

HYPNOSIS IN THE TREATMENT OF CHRONIC BACK PAIN

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This case study describes the various uses of hypnosis in the treatment of a complex case of pain control, exacerbated by a range of psychological issues. The case illustrates the utility of hypnosis, as an adjunct in the treatment of both physical and psychological symptoms.

Jack is a 28-year-old male on an invalid pension who presented with chronic back pain. He had an extensive list of prior hospitalisation and medication use, the description and severity of which is beyond the scope of this case report.

PERSONAL HISTORY

Jack was born with bilateral club feet, as was his older brother. His parents had not had any more children due to the high risk of other siblings having club feet. He had a good relationship with his mother but a poor one with his father, whom he described as remote and unloving. His father regularly abused alcohol. Jack was not particularly close to his older brother and resented the fact that his brother often received more attention than he had.

Jack attended high school till fourth form. He attempted various manual jobs (including as a slaughterman). He is now on an invalid pension, and has been for about six years. He had also worked as a bouncer in pubs.

Jack currently lives with his wife and four living children. The eldest child is his wife's by a previous relationship. They had one stillborn child. Jack has a caring supportive relationship with his wife and all the children, he is fiercely protective of them, and becomes very anxious when any of them is unwell. There was no history of sexual abuse.

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PRESENTING COMPLAINT

Jack was a patient well known to our practice, given his extensive history of illness and medical problems, which are not recounted here. I first met him in 1991 when he came complaining of chest pain.

A large heavily built man (with a thick body and small legs), his face was scarred from old acne, and he wore a crew cut and an earring. His manner was aggressive and sullen. He stated that he had been vomiting blood and an emergency gastroscopy showed a gastric ulcer compounding his hepatitis.

This meeting set the pattern for our interactions over the next two years. Before seeing me, he had already seen two young doctors in casualty, who dismissed his concerns. Jack, of course, did not help his cause by his aggressive manner and persistent questioning of their ability. This pattern of interaction with the medical community, and indeed people in general, had been in place for many years.

Jack felt his main problem was persistent back pain. He had been presenting to casualty requesting hospital admission and pain relief. One Saturday night in November 1993, he presented again, stating he felt his legs were going numb from the waist down. We felt his symptoms were out of proportion to the known injury and the physical signs. He saw one of my colleagues who, after phone discussion with me, told him he would not be admitted to the hospital again but that he was to be seen by me on the Monday for possible referral to a pain clinic and psychiatric assessment.

Reviewing Jack on the Monday, I confronted him with the view that, although pain was a problem, things were getting out of control and we had to take some positive action. He agreed.

I rang a pain clinic in Melbourne and discussed the case with one of the staff who was an ASH member. He suggested Aurorix, one three times a day (for underlying depression) and Endone (for pain relief due to his past history of liver problems and potential paracetamol toxicity). He suggested I begin hypnosis with some ego-boosting and pain-relieving techniques. I had just completed the basic course in hypnotherapy and was both far from confident and dubious that Jack would be a good candidate.

He had no obvious contraindications to hypnotherapy; in particular he had no psychotic delusions or major depressive symptoms. I remember thinking vaguely at the time he might have a possible personality disorder.

As is so often the case in rural medicine, one has to "take the plunge," and Jack was very keen to give something else a go. I arranged to see him in three days time.

TREATMENT

Session 1

I attempted to assess Jack using the Stanford Hypnotic Scale. In prior discussion

with him he stated he did not want to attempt any age regression. He said, "I had a lousy childhood and I don't want to think about it." He was able to score a plus for the moving of hands together, was not able to define a definite dream, and had declined age regression. He was positive for the post-hypnotic suggestion and post-hypnotic amnesia.

To my surprise it was clear he was in a deep trance. It took me three attempts to count him out. I felt he was an excellent hypnotic subject.

Session 2

We used a combination of Spiegel and relaxation with counting from 1 to 20 as a deepening technique. I chose to use a combination of special-place imagery and a transformation of glove anaesthesia technique. Jack chose, as his special place, sitting by the river in the bush and fishing. As he liked to have a beer with him we provided an esky filled with ice. I asked him to imagine his hand in the esky and becoming very numb; we then transferred this numbness to his back. We also decided to address his nicotine intake and so we used the image of breathing clear fresh air into his lungs, to imagine himself as a non-smoker. As I was using the esky as part of the scene, I decided to tackle his alcohol consumption later!

Session 3

Jack was delighted that, by using the glove anaesthesia technique, he was able to take nearly all his pain away. He described being aware of his pain but feeling separate from this, an example perhaps of what Hilgard and Hilgard (1975) called "the hidden observer."

A good therapeutic relationship had by now been established and I was able to explore some of the earlier events of his life. He described his early years as "spending more time in plaster than at home," often being 200 kilometres away from parents and family. He described himself as one of those kids with plaster up to his chest who rode around the ward on a skateboard.

He felt his hypnotic ability had been developed as a child having multiple injections, plaster changes, and wound dressings. He stated he could "turn off and be a million miles away."

I felt I was beginning to understand some of his, at times, bizarre behaviour in the past.

Sessions 4–10

We continued to meet weekly, sometimes using hypnosis, at other times talking about his past and problems with his parents and partner.

In this time Jack had a flare-up of his asthma. I started him on a more comprehensive asthma program (regular Ventolin, Becloforte, and antibiotics). He had ceased the Aurorix after one month and used Endone occasionally. We

had reduced his cigarette use to under ten per day.

During hypnosis, I continued to emphasise the positive things in his life, using ego-enhancing techniques.

Jack continued to have a good relationship with his wife and children. His wife described him as a devoted and loving partner (a different picture to the aggressive, threatening man I had first met). Many of the sessions were conducted with his wife present. We discussed their emotions and grief after their fourth child had been stillborn. Interestingly, his aggression was never towards his wife or children, but often saved for the medical profession and other authority figures.

Session 11

In a major setback, Jack's back pain had recurred and was much worse. He had been booked for drink-driving (0.12) and had lost his licence for 12 months. We discussed his addictive behaviour and he resolved to go to Alcoholics Anonymous for his binge drinking problem.

