTICALLY DISSOCIATED TASK INTERFERENCE
Victoria Farmer Douglass and John G. Watkins 147

PSYCHOTHERAPY AND HYPNOTHERAPY
William-Pitty. 153

ACCENTUATE THE POSITIVE: A DEVELOPMENT OF SPIEGEL AND SPIEGEL'S TECHNIQUE
Lorna Channon-Little 161

ELECTROPHYSIOLOGICAL CHANGES UNDER HYPNOSIS IN MULTIPLE PERSONALITY DISORDER: A TWO-CASE EXPLORATORY STUDY
Kathryn I. Cocker, Graham A. Edwards, John W. Anderson, and Russell A. Meares 165

CASE NOTES
Diane McGreal and Barry J. Evans; Norman Shum 177

BOOK REVIEWS 183

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EDITORIAL

One of my first tasks as editor of the *Australian Journal of Clinical and Experimental Hypnosis* was to review the roles of editorial board members. Under the editorship of Dr Wendy-Louise Walker, all associate editors resided in New South Wales and it was apparent to me that such an arrangement did not serve the best interests of the editorial process. This issue, therefore, sees a change in the membership of the editorial board.

Three of the previous editors have left the editorial board. They are Lorna Channon-Little, John K. Collins, and Douglas Farnill. I thank them for their services to the Journal and hope they will continue to serve the membership of our society by publishing manuscripts and book reviews in *AJCEH* and anthologies published by the Journal.

To widen the academic and clinical base of the editorial board, and to ensure input from branches of the Society, I have asked Kevin McConkey and J. Arthur Jackson to remain on the editorial board. It is my pleasure to let you know that the previous editor, Wendy-Louise Walker, has accepted my request that she become an associate editor. Wendy-Louise brings not only her considerable academic and clinical talents to the position, but her experience as an editor, and representation from the New South Wales branch. Wendy-Louise is President-Elect of ASH (1993–1995).

Three Victorian members have joined the editorial board at my request. Robb Stanley, Senior Lecturer in Behavioural Medicine, Department of Psychiatry, The University of Melbourne, took up his position as of the May 1994 edition. As you are aware, Robb is also President of ASH (1993–1995) and will shortly take up the position of Secretary-Treasurer with ISH. Greg Coman, current Treasurer of ASH, has also joined the editorial board. Greg is a research psychologist currently working for a state government funded mental health promotion project. The third new Victorian editor is Graham Scott, a dentist working in private practice in Melbourne.

With the appointment of these new associate editors, I believe the Journal has an appropriate mix of academic and clinical professionals, drawn from the three disciplines which comprise the Society's membership. I look forward to working with them to promote the educational activities of the Journal and the Australian Society of Hypnosis.

I also wish to welcome to the editorial board our new editorial assistant Ms June Simmons. June has quietly taken over the role of typing, copyproofing, book-keeping, and liaison with the usual calm efficiency she displays in her role as Victorian Branch Administrative Assistant.

Barry J. Evans
Monash University
November 1994

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HYPNOSIS IN THE TREATMENT OF BRUXISM

Felicity Wardlaw
Dentist

This is the case of a 40-year-old woman, who had been attending our dental practice for nine years. She was experiencing jaw and facial pain, associated with night bruxing which seemed to be related to stresses at work and a forthcoming holiday. A combined approach, using an occlusal night splint and hypnosis for relaxation and awareness, was used to control the bruxing and hence the symptoms. She was also encouraged to continue with the practice of yoga meditation and exercises to help manage daily stress. Over a period of several months, using these approaches, she was able to recognise the warning signals and to take appropriate steps to relieve her stress-induced symptoms.

Lynne is a 40-year-old single woman, born in Australia, who currently works as a public servant. During a routine dental visit, Lynne noted she felt she was clenching and grinding her teeth at night, as she was waking in the morning with very tender jaw muscles. The tenderness decreased as the day progressed. She thought that the grinding might be related to her anxiety about a forthcoming 10-week holiday, her first overseas.

When she returned from her trip she presented again with symptoms of tenderness. She was experiencing interrupted sleep and woke with the pain. This time she thought the problem might be triggered by work, as her situation there had changed. She had been threatened with retrenchment, or the possibility of an increased workload, as other people left the office and had not been replaced. She also found that she had become bored and dissatisfied with her work since returning, as she now had the "travel bug."

HISTORY

Personal

Lynne grew up in a bayside suburb of Melbourne. After finishing secondary school, she worked at various clerical jobs before attending university and completing an Honours Arts degree. She passed the public service exam, after

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a period of unemployment during the last recession (1983), and was offered a temporary position with the Office of Corrections in early 1984 and is still working in that office, although in a different area. She was given permanent status after two years.

She has shared a house in inner-suburban Melbourne with two other people for the past four years.

Regular sport is not part of her lifestyle although she periodically swims and rides her bicycle. She practised yoga regularly about 10 years ago and had recently attended a refresher course in the city.

I have no knowledge of her social relationships and I did not feel it was appropriate to inquire further.

Family

Lynne's parents live in the bayside suburb the family grew up in. Her father is now retired. Family rearing was Lynne's mother's domain and she now spends more time with her husband. Lynne feels that they have aged quite a deal in the past five years. She visits them fortnightly.

Lynne's two sisters are married, have children, and live close to her parents. They see more of each other than Lynne sees of them. Lynne is not particularly fond of her nieces and nephew and generally only sees them at family celebrations.

Medical

Lynne has a long-term diagnosis of epilepsy which is well controlled by Primidone. No episodes have occurred in the nine years she has been a patient at my practice.

During 1989 she had a period of depression and was on medication for 12 months — using Prothiaden. When she presented with symptoms of bruxism she had no current depression, and was in relatively good health (except for her jaw discomfort).

Psychological Assessment/Evaluation

Lynne appeared to be of above average intelligence. There were no symptoms of the depression for which she was treated two years ago, tested for using criteria in DSM-IIIR (American Psychiatric Association [APA], 1987).

Her anxiety in the dental setting was negligible and she was quite a relaxed patient during any procedure. She showed moderate anxiety (8 out of 10 on an analogue scale), prior to her overseas trip. She also showed moderate anxiety about her work environment on returning from her trip.

Dental

Lynne has regularly attended my dental practice for the past nine years. She has had extensive restorative and endodontic treatment and periodontal maintenance, both prior to and during that period.

Although not anxious about dental treatment, Lynne had, in the past, mentioned a revulsion at the thought of wearing full dentures. Both her parents wear full dentures, which might be a motivating factor for her regular attendance. She has not been reliable in her appointment keeping, although she has improved over time.

I had noted over the years that she showed signs of occlusal wear on her posterior teeth and that might have been an indication of bruxing (grinding or clenching). As there were no symptoms of jaw discomfort and she never remembered experiencing any, no treatment was deemed necessary other than to make her aware that grinding might have occurred.

DIAGNOSIS

Lynne was experiencing pain and discomfort in the muscles of her jaw. The pain was probably due to the increased muscle tension that had built up from abnormally strong forces of night bruxing. It is most probable that triggering factors might be a combination of both psychological stresses and occlusal interferences.

TREATMENT GOALS

The primary goal was to relieve Lynne's jaw pain and discomfort, allowing her uninterrupted sleep and improved functioning during the day. The most likely cause of pain was her nocturnal bruxing, so a treatment aim was the elimination or reduction in its occurrence to a non-destructive level. It was also a goal to help the patient reinstitute a subconscious control mechanism to regulate and decrease joint muscle activity, not only during the day but also while asleep.

TREATMENT RATIONALE

As bruxism is caused by both psychic and local occlusal factors, treatment should include the elimination of both. However, since both psychic tension and a local trigger factor have to be present to initiate bruxing, this dysfunctional habit can be eliminated by either psychic or local occlusal therapy.

Faulkner (1990) noted that many and varied treatments have been advocated for the treatment of bruxism. These include psychotherapy and the use of occlusal appliances to free the occlusion or to increase vertical dimension. Occlusal rehabilitation is possible but it is a more radical procedure and, in the dentate patient, is irreversible. Muscle relaxation, exercises, massage of the masseter muscles, drug therapy, biofeedback, and acupuncture have also been used.

Ramfjord and Ash (1983) have also recommended the use of autosuggestion, hypnosis, massed practice relaxation training, and physiotherapy as treatment modalities.

It was decided, in Lynne's treatment, to use a combination approach that addressed both psychic and occlusal trigger factors.

To alleviate any acute pain, I prescribed a muscle relaxant called Mersyndol. This was to be used at night as the patient required. An occlusal flat plane splint was made to be worn at night and local adjustment of occlusal interferences was made.

I also gave her conscious awareness exercises of tooth contact to be practised at times of greater stress and this awareness was reinforced with the use of hypnosis to access her unconscious. Hypnosis was used to reduce anxiety by body relaxation and also specifically to relax the muscles of the jaw — a phenomenon mentioned by Gerschman, Reade, and Burrows (1988) and Rose and Fitzgerald (1989).

Other stress-reducing activities, such as listening to classical music, allowing a quiet time to herself, and yoga were encouraged.

CHRONOLOGY OF TREATMENT

Pre-Treatment Sessions

At a routine dental visit, Lynne incidentally noted that she felt she was clenching and grinding her teeth at night, as she was waking in the morning with very tender jaw muscles. The tenderness decreased as the day progressed. At her next visit, several weeks later, Lynne mentioned that she was anxious about going on a 10-week overseas trip in the near future. She thought that anxiety about this trip might be contributing to her night clenching.

I explained to her some of the processes that may be occurring during bruxing.

Studies have shown that bruxing occurs during REM sleep and it is thought to be a non-verbal way of talking (during dreaming), to release the tensions that may have built up during the day and are expressed in dreams (Clarke, Townsend, & Carey, 1984). It was explained that just an awareness of this sometimes decreases its occurrence.

I made a number of suggestions to possibly decrease or eliminate the bruxing. These included relaxation, mind emptying exercises, and listening to restful music before bed, to reduce the amount of stress of the day. Other treatment options were discussed, such as splint therapy, which would form a physical barrier to stop the teeth coming in contact, with or without the use of hypnosis to increase sensory awareness and allow self-control.

Lynne had not had any previous experience with hypnosis but had been practising yoga for some years. She had also experienced meditative states. She seemed receptive to the possibility of using hypnosis as a way of managing her bruxing but, as she was leaving shortly for her overseas trip, she would contact me when she returned if her jaw discomfort was still a problem.

Session 1

Lynne returned for a routine dental examination and cleaning eight months later. Some restorative work was also required.

Her jaw was still giving her problems and she expressed interest in the wearing of an occlusal night splint and the use of hypno-relaxation and awareness exercises.

She had enjoyed her holiday, not being troubled by jaw pain while away. However, she had found it difficult to settle back into the routine of work and now expressed dissatisfaction with it. The thought of unemployment kept her from resigning.

It was decided to complete the restorative work required at later appointments and then to construct a splint. She was also asked to do some awareness exercises in the time between appointments.

If she found her teeth together she was to remind herself that at no time did she ever need to have her teeth in contact unless she was eating food. She thought the saying "lips together teeth apart," which I have used with other patients, sounded silly, so I gave her an alternate suggestion. I also suggested that if she had to concentrate for any length of time at work, she was to stop after about half to three-quarters of an hour and clench and release her teeth five times and to notice how the muscles of her jaw could relax.

Session 2

Routine restorative dental treatment was performed, her occlusion assessed for interferences, and impressions were taken for the occlusal night splint.

Lynne reported that she did not remember to do the exercises all that often, and that her jaw was particularly tender. A muscle relaxant (Mersyndol) was prescribed for the pain at night — half a tablet if required, with the warning that it would probably make her quite drowsy.

Session 3

The occlusal night splint was fitted and occlusal adjustments were made to ensure no interferences and a cuspid guided occlusion in lateral excursions. The over-extension of the disto-palatal margin was reduced, which made it more tolerable for the patient to wear. She did not seem particularly enthusiastic about wearing the splint, but knew it would help. As mentioned previously, she had expressed revulsion at the thought of wearing dentures or having foreign objects in her mouth, which might be a problem with the wearing of the splint.