Sessions 12 – 27

We kept meeting weekly. By now Jack had ceased smoking totally and we discussed his alcohol intake and the reasons why he drank. His self-esteem was slowly improving but was still very fragile. His back pain was variable and he was using Endone frequently. I wrote a court report for him and continued to treat his asthma which, after years of cigarette abuse, was slow to settle. There were multiple medical consultations with his wife and children (who had inherited their father's respiratory problems).

Several important issues surfaced during this time. The first was his poor relationship with his father, who is a heavy drinker and who is unable to express emotions except violently. The second issue was Jack's fear of leg amputation and being wheelchair-bound. He put this down to being told as a child by one of the doctors that this might happen one day. I was able to reassure him that this would not occur. We did only intermittent hypnosis.

Two months after his drink driving charge he attended his first AA meeting.

Session 28

Jack came in visibly agitated. He reported that the AA meetings were stirring up a lot of feeling, that he was depressed and weepy. He was not suicidal but was not sleeping. I put him on Sinequan 6 x 25 mg at night (he always needed large doses to have any effect, probably due to his body weight and long history of metabolising drugs and alcohol).

Our sessions mainly involved talking about his feelings, relationships, and back pain. He was regularly using the taped hypnosis material we had developed earlier in our sessions, for relaxation, with reasonable effect. The pain was

constant but bearable. He was not smoking and his asthma was improving.

Jack was not now drinking but was very threatened by AA. He didn't feel up to telling his own story in front of a roomful of people and was very anxious about this.

Session 29

Jack presented very distressed and frightened. He was much worse, now hearing voices in his head, vague voices, and he could not quite make out what they were saying. He was not suicidal.

At this stage I was worried about whether I had made an error and been using hypnosis on someone with a latent psychosis (a contraindication). I discussed this with my supervisor and a colleague in one of my tutorials. They felt that Jack possibly had a personality disorder and that a psychiatric evaluation would be helpful. In our area of Victoria, psychiatric evaluation was not easily obtained. I rang and discussed this case with a psychiatrist who suggested that, as I had a good rapport, I should keep working with Jack, and try the use of Melleril.

Jack was depressed and frightened by these events. He wondered if he was finally going "crazy." On reviewing him more thoroughly, however, his thinking was not disturbed, he was not having any delusions. He didn't show any of the other features of schizophrenia such as social withdrawal, poverty of thought, or cognitive dysfunction.

At this time, I listened to Wendy-Louise Walker describing hypnosis with a group who were, like Jack, highly hypnotisable. She stated that, at times, these people were often misdiagnosed as personality disorder or psychotic and their ability to dissociate would appear at times to be inappropriate and a disadvantage. Jack fitted her subset of patients very well.

After her talk I discussed with her how to manage Jack. She advised me to recommence hypnosis and use his very great hypnotic ability to advantage.

Session 30

Feeling much more confident, I reviewed Jack. He quite sensibly had ceased the Sinequan and the Melleril, neither of which had made much improvement.

Jack was frightened by what he called "the voices." We discussed these in some detail and he felt the voices were actually the muffled sounds you hear in the operating theatre as you are about to go under following an anaesthetic. For someone who had experienced general anaesthesia on at least 30 occasions, this made sense.

His main fear was the sense that he was "going mad, and would need to be locked up." I explained to him my meeting with Professor Walker and said he was not going mad, that his high hypnotisability was what allowed him to recall these sounds so accurately, and that by using hypnosis we could make these

troublesome voices disappear, just as he had with his back pain.

Jack went easily into his usual deep trance. By now I could shorten the induction time and use a combination of Spiegel and counting as a deepening technique to induce trance.

We decided that we would use the image of putting the voices, and indeed all his worries and fears, onto blocks and into a box. Then we would make them disappear by plunging this box to the bottom of a deep ocean.

Post-hypnotically, Jack related this had worked well but it had been a little scary. He stated he didn't want to get rid of all his troubles in the one go, so he had pulled a couple of the blocks back out of the box before consigning it to the depths! He felt much better.

Sessions 31 – 34

Jack continued to improve, his anxiety and depression lifted rapidly, and there was no recurrence of the "voices." We continued to use the box technique till he was able to put all the blocks into the box and get rid of them.

DISCUSSION AND SUMMARY

Jack demonstrates well several aspects in the treatment of hypnotherapy for the treatment of chronic pain. He presented a complex problem of alcohol and nicotine dependence, coupled with prescription medication abuse and chronic pain. He was involved in a very self-destructive pattern of behaviour. He has genuine pain from his back and feet. His fear of becoming wheelchair-bound was also a major factor in creating anxiety and depression. His long history of institutionalisation, coupled with poor parenting models, left him with low self-esteem and an inability to interact positively with the community.

His profound hypnotisability was a great advantage in initiating some change in his life. Once he could see positive things happening from these changes (apart from several setbacks) we have maintained progress.

I continue to see Jack who is still, at times, fragile. His back pain flares up and down. He and his wife are very dependent on our medical clinic and come to see us to solve many of life's problems. However, they are gradually becoming more confident and I hope, as the children become older, we will be able to reduce this dependence. I have started counselling his wife, who had a past history of sexual abuse.

We have made a number of major gains with Jack: He is now a non-smoker and a non-drinker, his weight has decreased from 110 kg to 95 kg, his asthma is improving, as is his general health, and he is more confident, his self-esteem having improved tremendously.

We have emphasised the positive things in his life, his good parenting skills, and his relationship with his wife. He is starting to feel more worthwhile as a human being.

At the same time we have decreased his need for investigations and hospitalisation. Jack is still dependent on the medical system that is our clinic, but is not using (and abusing) the casualty department and specialist doctors. This is giving the community a large saving purely in dollar terms. The cost of unnecessary tests over the years has been massive. Of course, it also means that he is now subject to fewer medical procedures.

Jack now realises that many of his problems and feelings of inadequacy revolve around his bilateral club feet, his poor self-image, and his early frequent hospitalisation as a child. He is beginning to understand the origins of his poor relationship with his father and is determined not to make the same mistakes with his children.

There are many factors in the treatment of chronic pain — a good rapport and a supportive relationship are central. Hypnosis was the main tool by which Jack began to regain control of his life.

Dealing with this man has forced me, very rapidly, to learn more about hypnosis and psychiatry. Together, we have been on a learning curve, and I feel we have both gained a great deal. Jack demonstrates well the saying that we are often taught best by our patients.