Care instructions for use of the splint were given: keeping it in water while not wearing it so as to avoid distortional dehydration of the acrylic; cleaning it with soap and a very soft brush; and soaking it in a medicated mouthwash once a week. Lynne was asked to wear it every night.

Lynne had not used the Mersyndol prescribed as she did not think it was necessary.

The Stanford Hypnotic Clinical Scale (Morgan & Hilgard, 1979) was given, on which Lynne scored 4, so I considered her a likely good subject for hypnosis.

Lynne commented afterwards that she had been to yoga on the previous evening, so found it very easy to enter trance (which she certainly seemed to).

She also commented that she was not aware of how much time had passed and that she felt alert and aware, and very relaxed after coming out of trance. She felt that she had particularly good imagery and was able to easily imagine a place she could be comfortable and relaxed in. Her suggestion for such a place might be at the beach or in the surf, swimming. She also liked the suggestion of listening to classical music.

An audiotape was not made of this session as it was intended to design an individually relevant hypnosis session for Lynne to deal with her specific needs. Once this was done it could be used by Lynne to reinforce our sessions by practising at home.

Session 4

This visit was to review Lynne's progress with her occlusal night splint and her first therapeutic hypnosis session.

Lynne found the splint "okay," but was taking a while to get used to it. Her jaw was much better in the mornings. However, the previous night she was grinding and woke in pain. She explained this may have been due to the fact that her house had been broken into the day before in broad daylight. She had become more generally anxious.

She also dreamt that she broke the splint by grinding and had to pick it out piece by piece.

For the hypnosis part of the appointment, Lynne was asked to lie back in the chair and allow herself to be as comfortable as she could. I then suggested she might like to close her eyes (which she did). She was then invited to listen to my voice:

> I would like you to listen to what I say and let that be a guide for you. You may find at times you drift away and are unaware of all I say, but then part of you will be aware, your subconscious will take note of what you need to know and understand. You may also notice sounds or noises, outside; the traffic — cars, trams, fire engines, ambulances, or inside; the phone, doorbell, people talking, the air-conditioner. All of them can become a part of the background of your awareness. If you hear a ring it may be a signal to deepen your experience of relaxation.

Lynne was then asked to focus on her breathing, narrowing her focus, suggesting the breathing in of comfort and out of tension. A progressive relaxation/ sensory awareness script was used to induce and deepen the trance, with particular emphasis on the relaxation of her jaw muscles and allowing her teeth to rest comfortably apart. It was also suggested that, as her body relaxed, her mind had relaxed too.

Classical baroque music was playing and Lynne was invited to further her experience of relaxation by listening to it in a special way, as had been suggested by Walker (1992). This deepening was further enhanced by her imagining that she was at a special place, the beach, as we had discussed at the previous session.

A modified script for the treatment of bruxism was derived from those suggested in Hammond's (1990) *Handbook of Hypnotic Suggestions and Metaphors*. It was suggested that whenever she felt herself clenching or grinding or even tightening her jaw muscles she would want to open her mouth slightly, enough to place her tongue between her teeth. This would allow the muscles to become loose and relaxed. Suggestions for subconscious protective mechanisms were also made.

As she had seemed a little apprehensive about wearing the splint, I reinforced the notion that it was a positive appliance and that even though it felt strange at first it would become more and more comfortable, possibly to the extent that she was not aware that it was in place, but was a part of her.

The music was again referred to, deepening her sense of relaxation and allowing her subconscious or conscious mind to reinforce what she needed to learn and understand. Lynne was lightened by counting from 10 to 1, after I had reinforced her sense of well-being and suggested she return all sensations to normal, becoming as alert and aware as she needed to be.

Lynne commented that she felt quite relaxed and "good," although her jaw was still a little tender from the previous night but not as bad as when she came in. I was not particularly trying to alleviate that discomfort.

She had been practising yoga in between her dental appointments and generally felt it was helping her to relax.

Session 5

This session was scheduled as a check for the occlusal splint and for recording the hypnosis content on an audio-tape for Lynne's home use.

Lynne reported that she did not go to yoga this week as she was too busy at work. She had not been wearing the splint every night, but when she wore it her jaw was comfortable and she was able to sleep through the night. When not wearing the splint, she woke, being aware that she was grinding her teeth. This continued to cause interrupted sleep and tenderness in her jaw in the morning. She reported that she dreamt she ate the splint.

An audio-tape was made using a similar induction, deepening, imagery, and suggestions similar to those of the last visit.

A classical tape was playing in the background, allowing incidental noises to become a part of the background of her awareness. Induction of the trance state was achieved by focusing on breathing and a progressive relaxation/ sensory awareness (jaws and mouth emphasis). The trance was deepened with beach-scene imagery and listening to the music in a special way to further the experience of relaxation. Suggestions of subconscious vigilant awareness of possible damage and harm prevention and a post-hypnotic suggestion that the splint will, surprisingly, become part of the self were made.

Instructions as to how Lynne was to use the tape were given while she was in trance. It was suggested that if she was listening to the tape at a quiet time, after which she needed to be alert and aware, she would regain

that state and retain a sense of relaxation and well-being, after being counted out from 10 to 1. If, however, she was listening to the tape just before sleep and wished to drift off to a deep relaxing sleep, she would do so. The counting out may be a signal to enter a deeply relaxing sleep state or she might find that the click of the tape finishing was that trigger. She was then counted out from 10 to 1.

After the hypnosis session Lynne reported she felt very relaxed and that she was feeling very comfortable. She said that her jaw was also quite comfortable.

Lynne was asked to listen to the tape every night for the first week and then every alternate night after that until she felt she did not need to. A review appointment was scheduled for a month's time. Lynne cancelled this review appointment, but attended the rescheduled one a few weeks later.

Session 6

Lynne reported that she used the taped hypnosis initially about every second day, but then found it hard to find time to listen to it. She also commented that she never seemed to get to the end, as she fell asleep.

She said that she was able to wear the splint much more easily now, being hardly aware that it was in. She confessed that she had not been wearing the splint all that much, except in the last few days, when she remembered that she had this appointment. She reported that she had been sleeping through the night and that her jaw was tender on very few occasions. She was still attending yoga classes and had a change in responsibility at work, which made it less boring. She also seemed much happier in herself.

It was decided at this time to assess any further occlusal interferences that might be a potential future trigger, but nothing of significance was noted.

Lynne was instructed that it might not be necessary to wear the splint all the time but at times she recognised were potentially stressful.

It was decided we would review her at her periodic six-monthly maintenance visit, but if she had any problems before that time she would contact me.

OUTCOME

By using a combination of splint therapy, hypno-relaxation, and other stress reducing activities, Lynne was now able to control her bruxing and hence relieve the symptoms that had prompted her to seek treatment. It cannot be conclusively known that the bruxing has been totally eliminated. It seems to be controlled to a manageable level so she does not experience pain and discomfort from her jaw.

DISCUSSION

Bruxism can be defined as the grinding or clenching of teeth at times other than for functional purposes (Faulkner, 1990). It is considered to be a component

of the syndrome known a temporomandibular joint (TMJ) dysfunction (Ramfjord, 1961). Stressful grinding of the teeth is frequently associated with pain that varies from slight morning discomfort of musculature to intense soreness of the teeth and severe pain of the TMJ and muscles of the face.

Chronic clenching of the jaws and grinding of the teeth can cause not only abrasion and fracture of the teeth, but chronic dislocations of the mandible (Solberg, Flint, & Branter, 1972). The muscle tension associated with bruxism can be related to headaches, earaches, tenderness of masticatory muscles, and painful spasms in such musculature as the sternocleidomastoid, temporalis, and frontalis muscle groups.

The relationship between personality or emotional states and bruxism has been previously documented (Graf, 1969; Gross & Vacchiano, 1973; Rugh, 1983; Schwartz, 1974; Solberg et al., 1972). Theorists from the psychoanalytic tradition have hypothesised that bruxism is an unconscious manifestation of repressed oral aggression (Pond, 1968; Walsh, 1965) and that bruxers tend to be oral-receptive and oral-aggressive individuals who attempt to gratify oral pleasures derived from their early childhood.

Modern approaches have provided both correlational and experimental evidence to support the assumption that at least a significant number of bruxers are under stress (Mercuri, Olsern, & Laskin, 1979). Ramfjord and Ash (1983) suggested that bruxism and its subsequent treatment must depend on the patient's threshold for tolerance of occlusal interferences. Depending on the patient's state of psychic stress, the same occlusal interference that acts as a very potent trigger factor for bruxism one week may not bother the patient or precipitate bruxism the next week.

Occlusal disharmony and interferences do not always cause bruxism. Almost every person has some type of occlusal interference. However, relatively few people have problems with bruxism, and these people usually encounter problems only during certain periods of their lives. No significant difference has been found in the incidence of occlusal abnormalities or deficiencies between dysfunctional patients and control subjects (Ramfjord & Ash, 1983).

Ramfjord and Ash proposed a possible mechanism for bruxism. Normally, nociceptive reflexes establish a pattern for avoiding occlusal interferences during jaw movements, but, during bruxism, occlusal interferences are sought out for bruxing contact and with much greater force than for normal mastication. In other words, the injury from bruxism is self- inflicted in spite of the protective reflex system.

This dysfunctional activity is still not completely understood. It appears that the inhibitory effect of nociceptive reflex inputs may be overcome by an overriding central nervous system (CNS) control and may also be influenced by certain peripheral inputs. Furthermore, a CNS excitory state (stress versus relaxation) might determine the overall balance between inhibition and excitation beyond the influence from the reticular peripheral reflex system, and thus have a dominant influence on bruxism.

Lynne showed signs of previous bruxing although she could not remember experiencing symptoms prior to this episode. It is quite common for bruxers not to be aware that they are grinding as they are unconscious or asleep at the time. A better history may be obtained by questioning the patient's family or spouse, or by having the patient ask them and report back to you (Ramfjord & Ash, 1983).

In formulating a treatment strategy for bruxism, consideration of both the psychological and occlusal components must occur.

As a dentist, I did not feel qualified to explore too deeply into her psychological problems, but was able to address the generalised aspects of her anxiety. This was done by making her aware of possible causative factors and helping her to use strategies to reduce their effect. Hypno-relaxation allowed Lynne to reduce her anxiety levels both physically and mentally (Clarke & Jackson, 1983).

Lynne was made aware of possible times when the bruxing may occur, such as times of increased stress or concentration during the day, or while dreaming when asleep.

During the day she was asked to identify these times and say to herself that she never needed to have her teeth in contact unless she was eating. She was also given exercises of clench/releases to do in short breaks during a period of long concentration so that she could physically feel the muscles relax.

Hypnosis was used to activate an unconscious awareness of teeth bruxing during sleep, allowing her to interrupt the cycle and prevent the damaging tension occurring. It was also used in a general way to allow Lynne to relax, both after sessions and at home with self-hypnosis, or with an audio-tape of the surgery session.

The maxillary occlusal splint acted as a passive appliance to interrupt the bruxing (Somer, 1991; Ramfjord & Ash, 1983).

The combination of this regime allowed Lynne to recognise the possible trigger factors, such as increased stress at work, and take the appropriate conscious action to relieve TMJ muscle tension. At night the splint acted passively to prevent contact and, with the adjunct of post-hypnotic suggestions of subconscious vigilance, prevented the muscle tension occurring. The overall effect reduced her symptoms to a manageable level.

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HYPNOSIS AS AN ADJUNCT IN THE TREATMENT OF PANIC DISORDER

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Rachel was a 36-year-old married mother of four children (aged 18, 5, 3, and 2) who lived with her husband and three younger children in rented Housing Commission accommodation in an outer Brisbane suburb. She was referred by her general practitioner with a two-week history of recurrence of spontaneous panic attacks. She had been seen as an outpatient for over three months at the time of writing this history.

PRESENTING COMPLAINT

Rachel described how, two weeks previously, she had been in Sydney looking after her mother who was suffering from a severe viral infection and how she was woken up at 11 a.m. from a catnap by her three-year-old daughter. She described feeling extremely anxious, within a short time progressing to having difficulty speaking and breathing, being markedly tremulous, with hot and cold flushes, sweating, and a fear that she was going to die or go insane. This attack was followed by several others over the next four days and in the fortnight prior to presentation there had been a total of six attacks, with marked anxiety between them. Rachel described waking up from sleep the night before presentation and having a full-blown panic attack which lasted for about half an hour.