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COMBINING HYPNOSIS AND NLP IN THE TREATMENT OF TELEPHONE PHOBIA

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Two neuro-linguistic programming techniques which have proven to be therapeutically effective are those of the "theatre" and the "collapsing of anchors." As both have produced good results when used individually, their combination is likely to provide a very powerful therapeutic intervention. When a hypnotic induction is also brought into play as a means of increasing patient expectancy of success, the combination can provide a vehicle for effective single-session therapy. The manner in which this approach to therapy might be applied is illustrated in the treatment of an insurance agent afflicted with telephone phobia.

In previous articles I have drawn attention to the efficacy of two NLP techniques: "the theatre" (Stanton, 1995), and "collapsing of anchors" (Stanton, 1989). When used alone, each of these approaches is very effective in helping patients achieve the change they desire. However, should they be combined, they become even more powerful, particularly when an hypnotic induction is used to enhance positive suggestion and patient expectancy of success.

The therapeutic applicability of this combination is demonstrated, in this article, with the case study of an insurance agent whose career was jeopardised through his inability to use the telephone. Though only one 50-minute session was available for the treatment of the client, this did not present a problem, as much can be accomplished within a single session. Studies conducted by Talmon (1990) have affirmed that the most frequent length of therapy of every one of the therapists in the Department of Psychiatry at the Kaiser Permanente Medical Centre was a single session, a finding repeated with outpatients in a number of other medical centres. As almost 80% of the patients felt they had received everything they needed from the single session, client dissatisfaction was not the reason for this brevity of treatment. Earlier studies (Jones & Vischi, 1979; Mumford, Schleisinger, & Glass, 1984) provide support for Talmon's finding in their conclusion that length of treatment does not proportionally enhance therapeutic benefits.

THE COMBINED TECHNIQUE

The Theatre

This technique, which I have modified slightly, derives from the work of Bandler (1985), who has emphasised the power of mental imagery in helping patients quickly overcome their problems. The following steps detail how Bandler uses both imagery and dissociation to promote change:

1. Patients are to imagine that they are sitting in the middle of a movie theatre. On the screen before them, they are to see a black-and-white snapshot of themselves in a situation just before they had a particular undesired response.
2. They then float out of their bodies up to the projection booth of the theatre, where they can "watch themselves watching themselves." From that position they are able to see themselves sitting in the middle of the theatre, and also see themselves in the still picture which is on the screen. Because of the distance involved, this picture will be quite small.
3. That snapshot up on the screen is then transformed into a black-and-white movie, this being watched from the beginning until just beyond the end of the unpleasant experience.
4. When patients reach this end point, they are to stop the movie, make it into a slide and turn it into colour. They then come down from the projection box, jump inside the picture, now large and colourful, and run it backwards to the original starting point as a movie. This should be done quite rapidly, taking only a few seconds. Everything is to take place in reverse with people walking and talking backwards. In addition, a comic soundtrack might be added together with anything else likely to create a sense of the ridiculous.
5. In my own use of the technique, I have added a fifth step in which the colour movie is then run forwards again, this time with events transpiring in the way the patient would have liked them to have occurred. Once this step has been completed, patients imagine themselves stepping out of the picture into the self in the picture theatre. After this reintegration, patients return to the reality of the therapy room.

Bandler argues that while the brain learns fear instantly, it also can learn, instantly, that it is no longer necessary to be fearful. Because the initially frightening experience looks so ludicrous when visualised in reverse, patients often lose their phobic response. As patients change their perceptions in this way, they come to a realisation that they have more control over their thoughts and, ultimately, over their lives than they had previously believed possible.

Collapsing of Anchors

This second technique (Bandler & Grinder, 1979) begins with identifying the response patients wish to change. Once they have done so, they sit with closed

eyes, recreating the unpleasant feelings associated with the unwanted behaviour pattern. Usually they reveal that they are experiencing such feelings through facial changes or altered breathing rhythm, although a verbal indication may also be given. The unpleasant feeling may be "anchored" verbally by a change in voice tone or volume, or non-verbally, perhaps by a touch on the right wrist. The therapist can then recreate the negative situation within the patient by a repetition of that particular "anchor."

Patients proceed to explore their experience in order to discover what resource they now possess which could be "taken back" into the past to change the unpleasant feelings. This resource might be increased confidence, trust, maturity, or relaxation, attributes patients now have which were not present in the initial, negative situation. One way of helping patients identify such resources is to encourage them to think of a relatively recent experience which they handled in a mature, effective, successful manner.

Should patients be unable to find a resource which, if applied to the original, unpleasant situation, would have produced a more acceptable outcome, they are asked to imagine how an admired person may have handled the situation. This usually produces the desired positive feelings. As patients' faces and breathing reflect these feelings, the resource is "anchored," perhaps, with a touch on the right elbow.

In a third step, the therapist touches the first "anchor" to recreate the unpleasant situation. As patients experience this, the therapist touches the second "anchor," bringing in the positive feelings of the resource. Patients, resting with eyes closed, take as long as is necessary for the unpleasant feelings to change under the influence of the positive resource. And change they usually do. Patients feel and "see" themselves responding differently, successfully, thus creating a new history.

The process is then generalised to other situations patients are likely to encounter in the future. The therapist says: "In the future, anytime you experience anything similar to your previous unpleasant situation, you will feel this [touching the resource 'anchoring']." Control can be passed to patients by having them trigger the anchor and generate their own positive state.

HYPNOTIC INDUCTION

The type of induction used is not critical (Stanton, 1975). Of more importance is the therapist's indication that, through the use of an induction, patients will be able to accept positive suggestions more deeply than would otherwise be the case and thus be more likely to achieve their desired therapeutic goals. By engaging patient expectation of success in this way the therapist makes powerful use of the placebo effect. As Oyle (1975) has expressed it:

some patients decide that only the proper herbs can heal while others put childlike faith in the power of the pill; still others insist that salvation can only be achieved by mastering a particular yoga position or by repeating a mantra. *Whatever you put your*

trust in can be the precipitating agent for your cure. [Emphasis added.] (p. 25)

Thus, if patients believe that, through experiencing a hypnotic induction, they will respond more positively to the treatment offered, that is what is likely to occur.

One hypnotic induction method I have found particularly effective in this context is to have patients relax into a very comfortable area within their bodies, experience the spread of this comfort to all parts of their bodies, and allow these areas to relax as they think about them. This approach is, to some extent, a variant on Jacobson's well-known progressive relaxation technique (1938) and is the one I used with James in the following case study.

A CASE OF TELEPHONE PHOBIA

James, an insurance salesman with over 10 years' experience, consulted me because of his telephone phobia. Due to a series of rejections, his confidence in his ability to sell insurance policies had been seriously undermined to the extent where it had become virtually impossible for him to pick up the phone to arrange an appointment. For James it had become a matter of either giving up the line of work he had previously enjoyed so much, one which had provided himself and his family with an excellent living, or overcoming his fear.

James was able to identify one particular "failure" that had upset him greatly in that each time he thought about this experience, which he did all too frequently, he felt extremely disturbed. He also recalled a recent occasion when his fear of picking up the telephone was so great that his hands shook, he hyperventilated, sweated profusely, became dizzy and nearly passed out. Both these incidents provided suitable material for the composite technique.

To raise James' expectancy of success, I explained how he would be able to accept and act upon suggestion more powerfully while in an hypnotic state and that he would be able to attain such a state through the following procedure. I suggested he go inside his body to find some area that felt extremely comfortable, possibly the most comfortable part of his whole body. Into this part he would be able to relax and as he did so, the unconscious part of his mind would do everything necessary to spread that comfort and relaxation through his whole body. As this was happening, any part of his body he chose to think about would "let go." In this way he traversed key areas of his body, allowing them to relax. It was suggested this relaxation would continue as he followed his breath in and out, "letting go" more and more with each out-breath.

James then imagined himself entering the theatre, sitting down, and seeing himself on the screen just before he entered the office of the client with whom he had experienced his memorable "failure." He then "floated" up to the projection box from where he could look down, simultaneously seeing himself in the theatre and this black-and-white slide on the screen. Because of his distance from the screen the slide was now quite small, as was the black-and-white movie of the traumatic episode which James now viewed. He stopped this

as a slide at the point when he left the client's office. As he viewed this movie, I maintained a touch on his right wrist.

Mentally descending from the projection box, James then entered the picture of himself on the screen, turned it into colour, and, as a movie, ran it backwards to the starting point, adding as much humour as possible. This time I maintained a touch on his right elbow. I continued to hold this anchor as he ran the movie forward once again, this time creating an entirely different scenario of a highly successful insurance sale, one which gave him a feeling of great confidence. As James enjoyed this experience I had him replace my fingers on his right elbow with his own, suggesting that, in future, on any occasion he wished to re-experience this confident feeling, he would be able to do so by triggering this anchor. I also suggested that every time he used the touch on the right elbow anchor, the more powerful it would become in generating this confidence.

As James sat quietly in the theatre, the screen now blank, I triggered first the negative wrist anchor, then the positive elbow anchor, collapsing these so that the latter replaced the former. James confirmed verbally that this had, in fact, occurred. We then repeated this procedure with the second highly negative incident in which James was unable to pick up the telephone.

CONCLUSION

In the treatment I have described in this article, use of an "hypnotic" induction is not mandatory. As I have previously indicated (Stanton, 1975), the use of such an induction is not essential to the production of change in people who are exposed to positive suggestion. However, because many people believe so strongly in the power of hypnosis, the therapist, through using the induction, makes use of this expectation and may appreciably increase the effectiveness of his intervention. If clients expect to be helped, this belief greatly enhances the possibility of this result being forthcoming. We tend to get what we expect (Rosenthal & Jacobson, 1968) and there exists widespread belief in the magical properties of hypnotism. There is the expectation, engendered primarily through stage performances, movies and television, that hypnosis is a fantastically powerful tool for effecting change in people. Thus, when exposed to a hypnotic induction, patients anticipate dramatic improvement. By embedding the two NLP techniques within such a context, their power to effect change seems to be enhanced.

The theatre, by employing the double dissociation of having patients visualise themselves in the audience and in the projection box, enables them to view, in a detached way, a previously anxiety-provoking situation without experiencing the intensity of feeling it had previously evoked. This sense of remoteness, of detachment, helps them modify the fear they had been attaching to the incident through a change in perception.

Many users of this approach comment that visualising the events of the initially frightening incidents in the running-backwards mode drains away much

of the negative emotion they previously evoked. It all becomes somewhat ludicrous. James certainly found this to be so, and over the ensuing weeks he recaptured his earlier selling skill, using the telephone with all his old flair. As his confidence returned, he regained both his enjoyment in selling and his competence in doing so.

Because this combination draws so heavily upon patients' visualisation abilities, it might be argued that its use is limited to those patients who are able to use their imagination in this way. This was an issue which once concerned me with many of my therapeutic techniques. Experience has shown, however, that when patients say they are unable to "see" whatever is suggested, if they are asked to act as if they could do so, the difficulty seems to disappear.

A more valid limitation is that of identification of a critical incident. James was able to specify both the experience which precipitated the first occasion when he had a problem with using the telephone to set up an appointment and also a recent very negative experience. If a patient is unable to identify at least one such incident, the combination technique would not be the intervention of choice. However, as such cases are relatively rare, the approach I have outlined in this article is likely to prove applicable to a wide range of presenting problems.

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HOW CAN HYPNOSIS ENRICH PSYCHOANALYTIC THERAPY AND VICE VERSA?

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This paper illustrates how knowledge of (a) hypnotic (trance) phenomena and (b) the functioning of suggestions can be usefully applied to psychoanalytically oriented therapies, both in neurotic and psychotic patients. Conversely, fundamental psychoanalytic concepts such as transference, counter-transference, regression, introjection and therapeutic "abstinence" (distance) can be considered in a useful way, not only for a better understanding of some processes underlying hypnotic therapy, but also to avoid certain typical errors. Excerpts from case histories will corroborate the thesis that both therapeutic systems can be combined in a very fruitful way.

INTRODUCTION

This paper does not, as the title might suggest, have the ambition of presenting an exhaustive theoretical discussion as to how hypnosis and psychoanalysis can be combined — far more illustrious authors have done that before me — nor will it offer an overview of the various possibilities to do so. The wealth of individual ways in which therapists have used their hypnotic skills and their psychoanalytic knowledge mirrors the creative potential of the dialectical use of both therapies. In the paper I shall discuss some aspects of my work wherein I found it especially interesting to be both hypnotherapist and psychoanalyst.