Over the last two weeks there was some associated agoraphobic avoidance with current inability to tolerate her usual visits to shopping centres, and inability to drive alone, due to anxiety. Furthermore, Rachel had begun to feel anxious in social situations, something which was not normally a problem for her, and she had cancelled various social engagements, including visiting friends, attending a wedding and going on a short cruise with her husband.

There was no associated depressive symptomatology other than a mild dysphoria regarding her anxiety attacks. There was no suicidal ideation or major neurovegetative disturbance. Stressors at the time of presentation included:

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1. mother's severe viral illness and visit to her mother in Sydney at the time of onset of panic attacks;
2. having three young children in the household;
3. husband lost his job four months ago and had been particularly verbally aggressive lately; and
4. physical illness — Rachel was suffering from bronchitis at the time.

HISTORY

Psychiatric

Rachel had a history of panic disorder dating back to the age of 20 when she developed severe spontaneous panic attacks. They settled well with phenelzine and relaxation and breathing exercises over a three-month period. She had no persistent generalised anxiety symptoms or agoraphobic or social avoidance symptoms after the spontaneous panic attacks settled.

Rachel had a short recurrence of panic attacks three years ago (aged 33) in the first few days following the birth of her second-youngest child. There did not seem to be any associated depressive symptomatology at the time and the attacks settled spontaneously with only the occasional prescription of oxazepam at the time by her general practitioner.

The patient had no other psychiatric history, including no past history of suicidal behaviour.

Family

The patient had a family history of a sister with panic disorder who was said to be oxazepam addicted. She also had a history of a maternal aunt who was said to have had a "nervous breakdown." There is no other family history of psychiatric illness, including no family history of suicide or alcoholism.

Medical

Rachel had a past medical history of pregnancy-induced hypertension as well as surgery for recurrent dislocation of her right shoulder and a laparoscopy (results unremarkable) for pelvic pain two years before.

Rachel had been taking oxazepam 15–30 mg per day for two weeks, prescribed by her general practitioner. She reported that these had settled neither her panic attacks nor her levels of anxiety. She was also concerned about becoming addicted to this medication. Rachel had no known allergies. She was a non-smoker and drank alcohol only occasionally, but she was drinking up to eight cups of coffee a day. She denied illicit drug abuse.

Personal

Rachel was born in Sydney, the fourth of five children, and her mother had a normal pregnancy and birth with her. Rachel had normal milestones and was an average student at school, leaving aged 15. Thereafter she worked as a nursing aide in a nursing home until she fell pregnant aged 16. Rachel

had a good relationship with her mother who was caring, strict, and very religious. Rachel's father died when she was two years old and she said this was a "hang-up" in her life. She missed her father when she was a child and said that no-one could replace him. Her mother remarried when she was 26 but she had little to do with her stepfather.

Rachel brought her first child up with the help of her mother until moving in with an alcoholic man seven years her senior, when she was 18. She lived with him for 10 years and he was verbally abusive and physically violent at times.

Rachel had been in her current relationship for seven years and had three young children from this relationship, aged five, three, and two. Her husband was a truck driver who had recently lost his job. There had been increased stress at home since he had become unemployed. Rachel's personality was described as generally quiet and passive and slightly anxious. However, she was not usually avoidant of leaving the home or mixing in social situations. She described some chronic dissatisfaction in her relationships with men, including with her current partner.

MENTAL STATE EXAMINATION

Mental state examination was unremarkable except for mild depression and mild anxiety at interview. There was no evidence of psychotic phenomena or cognitive impairment. Rachel presented as a woman of average intelligence who was reasonably insightful and cooperative.

The diagnosis, using criteria in DSM-IIIR (American Psychiatric Association [APA], 1987) was as follows

Axis I	Panic disorder with agoraphobia (recurrence after three-year remission)
Axis II	No diagnosis
Axis III	(1) Mild acute bronchitis (2) Excess caffeine intake
Axis IV	Moderate enduring psychosocial stressors (three young children in the household); Moderate acute psychosocial stressors (recent unemployment of husband, and visit to ill mother in Sydney)
Axis V	Current Global Assessment of Functioning: 55 (moderate symptoms and impairment).

DIAGNOSTIC FORMULATION

Rachel was suffering from her third episode, since the age of 20, of panic disorder with spontaneous onset, associated with some secondary agoraphobic and social avoidance. The family history of panic disorder, and the spontaneous onset of the disorder without proximity to severe psychosocial stressors, supported the hypothesis that Rachel had a significant genetic disposition to panic disorder. Other relevant factors to the aetiology of Rachel's panic disorder

included the recent overall high levels of stress in her household, including her husband's unemployment and the stress of raising three demanding children.

A relevant psychological factor in the precipitation of Rachel's current episode may have been her reaction to the illness of her mother. It can be speculated that the illness in Rachel's mother, although not life-threatening, reactivated in Rachel similar anxiety to that which had been experienced following her father's death when she was only two years old.

OVERALL MANAGEMENT AND COURSE

Rachel was commenced on dothiepin, 25 mg tablets, initially one at night, increasing by one tablet every two days until remission was produced. She required an increase up to 150 mg nocte before there was any remission in her panic attacks or inter-attack anxiety symptoms. Rachel was also advised to cease caffeine intake and to recommence slow-breathing exercises during periods of increased anxiety in order to promote relaxation as well as distract her from her anxiety and prevent hyperventilation. A full blood count was checked for anaemia and thyroid function tests were checked for hyperthyroidism. Also a multiple biochemical analysis was checked to make sure there was no evidence of diabetes or dysfunction of major organs such as the liver, kidneys, or parathyroid glands. Results were normal. To facilitate the settling of Rachel's spontaneous panic attacks and inter-attack anxiety, hypnosis was employed at an early stage. She was seen twice weekly initially and hypnosis was employed on her third session.

GOALS OF HYPNOTIC TREATMENT

Karle and Boys (1987) provide a good description of the rationale for the use of hypnotherapy in the treatment of panic attacks. They point out that sometimes panic attacks can have their origin in some unresolved conflict from childhood which re-emerges in adult life in response to some life stress, crisis, or other weakening condition which has reduced the patient's self-confidence, self-esteem, physical health or general physical and emotional stability. This description seems to apply well to Rachel's condition.

Karles and Boys go on to say that the earlier conflict or distress is reactivated when the patient's personal strength is at a low ebb and that, once several severe panic attacks have occurred, anticipatory anxiety and conditioned phobic anxiety to associated stimuli (in this case agoraphobic and social phobic components) then set in. The patient then becomes fearful and apprehensive about her next attack and the tension may overload her coping capacity, generating more symptoms. Karle and Boys describe how to interrupt this pattern of anticipatory anxiety and conditioned phobic anxiety by conditioned relaxation using hypnosis.

As Wolpe (1958) describes, in his treatise on "reciprocal inhibition," anxiety and tension cannot co-exist with relaxation and peace of mind. Thus, if

relaxation can be induced in the anxious individual, the co-existent anxiety can be reduced.

In Rachel, my goal was to induce a deep state of relaxation and thereby reduce her overall levels of physiological arousal as well as her levels of anticipatory and conditioned phobic anxiety via the technique of reciprocal inhibition. It was further planned to re-evoke conditioned anxiety-provoking situations in the trance-like state and, via reciprocal inhibition, undertake a systematic imaginal desensitisation of various social, agoraphobic, and anticipatory anxiety situations. Since the patient also lacked a sense of self-esteem and self-efficacy, ego-strengthening techniques were added with some specific suggestions to enhance self-esteem. No attempt was made at this stage to carry out any hypno-analytic uncovering. For example, it was not seen as a priority in this case to attempt age regression back to the age of two when the patient lost her father through death, although this would have been an interesting possibility to pursue in the future if other treatment techniques were not working.

Hypnosis was seen as an adjunct to facilitate relaxation and the behavioural management of the patient's panic disorder, to be carried out in conjunction with pharmacological treatment with the anti-panic agent dothiepin.

ASSESSMENT FOR HYPNOSIS

Rachel was assessed in her first hypnotic session (third treatment session) using the Stanford Hypnotic Clinical Scale (Morgan & Hilgard, 1979). Rachel was found to score relatively highly on this scale, scoring 4 out of 5 and only missing the item on post-hypnotic suggestion.

In the next session I carried out my standard induction and deepening technique and similarly observed Rachel to be moderately to highly hypnotisable. In my own induction and deepening technique I start off with eye-fixation, followed by suggested eyelid heaviness and closure. I then proceed to suggest sensations of relaxation, heaviness, and gravitational pull on the feet, legs, buttocks and back, as well as relaxation of the muscles of the neck and lower jaw. I then progress to relaxation of the shoulders, arms, and hands. Suggestions for relaxation and heaviness of the hands and feet are made and then suggestions for right-arm lightness attached to a helium-filled red balloon attached by a string to the right wrist are made. The consequent arm levitation is carried out and, following this, deepening is achieved by concentration on slow-breathing exercises with each breath out being associated with the word "relax." Further deepening is achieved by imagining passing through a wooden door and down a staircase with 10 steps to a relaxing place which the patient is asked to visualise. Rachel followed these tasks well, being able to produce arm levitation easily. Following a review of her experiences at the end of the second hypnotic session, she was able to visualise her relaxing place very easily and achieve quite a profound state of relaxation. She was able to summon

up vivid imagery of the relaxing place and, on my suggestion, to see a trustworthy figure giving her relaxing advice on my suggestion.

There is no doubt that hypnosis is applicable to the treatment of panic disorder. As Burrows (1980) notes, the commonest clinical application of hypnosis is in the treatment of anxiety and related state. As Hammond (1990) notes, simply the process of induction and deepening generally relieves anxiety. I have already made reference to the work of Karle and Boys (1987), whose techniques I used as a guide for my approach to the treatment of Rachel's anxiety. There is also plenty of literature suggesting the applicability of hypnosis to enhancing self-esteem in patients who suffer from low self-esteem. Rachel certainly falls into this category. Techniques for enhancing confidence, such as those described by Waxman (1989) and that described by Barber (1990), were also employed as guides in Rachel's treatment, particularly in the ego-strengthening part.

SPECIFIC HYPNOTIC TECHNIQUES CHOSEN

Hypnotic relaxation, ego-strengthening (with particular emphasis on enhancement of self- esteem) and imaginal desensitisation of conditioned phobic situations were the main hypnotic techniques employed in the treatment of Rachel.

PROCESS OF HYPNOTIC TREATMENT

The patient's hypnotic treatment had already begun in the first and second "assessment" (trial induction) sessions since these themselves induced states of significant relaxation. The general form of the induction and deepening involved eye-fixation, progressive muscle relaxation, arm levitation, control of breathing, walking down steps and arriving in a relaxing place (as described above). Ego-strengthening was employed in the first hypnotic suggestion following the two initial assessment sessions, and this proceeded along the lines of enhancing the patient's sense of confidence, strength, and capacity to handle the events of the day once she woke up. Specifically, the capacity to handle her children, her husband, and her worries about her mother's health were introduced into the ego-strengthening techniques. Also amongst the ego-strengthening work, specific suggestions for raising self-esteem were included. These involved emphasising the manifest and potential positive characteristics of the patient, including what she had achieved so far in her life, the difficulties she had overcome, the people she had helped, her capacity for empathy and love of other people, and her kindness. It was emphasised that although the patient had had doubts about her self-esteem in the past, it was now clear that she had many strengths and that as each day passed she would feel more and more confident in the fact that she was a good, kind, loving and lovable person.

The patient was also asked to visualise her relaxing place and to speak to an imaginary figure in that relaxing place. It was suggested that the imaginary

figure told her that she had the confidence to carry out her daily tasks and that she was a valuable, strong, and confident person. The imaginary being also suggested to Rachel that she would become more and more in touch with her own sense of inner strength such that, although naturally she had fears about her mother's health, she would be able to be strong and supportive to her mother and to continue on in strength despite her mother's illness.