First I shall have to try to distinguish what it means to me to be a hypnotherapist as opposed to being a psychoanalyst. Is there a difference in attitudes towards patients? I think there is not. In fact, for all psychotherapies

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the basic attitude towards the patient is one of "abstinent" acceptance, and this is so for psychoanalysis as well as for hypnosis. What distinguishes hypnosis from psychoanalysis is rather a different choice in the object of the therapist's interest. The analyst strives towards an understanding of images, fantasies, and symbols, while the hypnotist looks more for ways to produce them and to lead the patient into inner situations in which these images can develop. Also, the analyst's and the hypnotist's eyes are directed to different levels: The analyst investigates the results of a process and the hypnotist tries to understand and to influence the mechanisms of this process. A metaphor taken from the world of physics may illustrate this: Hypnosis operates in the area of energy levels, which it modulates, and psychoanalysis strives towards a decoding of information. Energy and information are quite different categories. When looking at things this way, one may ask how therapists can possibly operate without taking both levels into consideration. Probably the answer lies in the fact that all therapists do in fact consider both aspects in their own way, but that they use different names and concepts to designate them.

Another way in which hypnosis and analysis differ is in their attitude towards relationships in general. As an analyst I make an effort to understand the unconscious interactions with my patients, and I always bear the question in my mind: "What are we doing now unconsciously," while as a hypnotist I am interested in supporting these interactions and in directing them in a certain therapeutic direction.

To illustrate this, I am going to present two excerpts of case histories from my practice. Both show in a typical way how I normally handle the combination of hypnosis and psychoanalysis. The first example shows how hypnosis can enrich psychoanalytic work, and the second illustrates the reciprocal situation, but, of course, in each example one also can find ways in which the second enriches the first. It happens quite often in my psychiatric practice that a therapy which was originally planned as a hypnotherapy turns out to be an analytical therapy. Why is that? It surely depends on my therapeutic attitude, because it would be easy to insist in a more or less authoritarian way on abiding by the original plan and avoiding analytical discussions. Rarely do I choose to do so. The reason for this can best become clear with a concrete example.

CASE 1

A 60-year-old patient with an intellectual profession came to my practice asking for Ericksonian hypnotherapy. For this specific wish there were two reasons: Firstly Erickson nowadays means the top of the up-to-date treatments, and secondly the patient had already undergone psychoanalysis many years ago. The first hour went the inconspicuous way of a first interview: He told me of his private and professional problems, and described his childhood and the relationship to his parents, and his college life. He persisted with this self-description for two months in our weekly sessions! Seemingly Erickson and

hypnosis were forgotten. Were they only a pretext? Had we been seduced to hold on to the more familiar interactions of his previous analysis? Was the reason simply that he was professionally accustomed to verbalising? Anyway, in analytical terms it was resistance, but to what?

I played the analytical game with him, but always kept in mind his original wish for hypnosis. In one session he was talking about his mother very lovingly, the same mother who, he had told me in a previous session, had punished him with exaggerated severity because he had been surprised as a little boy while playing doctor with the neighbour's daughter. I pointed out the presumably ambivalent character of his feelings towards her. He agreed and expressed his confirmation in a metaphor. He said he felt like clinging to a raft which was drifting on the ocean and he couldn't decide whether to stay clinging or to risk swimming on his own. Both were possible, he said. With the hypothesis in mind that the ocean could represent — among other things — hypnosis, I took the tentative initiative to propose to him to visualise this metaphor of the raft in a hypnotic trance. He readily agreed and after a short induction he felt deeply relaxed and was surprised to feel well on the raft, which now brought him to the land.

A marvellously happy ending! One could be tempted to suppose that some breakthrough had happened at this moment. But in fact, at least concerning his attitude towards hypnosis, nothing had changed. He had enjoyed the oceanic feeling of having no burden, no obligation. As a good analytic subject he extensively reported his free associations to the contents of his hypnotic dream, but not a single word about any further hypnosis.

The question still remained: What was the meaning of his resistance against hypnosis? Some weeks later he reported an argument he had recently had with a professional superior. He had suddenly been bewildered by a strange feeling: a sudden and strong regressive urge to submit himself to "eat from the hands of his superior" as he expressed it. This feeling shocked him, especially because he deeply disagreed — with good reasons — with his superior and because he was convinced of his own intellectual superiority. This experience frightened him. I gave him an interpretation mirroring his repressed nostalgia for a symbiotic closeness, and linked it with a possible unconscious fear of hypnosis. It appeared this was a crucial point because he became aware that, although his single hypnotic experience gave no reasons for this, he was afraid of losing his liberty in hypnosis. It was an existential fear of being seized by a camouflaged symbiotic mother.

But on the other hand he now compared his earlier hypnotic experience with a hothouse: He felt there was a small plant which wanted to grow, even if he was still distrustful of the idea of entering into the hothouse. This was his first spontaneous and positive metaphor concerning hypnosis and, interestingly enough, this had become possible not through the earlier direct experience but through our analysis of his resistance. Ongoing therapy was characterised by a growing interest in, and even by a desire for, hypnosis. Let us stop the case

report here and take up again the question formulated in the title of this paper: How did hypnosis enrich the analytical work? Or let us perhaps ask it in another way: What did hypnosis mean in the context of this therapy?

The hypnotic situation consists certainly not only of a simple transference in the usual terminology, even if there is no hypnosis without transference. But recent research tends to show that, beside transference, there is also a phenomenon called "archaic involvement" which plays an important role in the experience of the hypnotised subject. This "archaic involvement" can be considered as a transference-like phenomenon rooted in the pre-verbal stage of human ontogenesis. Thus hypnosis by itself — and independent of the content of the hypnotic experience — actualises in therapy a pre-verbal element which can be of paramount importance for progress in therapy. Here we meet with the weak point of classical psychoanalysis: as a mainly verbal procedure it fails to access pre-verbal experience.

So now it becomes clear which theoretical considerations prevented me from making any effort to convince my patient to work hypnotically, as he originally had asked. Had I done so, the patient might have experienced relief from his tensions sooner, but it would not have been his own, free, and mature decision to overcome the threshold preventing him from working on his pre-verbal problems.