During the fifth to eighth hypnotic sessions (still being carried out at half-weekly intervals) the patient was taken through hierarchies of agoraphobic, social phobic, and anticipatory anxiety and assisted to relax during progressive steps down these imaginal hierarchies. These hierarchies were generated with the patient prior to the hypnosis sessions proper and she was able to proceed rapidly down each hierarchy given the very deep levels of relaxation and the increased sense of self-confidence she was building. Behaviour rehearsal was included wherein the patient imagined herself in several previously anxiety-provoking situations, handling them confidently and calmly, with a sense of inner strength and peace.

The first hypnotic session after the two initial "assessment" sessions was recorded on cassette and the patient was given this cassette to practise relaxation between sessions. Time was devoted during some of the treatment sessions to practising rapid induction into self-hypnosis whenever the patient began to feel anxious. This was done via eye-fixation, eye-rolling, progressive relaxation, feeling arm lightness, and feeling a rapid descent to the relaxing place. The patient reported that she was able to learn this self-hypnotic technique and put it into practice effectively whenever she felt an upswing in her anxiety.

OUTCOME

The patient had no further major spontaneous panic attacks after the first week of treatment with the combined hypnosis and dothiepin approach, but it took about three weeks before her overall levels of anticipatory agoraphobic and social phobic anxiety were substantially resolving. After three weeks the patient reported that she had began to drive her car by herself again and had begun to attend all social outings as she had before. She described an increase in her self-confidence and ability to cope with life and a renewed confidence in managing her children, dealing with her husband's unemployment, and helping her mother recuperate from her illness.

Rachel was treated with a total of eight hypnotic sessions and now mainly practises hypnosis at home with the aid of either the cassette tape I have made for her or self-hypnotic techniques. She practised these techniques twice daily initially and now practises them at least daily. She now attends for check-up once every four weeks and appears to be maintaining her improvement fairly free of panic attacks and inter-attack anxiety. Rachel appears to have returned to her premorbid level of functioning at this stage.

DISCUSSION

Since the literature on the aetiology and management of anxiety disorders is wide-ranging and embraces biological, psychological, and social approaches, it would appear useful to elucidate the underlying conceptualisation used in the treatment of Rachel.

My conceptualisation of panic disorder follows that of the influential work of Donald Klein (1981), who sees the *spontaneous and sudden* severe anxiety of the *panic attack* as the cornerstone of panic disorder. The second feature is *anticipatory anxiety*, which arises in anticipation of another panic attack. The third feature is *phobic avoidance*, which happens when one begins to avoid situations in which an attack has occurred in the past or where help does not seem to be readily available if a further panic attack strikes. Klein's conceptualisation has been very influential in the psychiatric literature and indeed was a major force behind DSM-IIIR (APA, 1987) reconceptualising agoraphobia as generally secondary to panic disorder rather than the other way around.

The origin of spontaneous panic attacks themselves has been described in both biological and psychological terms. There is good research evidence that some patients are born with a disposition to panic disorder which may involve an excess susceptibility to firing of the locus ceruleus in the brain stem (Gorman, Liebowitz, Fyer, & Stein, 1989). Others talk of the increased prevalence of traumatic early life events in patients with panic attacks (Faravelli, Webb, Ambonetti, Fonnesu, & Sessarego, 1985). Some have suggested that panic attacks often represent recurrences of unresolved childhood conflicts which re-emerge in adult life when under stress or in some sort of weakened condition or crisis. In their succinct and useful description of the origin and treatment of anxiety disorders with hypnotherapy, Karle and Boys (1987) subscribe to the theory of panic attacks as often reflecting some earlier childhood trauma which is reactivated later in life in times of stress, crisis, or weakness. They note that once a spontaneous panic attack recurs, the secondary anticipatory and phobic anxiety components can be set-up. Applying these conceptualisations to the treatment of Rachel, my first objective was to interrupt the spontaneous panic attacks. I therefore saw medication as an important part of this process. There is good evidence (Gorman et al., 1989) that tricyclic antidepressants interrupt the excess firing of the locus ceruleus when a patient is suffering spontaneous panic attacks. If this can be arrested with the medication, then often the anticipatory and conditioned phobic anxiety will also settle down. However, it is also well known that often medication alone is not enough to relieve spontaneous panic attacks. Hence my use of hypnosis to reduce the patient's level of arousal and increase her capacity to cope with stress so that the chance of having another spontaneous panic attack was further lessened.

To hasten the resolution of the secondary anticipatory anxiety and phobic symptoms, which can sometimes perpetuate the disorder even when the primary spontaneous attacks have been settled, I employed hypnosis. By producing

profound relaxation and linking this to hierarchies of anticipatory, agoraphobic, and social phobic situations, I was able to speed up the resolution of anxiety associated with these situations via reciprocal inhibition. The relaxation produced by hypnosis was paired with the anxiety of the anticipatory, agoraphobic, and social phobic situations. The two were incompatible, leading to a rapid reduction in the anxiety symptoms.

It is interesting to speculate whether, if the patient's anxiety symptoms recur despite the current treatment, it might be useful to try to age regress the patient to a stage in her life where she suffered childhood trauma. An obvious place to look would be at the age of two, at the time of her father's death or shortly thereafter. It would be interesting to see whether resolving any underlying conflicts about this traumatic separation would help reduce the patient's spontaneous panic attacks, irrespective of the fact that she also probably has a biological disposition to panic disorder. If such work was undertaken this would represent an "uncovering" approach to anxiety, much along hypno-analysis lines, as opposed to the biological, relaxation via trance, and behavioural approach taken in the management of this case so far.

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SPORTS IMAGERY AND HYPNOSIS: A POTENT MIX

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After emphasising the importance of the first treatment session, this article outlines the link between mental imagery and athletic performance. Particular attention is drawn to the enhancing effect of coupling hypnosis with imagery. A single-session treatment is described embodying relaxation, suggestion, and imagery — three elements characteristic of a hypnotherapeutic approach. The specific procedures used in the session are described together with brief case studies of a golfer, a cricketer, and a lawn bowler. These studies illustrate the power of the single-session treatment in the improvement of athletic performance.

MENTAL IMAGERY AND ATHLETIC PERFORMANCE

When clients are athletes wishing to improve their performance, mental imagery is likely to be one of the more effective ways of providing such help. Bandura (1986) has explained the contribution which visualisation makes to performance in the following way: 'When people visualize themselves performing an activity, they exhibit muscle electro-myographic changes in the same muscle groups that would have been activated had they actually performed the responses' (p. 61). That is, it would appear that, whether a neural pattern is triggered by a physical act or a mental act, the same message is transmitted to the muscles which react in the same way. As Liggett and Hamada (1993) have said:

> When the mind images a performance, impulses are sent to the appropriate muscles. These impulses are similar enough to the impulses in the actual performance that the athlete's gains from visualization parallel those from an actual practice . . . Visualization triggers and strengthens the brain-to-muscle neural connections of the final performance. (p. 191)

Support for such a view comes from Suinn (1976), who reported anecdotally that gold-medal skier Jean-Claude Killy, when preparing for a race, was unable on one occasion to practise on the slopes due to an injury. Instead of

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physical practice, he used imagery, mentally "seeing" himself performing at his very best. According to Killy, the race turned out to be one of his most successful.

Liggett and Hamada (1993) accepted the great value of imagery and believe that hypnosis may be used as a means of increasing its effectiveness. This is due to the athlete finding it easier, in a hypnotic trance, to concentrate attention more completely on the visualisation because distractions, both internal and external, tend to be minimised. A second benefit involves increased ability for the mental rehearsal of a sequence of actions to be slow enough to assure perfect form. For most athletes, and this is a third advantage of using the hypnotic state to enhance imagery, their imaginings are usually more vivid under these conditions.

One further advantage of hypnotic imagery for competitive athletes lies in their enhanced ability to more convincingly visualise performing in an actual competition. The emotional pressures generated by the real event are able to be experienced together with mental and physical reactions. This feeling of being in the event appears to be much more vivid with hypnosis than during visualisation without hypnosis, due to the increased intensity of the former. Mentally rehearsing actual competition in this way can help athletes to ready themselves psychologically for competition.

This is particularly true when such mental rehearsal includes a positive outcome. Woolfork, Parrish, and Murphy (1985) demonstrated the power of positive imagery in their study of the effect of imagery instructions on the simple motor skill accuracy task of putting a golf ball. Subjects in the positive imagery condition reported that "seeing" the putt go in the cup increased their expectations of success while subjects in the negative imagery condition indicated that their image of failure, that of just missing the cup, tended to erode self-confidence.

Such reports could be anticipated based on Bandura's (1986) self-efficacy theory: 'having people visualize themselves executing activities skillfully raises their perceived efficacy that they will be able to perform better. Such boosts of self-efficacy are likely to improve performance by reducing self-doubts and by enlisting the effort needed to do well' (Bandura, p. 62). This concept of mental imagery so relevant to the field of sports psychology may be embedded effectively within the framework of a single hypnotherapeutic session. The approach is one that combines relaxation, suggestion, and mental imagery — three elements which have been used in the definition of hypnosis (Stanton, 1982). The specific manner in which these elements might be used to enhance the performance of athletes is detailed below.

Relaxation

The session usually commences with the induction of a relaxed state. Many techniques are available to help people attain such a state but one of the simplest, and most effective, is to guide athletes into finding, within themselves, an area of comfort into which they can relax. As they do so, they can allow each breath to take away tension and strain (Rossi, 1986).

Suggestion

Once a state of relaxation has been created, suggestion is likely to be accepted more easily (Erickson, Rossi, & Rossi, 1976). Emphasising the idea that athletes have great inner resources of mind and body which they have not yet tapped creates a state of readiness for positive suggestion, this being the Ericksonian notion of people having within themselves everything they need. Such suggestion tends to be more effective when both visual and verbal elements are combined. Thus suggestion and imagery merge at this time. A particularly powerful metaphor using this combination is that of the inner strength (McNeal & Frederick, 1993) which focuses on helping athletes feel that they have within themselves the power to enhance their sporting performance.

This technique invites athletes to journey within themselves to the very centre of their beings, finding there a part of themselves termed their inner strength. They identify the images, feelings, thoughts, and/or body sensations associated with being in touch with this part of themselves. It is suggested to athletes that, in future, when they wish to contact their inner strength, they may evoke those same images, thoughts, feelings, and/or body sensations and, by so doing, will feel totally confident that within themselves they have all the resources they really need to achieve their goals.

To this technique I add the suggestion that athletes might like to deliberately use a specific cue, such as clenching the dominant hand into a fist, to strengthen the association. Once they can tap into this inner power, I suggest that every time they use the technique they will strengthen the linkage between their cue and their inner strength, evoking an ever-increasing confidence in its power to help them achieve their desired outcomes.

They also "remake the day" by thinking back over practice sessions and competition. First, they think of things they have done well, reliving these in imagination several times, praising themselves, and enjoying the situations. Second, they think of things which have not gone well. One at a time these are wiped out of the mind, athletes replaying each one several times the way they wish they had handled the particular situation involved. Thus, they make each performance successful, enjoying a stream of positive images which embody this success.

Age Progression or Success Imagery

Havens (1986) has defined age progression as a process by which the client is projected into the future, pointing out that: "once people have envisioned a pathway into a desirable future and have imagined themselves carrying out the necessary steps, there is a remarkable tendency to actually respond to events in a manner consistent with these outcomes."

It was this process that Erickson (1954) used when he introduced the crystal ball as a vehicle through which clients could project themselves into the future. From his experiments with patients using the crystal ball technique, he con-

cluded that it was possible for hypnotic subjects to imagine themselves attaining positive therapeutic goals that were attainable and realistic at some future date.

Age progression is, then, a very goal-directed form of hypnotherapy in which clients are encouraged to imagine both a future free of their problems and the specific steps which enabled them to attain this outcome. By so doing, they build positive expectations for the future, leave behind the effects of negative past experiences, and create self-fulfilling prophecies for themselves. In the words of Walt Disney: "If you can dream it, you can do it."

Emphasis upon ego-strengthening is an integral part of most successful age progressions although, as a stand-alone treatment, ego-strengthening suggestions are very effective in helping people improve the quality of their lives (Hartland, 1965; Kluft, 1983; Stanton, 1989). Torem's (1992) "back from the future" technique is an excellent example of the way in which age progression and ego enhancement may be fruitfully combined.