Even worse, I would have played the same role as his mother: I would have taken away his freedom at the very level where he was afraid of losing it. By analysing the resistance it became possible for him to approach it in a way which allowed maturing. His metaphor of the hothouse confirmed my attitude: One cannot accelerate the growth of a plant by dragging it.

The permanent implicit or explicit presence of hypnosis offered a crystallisation point for a new conception of symbiosis in the patient's mind: He could fantasise in a realistic way on how an hypnotic symbiosis with me could not only leave him his freedom but even protect it. And in the therapy I am really here, here and now, so fantasies become more potent than if they are directed to the childhood mother, whose existence belongs to the past.

This first example showed how hypnosis, even by its nearly "ghostly" presence, can introduce a core element into a psychoanalytic treatment: the pre-verbal experience. Now let us consider, guided by another case history, how analytical intervention can prevent hypnotherapy from getting stuck in a transference situation.

CASE 2

A female patient with asthma, about 35 years old, had already been in hypnotherapeutic treatment for some years. The main result of this was that she no longer had the dramatic attacks which had earlier on forced her to be hospitalised in the intensive care unit, and which had occurred increasingly often before treatment. In her weekly sessions she linked actual problems

reported in the waking state with past traumatic experiences she relived in hypnotic age-regression. For a long period this seemed to give her some stability, but this behaviour became increasingly stereotypical and I felt more and more nervous about it. Actually, every time she had to report on tensions in her actual life, she closed her eyes and drifted softly away into a trance where she relived again and again the same traumatic childhood scenes. But no sort of progress could be observed, and so I decided to let myself be guided by the countertransference feeling of irritation I had about it.

I wanted to try to explore what this escape meant. Doubtless this situation was stuck and had something to do with her transference. So every time she drifted away I asked her: "Where am I now?" in order to elicit some information about my role in these hypnotic retreats. In fact, in her childhood scenes, my role appeared to be restricted to that of a marginal spectator. When I proposed becoming more active by, for example, offering her a Teddy bear or a doll, I was met with reactions of distrust. This attitude was an impressive symbolic description of her transference and was in overt contradiction with her conscious help-seeking behaviour. Yet I could not identify whom I represented in it.

One day she asked me whether I would agree to her seeing another hypnotist who specialised in past life regression. It intrigued me to learn what would happen, and she reported a romantic story from which I quote the core elements: It happened in medieval Brittany. Her father, a powerful sovereign, didn't want her to marry an audacious knight who loved her, and he imprisoned her in a nunnery. Her lover abducted her with the help of other knights. Her medieval father was nobody else but her former partner in her actual life, with whom she has a child. She had separated from him, after years of argument, but was still ambivalent in her feelings about him. The bold knight was now a man she desired but who, unfortunately, showed little interest in her.

We didn't discuss the historical adequacy of this story but decided to analyse it as if it had been a dream, and the explosive result of it was a dreadful discovery: her father had abused her sexually as a child. For years she had hidden or repressed this memory in therapy. The incestuous trauma was the clue to our enigma: in her transference I represented her father, and I created, with the closeness of hypnosis, an unbearable situation symbolising the very incest. On the other hand she needed me as a therapist, so the best solution was indeed to keep me as distant as possible in her hypnotic experience.

It is a current feature of psychotherapy with incest victims that they feel a complete block to speaking of the core problem, especially with male therapists. Apparently it was easier for her to symbolise her experiences in the framework of a previous life and with a hypnotist unknown to her who would surely not understand the message. We can speculate that she was less afraid to confront me as her therapist with that discovery because it had been the result of the hypnotic work with somebody else. Anyway, it was the analytical work which allowed us to clear up the entangled transference situation created by the hypnotic work.

CONCLUSIONS

To conclude: Hypnosis could enrich psychoanalytic therapy in the first case by introducing the aspect of pre-verbal fear, but led to a somewhat paradoxical and startling therapeutic situation: the analytic work meant a resistance against hypnotic work, and this very resistance could be resolved by analysis itself. In the second case the hypnotic setting had led to an insoluble transference situation which could be broken through by the analysis of the situation. I am aware of the fact that there are perhaps other therapeutic ways to come to equivalent results and that the decision whether to work analytically or hypnotically ultimately is a matter of personal appraisal by the therapist. Therefore the reflections presented cannot have any absolute value. But we all know that psychotherapy can never claim to be an exact science, unfortunately. Or should I say "fortunately?"

CASE NOTES

The aim of Case Notes is to enable readers to contribute brief items and case material drawn from their own experience. These may be case situations in which hypnosis has been used in treatment or a description of specific hypnotherapeutic techniques used within treatment contexts. The contributor is asked to supply as much information as is needed to ensure the reader has an understanding of the situation, the therapeutic aims of the hypnosis, and outcomes. It may also be appropriate for the contributor to research the relevant research and clinical literature to justify and explain their use of hypnosis. While the standard criteria for publication in the journal will not necessarily apply to Case Notes, a clear exposition of the ethical professional practice of hypnosis will be required if the material is to be published.

THE GLASS ELEVATOR: A REGRESSION TECHNIQUE

Vicky Powlett

Psychologist

This procedure is useful to access forgotten or repressed memories without necessarily experiencing painful feelings that might accompany this recall. Images of the past may well be an amalgamation of many happenings, even "false" memories or confabulation. It is important to remember that it may be difficult to judge whether information or recalled events are genuine or false or even images woven in from books or films. It is what we perceive now that affects what we do in the present. You and your client should have a good reason for using regression and be able to set it within the context of psychotherapy. For example, it may be to explore the circumstances involved in the onset of an unwanted habit or symptom.

PREPARATION

You will have a good understanding of your subject's history, you will have taught relaxation and imagery techniques, your client will feel comfortable in

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talking or using non-verbal communication whilst in a trance. It is preferable for your subject to be able to use *visual* imagery (although I have used this script with a client who could not visualise but who could utilise auditory and kinaesthetic perception).

I prefer to explore earlier pleasant experiences when first teaching this technique. This enables your client to find out how it works and gain control. You will have explained to your client that this method assists her/him in avoiding or tempering the re-experiencing of emotions associated with a past event. It would be wise to hold a discussion about the imperfection of memory and recall. Do not promise that trance will improve recall, as hypnosis is more likely to increase the confidence in belief, not the accuracy. There may also be an opportunity to verify the accuracy of memory for non-traumatic events. It is useful to record the session on tape (with the consent of your client), as written records may well be condensed or even selective.