Initially Torem helps patients decide on a desirable future image, one with which they could be comfortable as representing a better life. In a hypnotic trance, they "time travel" to a specific time in the future which is made as realistic as possible through suggestions utilising all the senses. Ego strengthening is used to encourage positive thinking and a sense of accomplishment in coping with life's stresses. Clients store these positive feelings, images, and sense of accomplishment, which are to be considered as special gifts they bring "back from the future" into the present, gifts which will guide them both consciously and subconsciously in their journey of healing and recovery. In this way, the future is experienced as the present with a future image of successful living being internalised in a scene associated with a sense of joy, pride, and self-mastery. Such an approach has obvious application to improved athletic performance. Three cases selected at random demonstrate the possibilities of the single-session treatment modality.

John, the Golfer

John, a 37-year-old amateur golfer, had one treatment session along the lines suggested above. In the relaxed state, he accessed his inner strength, "remade" his last practice session and the tournament he had played the previous weekend, and used age-progression success imagery to prepare himself for his next tournament. This he did by creating a "success videotape" of all the very best shots he had played throughout his career. Through mental imagery, he "saw" himself hitting these one after another, then he "saw" himself playing the same succession of excellent shots in his next tournament which was to take place three days after his treatment session.

John did extremely well in this next tournament but his success was not limited to this single performance. Over the three months preceding treatment, he played 24 18-hole rounds in various competitions, his average score being 84. For the 21 18-hole rounds that John played over the next three months, his average score was 75. A one-year follow-up found his average score to

be 72, reflecting a maintenance of the initial improvement. John had continued using the techniques learnt in the single session and felt no need for further treatment. One session had met his needs.

Gary, the Cricketer

Gary, a 24-year-old opening batsman for his local club, also believed that the single session was all he required. His average score for 10 innings prior to treatment was 31. For the 10 innings which took place after the one session treatment, his average score was 47. A one-year follow-up found Gary's batting average to be 58, indicating he had improved further.

As with John, Gary had continued to make use of the techniques taught to him in the single session. In particular, he embraced the success videotape concept very enthusiastically, employing it as his basic method of mental match preparation. However, for maximum effectiveness, he needed to follow the pattern of the session, relaxing into the comfort and letting go the breath before attempting to use his success imagery.

Jane, the Lawn Bowler

For Jane, a 63-year-old A-pennant lawn bowler, it was the inner strength metaphor which struck a responsive chord. She was totally convinced that, whenever she was under pressure in a match, if she clenched her fist she would be able to tap into an inner power which would help her perform at her best.

Her record confirmed her belief. Over the year previous to her treatment session, she won seven singles matches out of 18 played, a win percentage of 39%. However, in the year after treatment her record was 13 wins out of 22 matches played, a win percentage of 59%. Even more gratifying was the further improvement noted over the next three years for, at the end of this period, her win percentage was 72%.

CONCLUSION

These are not isolated cases. They are typical of the results athletes gain from a single-session treatment conducted along the lines explained earlier. As would be expected, not every athlete benefits, and not every athlete who does show initial improvement is able to maintain that improvement. However, most athletes are not only able to record improvement comparable to that quoted above but, on a number of occasions, far exceed it.

The three elements of relaxation, suggestion, and imagery would seem to provide a very potent mixture enabling athletes to fulfill their potential more successfully. Many variations on these elements are possible but the reasonably straightforward approach described in this article does seem to work very well. Athletes enjoy their session, demonstrate considerable improvement immediately afterwards, and appear able to apply the techniques to ensure further improvement.

Such improvement is not limited to the sporting arena alone. Because of the straightforward nature of the techniques covered in the single session, athletes are able to make use of them to more effectively cope with everyday life. The concepts of relaxation, inner strength, remaking the day, and age-progression success imagery are all easily transferable to a wide range of situations and, as an additional benefit, are easily taught to family members. This was a point often made by the athletes during the follow-up contact through which I checked on their progress.

Due to its reliance on relaxation, suggestion, and imagery, I have referred to the single-session approach as hypnotherapeutic, but such a definition is not really of great importance. What is of importance is that this simple one-session treatment does seem capable of eliciting considerable improvement in the performance of athletes. It would seem worthy of wider usage.

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HYPNOSIS IN THE TREATMENT OF CONVERSION HYSTERIA

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This case study illustrates the use of a psychodynamic approach to the treatment of a client with conversion hysteria, with hypnosis as an adjunct. The client sought treatment for recurrent spontaneous dislocation of his shoulders which occurred while he was asleep. Using hypnosis in conjunction with other forms of psychotherapy, his unconscious conflicts were reached through dreams, automatic writing, and drawing.

CASE HISTORY

Mr K, a 26-year-old man, came to see me with a request to help him with his self-esteem problem. He was accompanied by his sports coach, who reported that Mr K had the potential to be a national champion in a self-defence sport. He could not understand why Mr K did not perform to the best of his ability. At training, Mr K performed better in the presence of his coach than when he was by himself.

Two years earlier, Mr K had nearly become the state champion. More recently, in another contest, he refused to fight at the very last minute. His coach reported that in the last six months Mr K had difficulty concentrating or meditating, and reported a great sense of inferiority. The coach suspected that it was to do with Mr K's upbringing. Mr K's vagueness and absent-mindedness were detrimental, not only to his performance, but also when he was teaching other students. He could not remember the names of students, nor could he demonstrate techniques adequately to the class.

Mr K is the youngest in a family of three children. His older brother is a homosexual and his sister is married. He said that his relationship with his parents is superficial. His mother, an emotional woman, verbally abused him as a child. His father, a retired executive, had always been emotionally distant from him. Both parents were always pushing Mr K and his brother

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to compete in swimming competitions. His brother became the state champion in swimming, at which point his parents tried to talk Mr K out of participating in the same sport. He took up self-defence courses when he was 13 years old. Since that time, he had remained determined to become a champion, with or without his parents' help and emotional support.

Four years prior to the present therapy sessions, Mr K had seen me several times for confidence building, prior to his state championship exams. Following an injury to his nose during the competition, he had developed a fear of failure, particularly in relation to competitions.

When I saw him again, at the start of our present therapy, Mr K was very withdrawn and had no memory of me or of my clinic. He reported that, while asleep, he had spontaneously dislocated his right shoulder three times and his left shoulder once. He had been treated with acupuncture by a medical practitioner and had also been treated by a chiropractor and a shoulder specialist. He had not been using the upper part of his body during the last six months. It had been suggested that he should undergo surgery to tighten the ligaments in his right shoulder. He reported the doctors did not know the cause of his spontaneous shoulder dislocation, which occurred in his sleep, but they had hypothesised that it could be epilepsy that caused the dislocation, although there was no firm evidence of this.

On presentation, Mr K appeared vague, dazed, confused, withdrawn, and frightened. In this first session, I interviewed him in the presence of his coach. Mr K looked very vague, quiet, and his eyes had a fixed look about them. He looked distant or detached. I reassured him that I was not ignoring him but I needed to ask his coach a few questions before the latter left the room. Mr K answered me in a timid and faded voice. After I finished interviewing his coach I reassured Mr K that he would be safe with me. There was nothing to be fearful about because I was there to help him.

The rapport building was not too difficult because I already knew him from his earlier visits. He could recognise my voice, although he couldn't remember my name or my clinic. In order to allay his anxiety, I clarified the myths of hypnosis by drawing the distinction between stage and clinical hypnosis. I reassured him that I would not make a fool of him or humiliate him. I then obtained his consent to use hypnosis as an adjunct to psychotherapy.

Mr K's main concern was the dislocation of his right shoulder and he was curious to find out the cause of this. I indicated that hypnosis may be useful to find out the cause or causes of its recurrence. The goal of therapy then was to give Mr K the emotional support he needed while undergoing therapy. I informed him that it would be a long-term therapy, since his complaint was indeed a complex one. We agreed that the aim of therapy was to explore the cause or causes of his injury. Mr K's goals were to build his self-confidence and concentration so he could resume training.

My provisional diagnoses were:

1. conversion hysteria;
2. low self-esteem;
3. lack of concentration;
4. anxiety;
5. chronic depression; and
6. insomnia.

The therapeutic sessions lasted for nine months. What follows is a description of the use made of hypnotherapy as an adjunct to my treatment of Mr K.

TREATMENT: FIRST PHASE

Sessions 1 and 2

The first phase of treatment comprised investigation of his problem, building rapport, assessment of suggestibility and hypnotisability, and ego-strengthening. During the first session Mr K was so vague that I wondered how I would be able to treat him. I remembered from his earlier therapy that he was a keen hypnotic subject. To allay his anxiety I gave him a progressive relaxation exercise and took him to a medium depth of trance with ego-strengthening post-hypnotic suggestions (Hammond, 1990). My goal was to help Mr K to focus inwards and encourage him to do self-hypnosis at home.

In trance, I told him: "Your shoulders are relaxing . . . feeling easy . . . as you relax more and more . . . The deeper you relax the more you enjoy the state of calmness and tranquillity. Tonight when you go to sleep you will sleep a deep natural slumber waking up in the morning feeling satisfied with your sleep . . ."

Mr K felt relaxed when he opened his eyes and was keen to embark on his therapeutic journey. Because he was familiar with meditation I reminded him to practise it at home in between sessions. The ego-strengthening was repeated in the second session while I continued to interview him and assess his non-verbal and verbal processes.

Session 3

In the third session, Mr K was less anxious, although he was still very quiet and subdued. The absence of critical thinking was evident. I decided to assess his hypnotic susceptibility using Spiegel's Hypnotic Induction Profile (Spiegel, 1973).

Using Spiegel's personality matrix, Mr K scored between Grades 3 and 4, suggesting that he suffered from depression, anxiety, and character disorder. The latter is characterised by personality traits such as stubbornness and rebelliousness. According to Spiegel, the HIP assessment is reliable with its measurement for hypnotisability. Any variance in the actual experience for hypnosis may be due to interpersonal interaction between the therapist and the client.

This assessment was consistent with Mr K's presenting symptoms: He was highly anxious, depressed, rebellious, and stubborn in nature. Further exploration of his attitudes towards his parents and authority figures suggested that

he resented those who forced him to do anything that he did not want to do. In the clinical situation, for example, he would not comply with homework tasks, although he might have agreed to do these.

Session 4

In this session, Mr K recalled an anxiety dream, which showed his ambivalence towards winning sports competitions. In the dream, he won a competition and collected a large financial reward. He did not know to whom to give the money, his coach or the school. After discussing the dream, Mr K admitted that he was ambivalent about fighting his coach in a contest in case he beat him. This worried him, as it would provide a significant loss of face for his coach.

Mr K's sense of confidence was boosted with visualisation under hypnosis. I asked him to visualise that he was a tiger, then an eagle. This was implemented after he told me he had two big posters, one of a tiger and the other of an eagle. He said he absorbed the powers of these animals by looking at them. Under hypnosis, and using his own words to describe the qualities he would like, I asked him to visualise himself as a tiger. The following post-hypnotic suggestions were given: "See yourself like the tiger, very tough, very strong, very adaptable, very graceful, as you approach your opponent . . ."

Session 5

In the fifth session, Mr K was anxious because he was going to be hospitalised for an operation on his right shoulder. The operation was to repair his torn ligaments and to insert a pin to immobilise the loosely floating ligaments. He was worried about complications that might interfere with his training, as he was keen to return to full training. During this session, we talked about the forthcoming operation. At the conscious level, I reassured him that the operation would stabilise his right shoulder and that he could use meditation or self-hypnosis to speed his recovery before and during hospitalisation. This would give him not only a sense of calmness and tranquillity but would also deeply relax all the muscles, particularly around the right shoulder joint, to make them malleable for the orthopaedic surgeon to operate. Using a modified version of Hammond's (1990) preoperative hypnotic script, I repeated the concepts outlined above.

Using a progressive relaxation induction technique, I emphasised that his muscles were totally relaxed, his right shoulder joint feeling loose and limp and his whole body completely relaxed. The post-hypnotic suggestions were given in a directive manner, to avoid any vagueness in the message that he would benefit from the operation. This was necessary because he had some doubts about the usefulness of the operation.