COMMENCE WITH A FAMILIAR RELAXATION INDUCTION

When your subject is in trance, say:

Now as your body has relaxed . . . your mind can also relax in a much more active way. I would like you to imagine yourself . . . in the building that you described to me earlier on. This building has been built on strong foundations, there are many floors/levels . . . You are on the -th level [i.e. the same number as your subject's age] In front of you is a lift (elevator). . .

You can see the doors and the buttons that allow you to open them. It is interesting to see what kind of lift this is . . . I wonder if it is modern or antique . . . perhaps you would describe what it is like? . . . And does it have a glass safety door or a grille? . . .

Remember that is the door that will allow you to look out and decide whether or not you will choose to move out and fully experience or relive a past event. You will have plenty of time to make up your mind . . . and . . . when you are at a particular level . . . and . . . if you decide that you feel uncomfortable, you may step back into the lift again and close your safety-glass door and watch at a safe distance . . .

Would it be alright for you to enter the lift and describe what it is like inside? . . . And how is it controlled? . . . Are there numbers indicating the floor levels? . . . Are you aware of how you will make this lift go UP or DOWN? . . .

Make sure all is clear to you, as well as to your subject.

Are you ready now to use the lift? . . .

Fine! I'll count back to the age that we talked about . . . to that very happy day when you celebrated your tenth birthday . . . wedding . . . second anniversary . . . [Whatever you have agreed on.]

Of course as we proceed, you may choose to stop briefly at another time . . . at all times you are in control. If you decide to stop, just tell me or raise your hand and I will stop counting.

Proceed to count slowly from subject's current age year by year until you reach

the target age, unless your client makes an unscheduled stop on the way.

When the lift has stopped, let me know . . .

Now open the outside door (using the lever or button . . .) while you look through the glass door. OK, if you are ready to go out . . . slide back the glass door and go out . . . and you are — years old, and you are now looking around . . . take your time . . .

Tell me, what is happening? . . .

Make sure your questions are neutral and objective.

What are you aware of? . . .

Do not ask leading questions. If subject has already commented on the presence of others, then ask:

Are you aware of sounds or conversation? . . .

In order to avoid contamination, do not use “facts” that you were told out of hypnosis, or gathered from other sources.

If subject is describing a distressing or traumatic experience and starts to show distress, remind your subject that s/he can step back into the lift and view the events from afar, from behind the safety of the glass doors . . .

and let go as much of those feelings as you choose or need to let go. If you are now ready to return to the present, also close the outer doors. [Allow a response from subject that s/he is ready] . . . I am now going to count slowly from . . . [the age and the level number] to . . . [subject's present age.]

Activate the lift now and you may choose to watch the numbers of each level as the lift returns to where we started today, or you might just choose to concentrate on the feeling of moving to the present day.

Count slowly in time with the exhalation of your subject, year by year . . .

And as you approach your current age, you will be ready to have the lift stop at . . . [subject's present age]. That's fine. Now open the doors . . . Look out and if you are ready to do so, step out . . . and now open your eyes, giving yourself time to make the transition from being deeply in trance to being alert and ready to continue our discussion.

FURTHER CAUTIONS

Be prepared to maintain your neutral responses so that you do not give weight to particular memories. Be aware that your subject may already have spontaneous amnesia for some of the events described while in trance. Do not be tempted to include any suggestion for therapeutic enhancement. To do so could confuse your client (and may also contaminate recall). Remember this is basically a fact-finding mission — the glass elevator is a protective device to be used, as needed, by the client to avoid or reduce repressed or unwanted emotions.

Acknowledgments to Maxwell Smart for his concept of the invisible glass wall of protection.

COMMENTARY ON MILNE

Helen Ritter

Medical Practitioner

I write with regard to Gordon Milne's article "Repressed memories sometimes a minefield" in the November 1995 journal [*AJCEH*, 23(2), 158-165]. In his discussion of the issue he cites a case in Bunbury in October/November 1994. I draw to your attention that, unfortunately, his material is factually incorrect. Milne states in his article that the women's therapist was John Manners. In fact, the sisters attended different therapists who were in different disciplines, used different techniques, lived over two hundred kilometres away from each other, and were unknown to each other until some time into the second sister's therapy. John Manners was never in charge of the younger sister's management.

The evidence from the trial which Milne quotes, referenced to Bettina Arndt, is highly selective and only a very small part of a seven-week trial. Unfortunately, Arndt only attended the second half of the trial and was present for little or nothing of the prosecution case. This may have influenced her assessment of the case. She was also absent during the *voir dire* which preceded the trial in which the presiding judge specifically looked at the validity of repressed memories as evidence in a court of law and, as a result of the expert evidence presented, allowed the trial to proceed.

This issue is too important and sensitive to allow factual inaccuracy to creep in and be presented as truth. Our discourse on this matter, as professionals, must be based on facts.

REPLY TO DR RITTER

Gordon Milne

Psychologist

In discussing the Bunbury case, I was largely dependent on a lengthy report by Bettina Arndt, a journalist who was present at the trial. Ms Arndt has a Masters degree in Clinical Psychology from the University of New South Wales. She

has, for some years, practised journalism, specialising in community and family matters, especially where sexual relationship problems are involved. The transcript of evidence from the trial was initially unavailable, as certain names were suppressed.

Dr Ritter's statement that John Manners was never in charge of the younger sister's management is in disagreement with the trial report. In her review reported in the *Weekend Australian* [29 November 1994] Arndt stated, referring to Manners' denial of possible contamination between the two women's stories, that "court evidence revealed he conducted 14 joint sessions with the two sisters." This is borne out by a statement made during a recent *60 Minutes* programme in which Jana Wendt interviewed the two sisters. Also, "There is court evidence that during a 15-month period the two women exchanged details of their developing memories. For instance, [the older] had her first satanic abuse memory in January 1993 and informed her sister of this memory. Six months later [the younger] came up with her own memory of crucifixion, candles, and blood."