> When you go to hospital . . . you will feel so relaxed . . . so calm knowing you are going to get your right shoulder fixed. The night before the operation you will sleep soundly . . . any medication for sleeping will help you even further . . . sleeping soundly . . . ready for the operation . . . feeling relaxed

> . . . so relaxed . . . so safe . . . so secure. In the hospital bed you will continue to feel calm and relaxed . . . feeling drowsy while waiting for your premedication just before the operation. You will hear the relevant things said by the nurses and doctors and still remain relaxed. Deep down, your inner mind knows that you can trust the surgeons to operate on you, the anaesthetist to look after you . . . maintaining a deep relaxed state throughout the operation. You will be in the good hands of the expert . . . who will mend that right shoulder. When you lie on the operating table your right shoulder will continue to stay loose and limp . . . and ready for the operation. No fears . . . no anxiety . . . simply enjoying the rest while the surgeon will fix your right shoulder. All the nurses, and other staff will be there to support you in every way. When you wake up from the operation you will feel as if you have slept for so long . . . Any pain in your right shoulder will be bearable because you will have had a good rest while under anaesthetic. In no time you surprise yourself because you feel such a relief to have that shoulder back to normal. You are looking forward to using your shoulder in training again. When you get back to the recovery room you will feel calm and peaceful.

Mr K informed me in the next session that his operation was a success. He was determined to speed up his recovery by continuing with the therapy and build his confidence about his future.

In this session, I assessed further Mr K's personality characteristics. His scores on the Clinical Assessment Questionnaire (CAQ), Form A, suggested that Mr K was highly insecure, self-sufficient, conforming, controlled and above average intelligence. These traits were confirmed with his scores on the Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975). These showed that he was emotionally inhibited, liked to please others, and was rigid with his thinking. The rigidity in his thinking was evident in his uncritical acceptance of his coach — his coach was never wrong in his perception.

SECOND PHASE: INTEGRATIVE THERAPY

The second phase of therapy took 23 sessions. During this period, the hypnotic interventions were directly or indirectly geared to reach the unconscious to find the cause or causes of his sense of low self-esteem and the recurrence of his dislocated right shoulder. The therapeutic relationship was positive and Mr K's motivation was still high. In some sessions, we explored Mr K's fears and anxiety by free association. Insight therapy using object-relation theory (Klein, 1988; Winnicot, 1985) was used in conjunction with such hypnotic interventions as age regression, automatic writing, coupling techniques and some cognitive behavioural approaches.

Session 6

My clinical observations showed that Mr K appeared very tense most of the time and he reported that he was so. For this reason, I discussed age-regression

techniques with him, suggesting that they might be helpful to get some insights to his problems and in so doing, release some of his tension. For the purpose of this report, I will highlight the findings of the significant regression exercises that shed light on his miseries. Mr K reported that he had discussed the possibility of a competition against his coach in that week. This occurred after he had gained some confidence as a result of having assimilated the power of the tiger in previous sessions under hypnosis. His diplomatic confrontation with his coach (as in the graceful attack of the tiger spirit in him) validated my hypothesis that he had a fear of success rather than a fear of failure.

In response to my appeal to Mr K's unconscious mind to let his conscious mind know about his difficulties, Mr K revealed two dreams. In the first, he reported dreaming he was like a ghost. He said he couldn't believe that no one saw him. He felt intrigued and then disappointed. The second dream showed his anxiety about his father paying for the cost of his operation. This dream was based on an anxiety dream about his hospitalisation. The first dream related to his sense of worthlessness, the core of his problem.

Then Mr K revealed that his brother, Jim, had sexually abused him when he was 14 years old. The first time, his brother asked him to masturbate for him. Mr K agreed to a regression technique to relive the traumatic experience. After achieving a deep level of hypnosis, as indicated by his ideomotor finger response when he counted from 1 to 60, Mr K was ready to work under deep trance. Mr K was very angry with his brother and verbalised: "I don't like this . . . I am angry with you . . . I am angry with you, Jim . . . It's wrong . . . leave me alone." Then he said he saw Jim leaving. At this point in this deep level of hypnosis, I gave therapy. I gave the post-hypnotic suggestion: "The past is the past. From now on you will feel better within yourself. The past did happen and cannot be undone . . . but we can understand it and learn from it [Erickson, 1979]. Now see yourself making up with Jim, let the anger feeling fade away. As you look up into the sky you can see a lone cloud . . . see yourself drift with the cloud . . . feeling free and peaceful. When you wake up, all your senses have returned and you will continue to experience the sense of peace and security."

Session 7

In this session Mr K presented two dreams. He dreamt the first dream the night of the regression analysis with his brother. In this dream, he was in Queensland for a holiday. There he met a girl whom he had known for many years. Suddenly he was in his car speeding at 120 km/h in reverse. Then, a police car stopped him. He thought of an excuse and said that his shoulder hurt. The police didn't believe him. Just as the police started to believe him, he woke up feeling glad that it wasn't real. He remembered seeing the police lights flashing.

We discussed the possible meaning of the dream. The dream suggested that, for some reason, Mr K was resisting going forward in his progress. This

was implied in the way he manipulated the policeman in the dream. In waking life he was, in fact, manipulating reality by using his shoulders as an excuse for his own unresolved inner conflicts.

The second dream occurred the night before the seventh session. Mr K was in his flat. The local policeman was looking for someone who had done something wrong. The criminal was also there. Mr K helped the policeman put the handcuffs on the criminal and brought him to the policeman. The policeman had fallen down and Mr K helped him back on his feet. He sensed, in the dream, that it was an assault. Mr K woke up with no feelings about the dream. I offered an interpretation that the dream could mean that Mr K was then ready to confront his unresolved inner conflicts. He accepted this interpretation.

For the hypnotic dream intervention I used the "old wise man" technique in the following way with the intention that he would break some of his resistance. Starting with progressive relaxation going down 30 steps, "going down twice as deep and twice as relaxed each time" until he experienced a depth 60 times deeper than when he started. Then I asked him to indicate with his right index finger when he had reached the level.

> Now you are going on a special journey . . . by foot . . . by yourself . . . It is a long journey . . . As you go into the distance . . . you become so absorbed in the journey . . . As you walk . . . you can feel the gentle breeze on your face . . . your skin . . . feeling pleasant . . . calm . . . and free . . . You can hear the sound of the birds . . . in the bush . . . pleasant sounds . . . you can hear your favourite singing . . . I want you to really enjoy this journey.

Twenty minutes into the trance, I took him to an old but beautiful cottage on a hill to meet the wise old man:

> Now you can see a beautiful cottage on a hill . . . you have never seen this cottage before. You feel pleasantly surprised . . . you begin to feel curious . . . allow yourself to wander . . . into the cottage . . . when I count 1 to 7 . . . you find and go up the seven steps . . . still remaining curious . . . and calm . . . feel free to go inside. Now you can see a wise old man sitting on a beautiful velvet cushion. He is surrounded by beautiful colours that give you the feeling of joy of being there . . . As you approach him he stretches his hand outwards as if to reach you . . . As you get closer . . . you can see a precious stone in his right palm . . . see him closer . . . he is giving you a special gift . . . a precious stone . . . See yourself receiving this gift with joy . . . A sudden feeling of joy . . . having the gift in your hand . . . you feel easy and relaxed, firmly gripping the gift in your hand You feel so good. As you look into the precious stone . . . you begin to see its different faces . . . you examine it, turn it around with your other hand. From time to time it sparkles in the light . . . the different aspects of the stone fascinate you . . . When you wake up you continue to feel good and remember this dream as a pleasant experience. You know deep inside you that you will have the gift with you always.

Then I counted from 7 to 1 as he visualised himself going down the steps leaving the cottage. I then counted from 30 back to one, to bring him back to a fully waking state, "feeling the sense of energy returning as I count from 5 back to 1 . . . with your eyes open and fully alert at the count of 1."

After the session, he felt relaxed, calm, and good within himself.

Sessions 11 and 12

Mr K's fear of threat was highlighted in this session. One night, when he was at work, he was threatened by a trouble-maker, who claimed that he (the trouble-maker) was trained in self- defence. Mr K suddenly felt frightened. That night he dislocated his left shoulder in his sleep. He said he was screaming with pain and had to be rushed to hospital. The next session he came in to my clinic in his sports gear, feeling angry as if the treatment had gone wrong. He felt calm after explaining very carefully the antecedent event to his dislocated left shoulder. In this session I gave him post-hypnotic suggestions for ego-strengthening. This was a very important strategy to rebuild the hypnotic rapport and trust with me and in the procedure for hypnosis.

Session 13

The most penetrating aspect of this session was Mr K's reliving of a dream in which he had been attacked by, and was petrified by, a monstrous unicorn. This dream suggested a clue to his inner conflict, which I suspected was related to castration anxiety. In other words, he had a fear of threat from authority figures.

Mr K also reported he dreamt that he was near his parent's house. There were vicious wild animals around the neighbourhood. They were such a serious threat that the army had been brought in. The animals went close to his parents' house. He remembered clearly that the animals were prehistoric. I pointed out to Mr K that we could retrace the dream to meet the prehistoric animals. Reliving his dream, he could very clearly see a unicorn, which bit his left hand. The blood petrified him because the blood looked real. The unicorn had big teeth and he was scared of the teeth. His hand was bleeding but he could not feel the pain.

In a deep trance state, I asked him to ask the unicorn to leave and verbalised: "Go away . . . I don't want you . . . I don't need you."

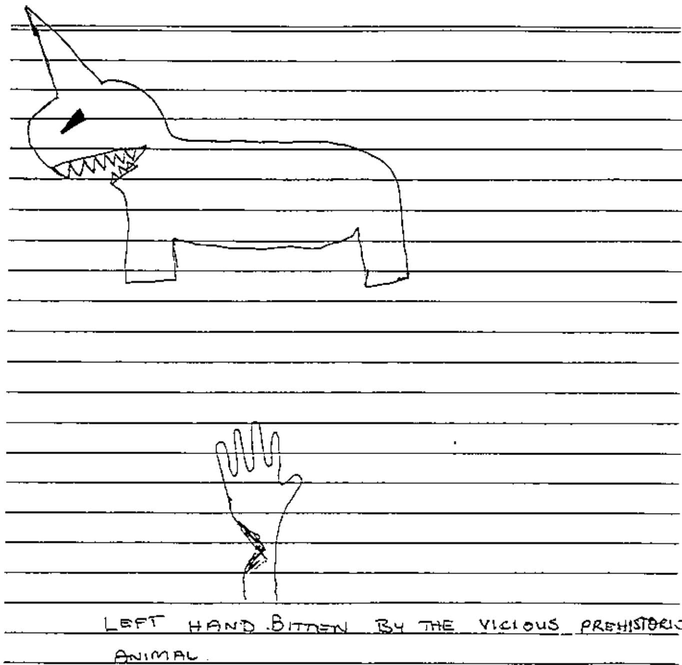
Then I gave positive ego-strengthening post-hypnotic suggestions: "Now I want you to visualise the unicorn as a friendly unicorn . . . make friends with it . . . let the unicorn protect you whenever you need protection in the future. He is now your ally . . . to protect you . . . "

When he came out of the trance I asked him to draw the unicorn (Figure 1).

The outcome of this session was positive. Mr K reported that he began to relax at social gatherings. He had been to a party and enjoyed himself. He also did not shake or feel frightened at work.

Several dreams which are not described in this report revealed Mr K's unconscious rapport with me. There were three types of dreams: (a) those

Figure 1 Drawing of Unicorn



indicative of his positive and some negative transferences; (b) those indicating his unconscious resistance to working through his inner conflicts; and (c) those that indicate break-throughs.

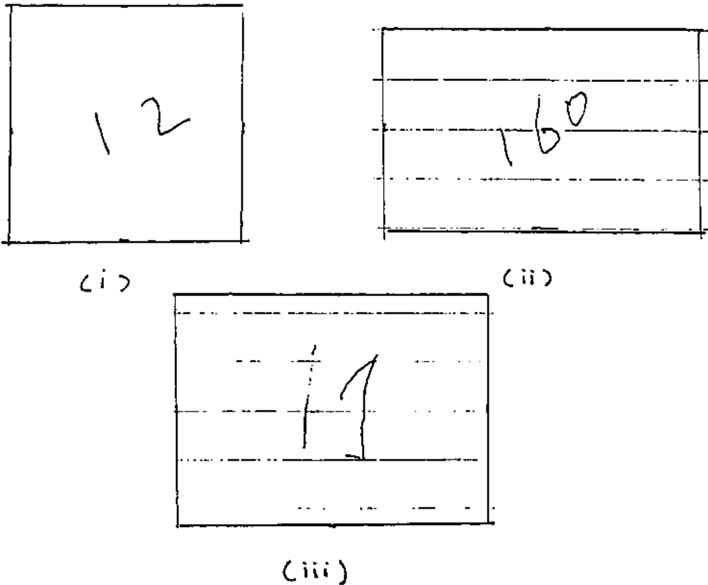
Sessions 14 to 16

In these sessions we agreed to try automatic writing exercises to see whether we could reach the unconscious mind or the hidden observer. I explained to him the hidden observer was that part of him which knew the secret of his problem. That part is highly intuitive, logical, and creative but remote or dissociated from his normal functioning.

After inducing a deep hypnotic trance by using the fractionation method and ideomotor signals to communicate with the hidden observer, Mr K produced three automatic writings which I believed to be genuine. In the first automatic writing he was asked to write a number. The result was the number "12" (see Figure 2). The numbers, if added together, make three, and, according to Freudian theory, could be interpreted as sexually based. The second automatic writing was a response to my request to write an address. He wrote the number "160" which he claimed made him feel very nervous while he was writing it. My intuitive thought was that this could be an

exaggerated version of my address, No. 16. The third automatic writing was a word written in response to my instruction to write anything on the piece of paper. The result was the letter M.

Figure 2 Automatic Writing



The automatic writing technique did, in my opinion, reveal some clues to Mr K's unconscious processes, although I could not interpret them at this stage because I thought it would threaten his trust and hypnotic rapport. However, I did want to help Mr K to interpret them, under trance, when he was ready to expose their meanings. That is, the interpretation would only be carried out whenever he was ready to do so.

THIRD PHASE

The third phase comprised five sessions. Mr K and I followed closely the continuity of his progress made through dreamwork and cognitive behavioural approach to social skills, communication exercises, and general reflection on the therapeutic processes. I also prepared him for wider reading on his personal development and interpersonal skills. He showed improvement in all areas, especially his sports training and meditation, and he became less prejudiced about people who do not have the same values as himself. At work, he felt confident when faced with trouble-makers, handling them by himself with ease. He was now able to meditate for one hour instead of 10 minutes, which was the case at the beginning of therapy, when he suffered from the lack of concentration.

Mr K reported that he dreamt while meditating that his spirit rose and left his body. He was screaming with pain because he felt he wasn't inside himself. It was a penetrating dream-like phenomenon. We talked about the dream and I left his "hidden observer" to work it through. In this, the second-last session, I did ego-strengthening to boost his confidence by reminding him that he would achieve his national championship status when he was ready for it. Meanwhile, he can use both shoulders to full capacity.

RESULTS

The therapy was a success. The criteria for success were based on Mr K's positive feelings about himself, the return of normal functioning to both his shoulders, and his ability to concentrate and meditate for two hours in preparation for his sports exam. In the last session, Mr K reported that he had dated a girl the week before and felt good in himself. He also said that he felt comfortable talking to his parents.

One month later I rang him to find out his progress. He said that he was pleased with his progress: he was busy training, preparing for two sports exams, and he was using his shoulders to full capacity. However, he had some doubt about his second exam, in which he had to stand in a most uncomfortable and awkward position for 10 minutes.

I also rang his coach, who reported he was very pleased with Mr K's progress, in that he was able to concentrate well and enjoy his training once again. He was also using his shoulders without fearing that he would dislocate them. The three months follow-up was also positive. Over the phone Mr K said that he was "feeling pretty good." There was no further need for acupuncture or massage to his shoulders. He had a relationship with a girl for three months and felt good about himself. His sexual performance was also good. He had failed that part of his sports exam which he had felt uncertain about, but reassured himself that he would pass it next year without any problems. His training had improved considerably. Finally, he said he was more determined to win the championship and hoped that to do so in the next three years.

DISCUSSION

The therapeutic process was monitored, hypothesised, and tested and therapeutic interventions were implemented with hypnosis as an adjunct to psychotherapy. Techniques such as ego-strengthening, age regression, progression techniques, memory revivication, ideomotor responses in the form of automatic writing, drawing, hypnoanalysis, and dreamwork were implemented. There were 15 dreams, three automatic writings, a drawing, and regressions. It is interesting to note that eight of the dreams recorded occurred during the second phase of therapy. The second phase required 23 of the total of 33 sessions. Depth analysis occurred mostly during this period.

My theoretical orientation was psychodynamic and the "therapeutic journey" was process-oriented. I felt that I needed to be very sensitive with every move, because Mr K would not tolerate any form of coercion, however small it might be. His stubbornness and sense of rebelliousness were evident throughout the first and second phases of treatment.

The dream analysis was interesting to monitor. Only impressions of the dreams were discussed as most of the dreams were related to the therapeutic process or directly related to his fears of threats from authority figures, either at work or at home.

Hilgard, cited in Fromm and Shor (1979), asserted that, in experimental tests of dissociation, evidenced by automatic writing, subjectively real dissociation might indeed exist with or without the interference of both conscious and unconscious processes. The interference between the two activities, one conscious, the other subconscious, is a question of degree. This is validated by Mr K's experience in the three times he produced the automatic writings. In the second writing, in particular, he felt highly anxious. We both agreed that he may find the meanings in hypnosis when he is ready or resilient enough to encounter his unconscious conflicts relevant to the automatic writing.

CONCLUSION

The success of the therapy was due to several factors. They were:

1. a good rapport between the therapist and client;
2. the client's belief and motivation that hypnosis would be a useful tool; and
3. the depth analysis, which met Mr K's expectation, in that he requested the integration of his conscious and unconscious minds. A good repertoire of techniques and theoretical knowledge of hypnosis is necessary in order to reap the full advantage of the use of hypnosis in the treatment of psychosomatic symptoms. In retrospect, I feel both Mr K and I have mutually co-operated at his level, the spiritual level, which he had requested at the beginning of his therapeutic journey.

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HYPNOSIS AND BREATHING TRAINING IN THE TREATMENT OF ANXIETY: THREE CASES

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The symptoms of panic have been linked with hyperventilation, and control of panic symptoms with control of breathing. Combining hypnosis, breathing training, and home practice with a tape-recording was successful in ameliorating symptoms for three different cases presented here. The regime is not a therapy in itself but a useful adjunct to more conventional treatment when symptoms of panic or hyperventilation are encountered. There is a possibility that it could be more generally useful in more widely variant forms of anxiety.

The combination of breathing training and hypnosis to gain control over the symptoms of panic has proved useful. The breathing pattern is one of taking one breath every five seconds (12 breaths per minute). The person establishes the pattern through frequent practice by using an audio-tape daily. An overlearnt pattern of breathing is then associated with the relaxation response. This paper looks at three cases where such a program has proved useful in symptom relief: first, simple phobia with panic symptoms; second, simple phobia with few panic symptoms; and third, anxiety-related incontinence. The use of breathing training should be considered as an adjunct to regular forms of therapeutic intervention and not a therapy in itself, albeit a useful treatment.

Panic disorder is a common complaint. Norton (1985) reported that one-third of college students had experienced a panic attack at some time. It is frequently associated with one of the simple phobias and later, in the natural course of the complaint, the development of agoraphobia. Michelson et al. (1990) argue that an effective treatment for panic disorder is a preventative for the development of agoraphobia, which affects and disables up to 5.8% of the population (Weissman & Merikangas, 1986). Panic disorder patients

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are seen frequently, not primarily by psychologists but, because of their associated health fears and stress-related disease, by medical practitioners (Sheehan, 1982). These people are also at risk in developing dependence upon alcohol or drugs, both medically prescribed and illicit, in an attempt at self-treatment (Michelson et al., 1990).

DSM-IIIR (American Psychiatric Association [APA], 1987) symptoms associated with panic disorder are those of adrenal arousal plus pCO_2 depletion: dyspnoea, palpitations, chest discomfort, choking, dizziness, feelings of unreality, paraesthesia, hot/cold flashes, sweating, faintness, trembling, and irrational or catastrophic fears. Phobic symptoms are those of situational avoidance often associated with an animal, heights, or enclosed spaces.

Recently there has been an upsurge of interest in questioning the aetiology of the symptoms, in the attempt to get a safe, non-drug treatment for this large group of distressed individuals. Klosko and Barlow (1987), cited in Michelson et al. (1990), used an interoceptive exposure procedure using the hypothesis proposed by Wolpe (1982) that the symptoms are due to a conditioning process that can be reversed. As hypnotists know, the imagination can be more powerful than reality in eliciting excessive emotion, and using an interoceptive technique is theoretically attractive. Their study compared the interoceptive technique, with 80% becoming panic-free, with in vivo exposure and a 40% panic-free rate.

The aetiology of symptoms in panic can also be explained by the cognitive model of panic (Clark, 1986) based upon cognitive theory (e.g. rational-emotive therapy). The onset of anxiety and adrenalin release, or even exercise, caffeine, or hyperventilation results in bodily sensations. Panic disorder patients perceive the sensations as noxious and the first symptoms of a catastrophic happening, for example, fainting, heart attack, or even death. These misinterpretations raise anxiety, which produces further symptoms of adrenalin arousal, and panic can result. Because of the prevalence of catastrophic thoughts, the treatment is based upon counteracting these thoughts by substituting rational explanations of the body sensations and training the patients in techniques of cognitive reappraisal.

The symptoms can also be attributed to an increase in activity of the locus ceruleus in the brain stem because of extra sensitivity of the system (Gorman, Liebowitz, Fyer, & Stein, 1989). Drugs that potentiate the release of adrenalin can cause panic attacks and adrenergic antagonists can abort attacks. Hibbert (1984) suggests that panic disorder patients differ from others as they probably have a fundamental beta adrenergic hypersensitivity.

The symptoms of pCO_2 depletion were described by Ley (1985), in which he presents his theory that hyperventilation and panic result from the fear that suffocation will ensue without hyperventilating. He describes how the blood CO_2 partial pressures go down with the excessively frequent or deep breathing. He believes that the catastrophic thoughts are a result of the depleted CO_2 and subsequent hypoxia affecting the brain (Ley, 1991).

Hyperventilation causes a wide variety of symptoms in various organ systems other than those listed above. Lum (1981) attributes these changes to physiological changes in the central nervous system. The CO_2 molecule diffuses in and out of the blood and neurones easily. Should the blood pCO_2 fall, then the CO_2 in the neurones is attracted to the bloodstream to help redress the lack. This leaves the neurone with less CO_2 and thus with an alkaline internal environment. Alkalinity has the initial effect of increasing neuronal activity. However, with increasing amounts of CO_2 depletion, anaerobic glycolysis begins with the effect of increasing lactic acid. In some cases the neurone becomes quite acidic, decreasing activity to normal and eventually to a state of inertia. The panicker experiences biochemical changes as excitability early on, with heightened muscular reflexes and hypersensitivity to sensory stimuli, but eventually all this disappears, giving way to exhaustion.

Another effect of decreased pCO_2 is a constriction of cerebral arteries. This allows less blood to flow through the brain, resulting in a hypoxia that is compounded by a subsequent process that slows the uptake of oxygen into brain tissue. The symptoms of dizziness, feeling faint and lack of concentration are due to hypoxia, as are associated hallucinations and feelings of depersonalisation. So we have a brain that is not only suffering the consequences of metabolic disturbances within the neurones, but a generalised hypoxia as well further disturbing neuronal functioning.

Ley's (1991) treatment regime involves retraining of breathing habits to prevent attacks and to lessen their potency and duration. He recommends reducing ventilation by taking smaller and less frequent breaths.

The treatment used in the following three cases involves the principle that an overlearnt pattern can be used more easily in situations of panic than any cognitive technique.

A hypnotic induction that includes progressive muscular relaxation and suggestions designed to lessen symptoms of anxiety is part of the routine with such patients. After successfully introducing this type of hypnosis, an audio-tape is given out to be used daily for a fortnight. The tape is made with the same style of induction with which the person is now familiar. When using the tape at home, she/he is more likely to enter into the same sort of hypnotic trance as she/he did at the last appointment. In this way, an association is formed between hypnosis involving relaxation and the new breathing pattern. After the induction on the tape, the suggestion is made that regularly using the tape is training for the subconscious so that the breathing technique becomes automatic. It can then be used whenever the person is hyperventilating. A light knock is then produced at five-second intervals. The suggestion is made that breathing in is started with the sound and a count of 1, 2; breathing out is at the count of 3, 4; and 5 is a rest. Although it takes some practice to get into such a rhythm, it prevents both breathing too fast and too deeply. The tape continues for a 10-minute practice session, ending with the usual reorienting routine with which the patient is familiar.

CASE REPORT 1

Paul, at 38, is a tall, handsome man, one of the "movers and shakers" of the business community. He is an entrepreneur and, on first meeting, exudes self-confidence. He also has several simple phobias. He avoids lifts and other small places, hates flying, and becomes distressed at the thought of going into high buildings. He contacted his general practitioner when he found himself becoming obsessed with the new location of one of the sections of the company that had relocated to the 32nd floor of a new high-rise building. In the normal course of his business, he would have to visit this office frequently. He found himself feeling extremely resentful that they had relocated to such an awkward location. Paul had been using alcohol and prescription benzodiazapines for some years in order to control his symptoms. His general practitioner, who is trained in counselling techniques including hypnosis, saw him regularly, gradually decreasing Paul's dependence upon the drugs and using hypnotic suggestive therapy to treat the phobic symptoms. As their rapport grew and as Paul's phobic symptoms remained recalcitrant, it became obvious that Paul would need more psychological help than the GP could provide.

Paul had also participated in an in vivo treatment program run at the local airport for his flight phobia, but to no avail. He found the treatment distressing and requested that this type of therapy (in vivo exposure) be avoided.

The first session was devoted to history-taking, and developing the beginnings of rapport. Early in the session, Paul "took charge," saying that he was not at all sure that psychological treatment was warranted. During this past week he had twice ascended to the 32nd floor of a high-rise and, although he was not comfortable, he had achieved it with only a couple of beers to fortify himself. He felt that he was on the way to recovery.

In the second session Paul described a visit to the 32nd floor office that went perfectly. He was relaxed and confident during this visit, positioning himself away from the windows. However, later in the week, as he walked from his car towards the lift, he knew that this visit was not going to be so easy. He made himself continue as he was due at an important meeting, but he was ineffective and distressed throughout. The third visit that week was accomplished only with two diazepam tablets.

Paul responded well to progressive relaxation, followed by simple anti-anxiety hypnotic suggestions with imagery. His restless movements disappeared during the hypnosis and became much reduced afterwards. His "homework" was to practise the relaxation technique.

In the third session, I asked Paul to describe his symptoms exactly. His description was much more full than before. Physiological symptoms included a racing heart, weak knees, a dry mouth, and a feeling of choking that was probably the most distressing of all. He said his breathing rate was increased and that his whole musculature tensed up. No matter how he attempted to sit back and relax, his muscles remained uncontrollably tense. Psychological symptoms included a variety of automatic catastrophic thoughts: He was about

to make a fool of himself, he was going to fall down, and he was having a heart attack. Once these thoughts occurred, it was impossible to ignore them until he was out of the situation. Other psychological symptoms included an inability to concentrate or to converse naturally.

When Paul did a 90-second hyperventilation challenge, he exclaimed: "That's it exactly! I'm getting all my symptoms! I have been hyperventilating!" While overbreathing, Paul had found himself tensing up. He then attempted to control his musculature in his usual pattern, which included an arm movement towards his face.

It was this movement that clued him into the realisation that hyperventilating was operative in his case. Paul went on to explain that as a grieving child of 11, he suffered from tingling hands and sensations of his hands being huge. A few years ago he became concerned about the tenseness of his breathing and, obtaining a self-help book on breathing control, taught himself to breathe diaphragmatically. It was upon reading this book that he related the tingling hands to hyperventilation.

Ley's (1985) theory of hyperventilation was discussed, including the effects a lowered pCO_2 can have upon the brain and resulting automatic thoughts. It was decided that he could use this as a basis for a cognitive intervention if needed.

Paul's first attempt to breathe more slowly and lightly resulted in discomfort and he was forced to take a deep breath at the end of 30 seconds. Hypnosis was then induced to reinforce the four aspects of treatment covered so far in his treatment. The anti-stress suggestions of the previous session were repeated and a suggestion was given to him that he would become more aware of his breathing. By bringing breathing into consciousness, he could then deliberately breathe "light and slow." When an automatic catastrophic thought occurred, he was to reassure himself that it was only the result of overbreathing, and he could use the 'light and slow' pattern to re-establish more CO_2 in his brain and thus gain control over the thoughts. Reinforcement of the progressive relaxation program was again made in hypnosis. The tape was then given to Paul, and he was requested to use it daily.

At the next appointment, Paul related that both he and his wife had been using the tape every morning. They both found the breathing rate rather quicker than what was comfortable on first awakening, but persevered. The first time Paul used the technique, his symptoms immediately disappeared. He was careful to explain that it did not decrease his dislike of going up in the lift or the thought of being so high in the building, but he had no panic.

Several months later, Paul was routinely using the breathing rhythm in frightening situations, but only rarely using the practice tape. He was appreciative of being taught such a useful technique and effusive in his gratitude.

CASE REPORT 2

Robyn is a 32-year-old university student and mother of two children. Her presenting complaint was a phobia of vomiting which was getting worse. Her

motivation to get treatment was precipitated by an episode of simple food poisoning experienced by her son. Robyn had been unable to cope, and had felt guilty as a result.

Robyn's vomiting phobia was the most acutely distressing of many problems which were long- standing and complex. The main part of her treatment took many months and is irrelevant to this discussion.

Robyn complained of avoidance behaviour, some obsessive thoughts, and feelings of anxiety whenever out of the house in case she saw evidence of vomit. She avoided parties, pubs, flying, and going on boats as situations in which people were likely to vomit. She became fearful whenever her children (also colleagues and her husband) complained of stomach pains or feeling unwell. Her primary fear was vomiting herself. She responded moderately well to a progressive desensitisation process involving hypnotic imagery up to, but not including, any imagery concerning her own sensations of becoming unwell. This she blocked totally.

Robyn had not described panic symptoms in relation to her vomiting phobia. However, one day, at her part-time job, she was required to work with a woman who was obviously unwell with a stomach "flu" but unwilling to go home and be docked much-needed pay. Robyn experienced extreme anxiety and left work herself. She described symptoms of a pounding heart, faintness, lack of concentration, overwhelming thoughts and fears about catching the virus, and hyperventilation.

On her next visit, Robyn was asked to do a hyperventilation challenge. She reacted without panic symptoms. However, because the 'flu' episode had included many panic symptoms, I felt it could be useful to learn the breathing technique so that she could associate the relaxation response with controlled breathing should such a situation develop in the future. Robyn is highly responsive to hypnotic suggestion.

At the next fortnightly appointment a delighted Robyn described a massive improvement in her phobic symptoms. She said she used the breathing pattern several times every day, and her phobic anxiety and repetitive thoughts quickly vanished every time. Two months later, the symptom relief had continued to be successful, and she was using it to control for examination nerves.

Robyn found the technique so useful that she had her eight-year-old use the tape until he overlearnt the breathing pattern as well. She said that he frequently came home from school reporting that he had used "his breathing" successfully when confronted with an uncomfortable situation.

CASE REPORT 3

Jenni is a 49-year-old physiotherapist who presented with distressing symptoms of urinary incontinence. After her general practitioner had ascertained that her symptoms were not related to her menopause, Jenni was referred for hypnosis. She had been on an incontinence training programme, and she knew that her bladder capacity at times was over 800 ml, so there was nothing

physically wrong with her apparatus. She also knew that her symptoms were worse when in stressful situations. She was highly suggestible, could not control her bladder while swimming or in the shower, and had great difficulty whenever seeing or hearing a running tap. The need to void grew unbearable when in a toilet, and she could rarely get her panties down in time without losing some urine.

Although Jenni entered into hypnosis easily, and enjoyed the experience, her initial response to direct suggestion was an exacerbation of symptoms over the next week. She had embarrassed herself by thoroughly wetting her jeans at a sporting meet as she could not get them down in time.

Jenni's history included many associations with incontinence, including a rape situation which resulted in emptying her bladder involuntarily. Therapy focused on these associations and the hypnotic part of her treatment was confined to relaxation and anxiety control.

Jenni mentioned that her jogging program had been interrupted by the incontinence, as the jarring motion of running made her feel that she needed to void even when she had just done so. She always had some escaped urine in these circumstances. In the context of running she mentioned that she sometimes got paraesthetic feelings in her fingers, and she would have to stop. When I queried whether she hyperventilated, she said that she had always thought that probably she did hyperventilate when running. I gave her the tape to help with the exercise-induced hyperventilation symptoms.

A week later, Jenni reported that she had used the tape four times before it occurred to her that often her incontinence symptoms were exacerbated by panicky thinking. I had not raised this association with her. As a result of using the breathing technique, she was happy to report that her incontinence problems were "80%" controlled. Whenever Jenni felt a need to void that was clearly inappropriate, she switched to her 12-breaths-a-minute rhythm, and the feeling left her. She was still experiencing problems with swimming and showers (the 20% that continued unabated) but those situations were not socially embarrassing, and not associated with feelings of panic.

DISCUSSION

All three people got immediate benefits from learning a breathing rhythm that was physiologically sound and psychologically appropriate. All three were delighted with their new control over extremely distressing symptoms that were disrupting their lives. All three came to treatment with problems reaching far into their past histories, and all three needed more treatment than the symptom relief gained from the use of the breathing technique.

It seems probable that Paul's hyperventilation dates at least from the time of a severe childhood trauma. The first symptoms of decreased pCO_2 were the tingling and the abnormal perceptions of his hands shortly thereafter. Paul developed rapport with me only slowly, evidenced by the change in the symptoms described from the first to the third session. This is a problem

seemingly ignored by the literature, as most case histories, hospital records, and descriptions of patients rely on the information gained on initial interview. Paul, who has never appeared anything but forthcoming, and is intelligent and educated, described his experiences with much more self-disclosure after rapport had been established.

Robyn did not react to a hyperventilation challenge. It appears that the breathing training was directly useful for her symptoms of anxiety. Perhaps the sense of control that she was gaining in a situation that was perceived as out of control allowed her symptoms to abate. It is interesting that she shared this new-found control measure with her child, and that he could find it useful also. Research is needed to investigate whether such a simple procedure would prove to be more generally useful in various other anxiety disorders.

Jenni could perhaps be seen as suffering from an individualised form of social phobia, with the incontinence superimposed upon a fear of socially embarrassing herself. Her new-found control over her incontinence appears to be related to a control of both the physical symptoms of anxiety and catastrophic thoughts related to embarrassment.

Neither Robyn nor Jenni had described panic symptoms in relation to their presenting complaints, although both had suffered increasing anxiety problems for years. Perhaps each felt that it was unnecessary to describe the physical symptoms of distress in detail, preferring to concentrate on the description of thoughts and emotional tension when talking to a psychologist. It is obviously worthwhile querying people about the details of their distress if they are not forthcoming.

Paul, Jenni, and Robyn are all intelligent, educated people who found this type of explanation of their symptoms appealing. Because panic disorder patients have overlying concerns about being out of control, anything that increases the person's sense of self-mastery is reassuring. These people are also particularly diligent and they were motivated to find the time to practise with the tape daily.

In summary, combining a hypnotic induction that includes relaxation and breathing retraining for the effects of hyperventilation has worked well in these three different cases. The regime proved to be a useful adjunct to more conventional treatment, and because of its simplicity and ease of administration, could possibly be more widely used with other forms of anxiety.

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