The younger sister was recorded as having sought the help of a hypnotherapist, but it seems this was for a single session only, with nothing clearly emerging. There was also some therapy with a local medical practitioner, and both women were examined pre-trial by a Perth psychologist who diagnosed post-traumatic stress disorder. None of these excursions seemed to warrant comment in my discussion of 700 words based on a 3000-word report.

Dr Ritter stresses that Bettina Arndt missed the prosecution evidence and was, therefore, not able to present a balanced assessment of the case. She specifically mentions the *voir dire* in which the judge, having regard to "expert evidence presented . . . allowed the trial to proceed."

One wonders about the sorts of evidence which *persuaded* the judge in the *voir dire*, in the absence of the jury. How much of it was based on the latest formed opinion on repressed memories and the delayed recall of satanic childhood abuse of the kind described by Bettina Arndt? However, in all fairness, an inspection of the *voir dire* transcript is needed before one can speak with certainty.

It seems sure, however, that two voices of reason were heard: from the judge who said that corroboration of repressed memories was essential and from expert witness Professor Donald Thomson, forensic psychologist, who also warned that recovered repressed memories of age-old sexual traumas needed independent validation; but these were lost in the emotional turmoil which infected the jury.

The *International Journal of Clinical and Experimental Hypnosis* has published two special issues on repressed memories and delayed recall, each of forensic interest. They were October 1994 and April 1995.

REVIEWS

Contemporary International Hypnosis. Graham D. Burrows, AO, and Robb O. Stanley. Chichester: John Wiley & Sons. 1995. x + 393. \$US59.95 + \$US20 postage and handling, hardcover.

Contemporary International Hypnosis represents the edited proceedings of the XIIIth International Congress of Hypnosis, held in Melbourne in August 1994.

This anthology is aptly named. It is truly international, with contributions from authors in Australia, the United States, New Zealand, Europe, South Africa, South America, and Asia. The list of contributors reads as a Who's Who in current hypnosis research and practice, including Peter Bloom, Joseph Barber, Michael Yapko, Peter Sheehan, Kevin McConkey, and Graham Burrows, AO. The Australian Society of Hypnosis is also well represented, with numerous local authors providing papers. Nor is the book's designation as "contemporary" a misnomer. The issues addressed are those which confront both academics and clinicians in their continuing research into, and practical applications of, hypnosis.

The editors, Graham Burrows, AO, and Robb Stanley, have long been in the forefront of Australian hypnosis. It is to be expected, therefore, that they would compile, in their words, "a stimulating and interesting series of papers, keynote addresses, and invited addresses." The reader cannot be disappointed. The papers presented are of relevance to all those working with hypnosis, whether in the clinical or research field. The volume of papers (44) is such that a detailed review is impractical, however they address a range of conceptual and practical issues. The latter explore the use of hypnosis in such diverse areas as MPD (now called Dissociative Identity Disorder), pain, trauma, dystonia, whiplash, diabetes, eating disorders, dermatological conditions, sexual dysfunction, stuttering, dental procedures, and sport.

One important conceptual issue addressed in many of the papers is the relationship of hypnosis to the recovered/false memory debate, particularly in the forensic setting. Such an emphasis befits a subject which has raised high levels of concern in the hypnosis and wider community and which is fraught with danger when handled inappropriately. We are all aware of cases where irreparable damage has been done through unskilled or partisan use of hypnosis. Dr Eric Hoencamp, in his keynote address to the congress, reported in the present volume, makes some useful points regarding the differences between "therapeutic" truth and "legal" truth. He clearly sets out the problem

of confusing the two and offers, in a succinct way, some valuable principles for every practitioner who can become involved, willingly or otherwise, with legal complications to their therapeutic work.

Dr Peter Bloom, current President of the International Society of Hypnosis, in his keynote address, explains the four goals of his presidency. These goals are relevant to the Australian experience. Of particular note is his call for the development of closer links between clinical and experimental hypnosis. At a time when efforts are being made to develop a uniform Australian national standard for hypnosis practice, his thoughts are particularly relevant.

In short, this book has something for everyone. It would be an invaluable addition to the library of every hypnosis practitioner.

CHRISTINE FFRENCH, Monash University.

Entranced. One-hour video with Graham Wicks, MBBS. Adelaide: Richard Sprod Productions. 1995. \$295.00.

Entranced is an hour-long video focusing on the medical uses of hypnosis. It would be extremely useful for health professionals interested in learning about the medical applications of hypnosis. It could also serve as a useful training aid for health practitioners who are participating in an approved hypnosis training program. The video has the potential to be used as an aid for clients who are interested in hypnosis as an adjunct to their treatment regime.

The video deals with hypnosis in its historical context and presents a number of case studies which illustrate various hypnotic techniques, applied across a range of medical problems. These include age regression techniques; the phenomenon of post-hypnotic amnesia; and dissociation. Hypnosis is discussed as a treatment or treatment adjunct to problems such as pain control, burns, phobias, childbirth, bleeding control, and as an anaesthetic.

The video is generally well presented and professional in its depiction of hypnosis. However, there are sequences where it tends to move from one treatment to the next without a detailed explanation. In one scene, a client is distressed during an age regression sequence but, unfortunately, the therapist does not describe how he deals with the anxious client during this procedure. Overall, however, the subject matter is competently and interestingly presented.

One warning: unless you work in a casualty ward or are accustomed to eating dinner while watching programs such as 'RPA,' we encourage you to view the cassette on an empty stomach, as it includes explicit and graphic medical procedures.

At a cost of \$295 the cassette is expensive, but given the quality of its production and its usefulness for hypnosis practitioners, it would be a worthwhile investment.

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BOOKS AVAILABLE FOR REVIEW

The journal has available a small number of books for review by members of the Society and this number is expected to increase in the future. Readers interested in reviewing books should apply to the Editor. Reviews are subject to editorial review prior to publishing.

- Gordon Milne *Hypnosis and the Art of Self-Therapy*. Melbourne:
Lothian Books, 1994.
- Dylan Morgan *The Principles of Hypnotherapy*. West Yorkshire:
Eildon Press, 1996.
- Thomas M. Robinson *Plato's Psychology*. (2nd ed.). Toronto: University of
Toronto Press, 1995.
- Colin A. Ross *The Osiris Complex: Case Studies in Multiple
Personality Disorder*. Toronto: University of Toronto
Press, 1994.
- Louise Samways *Dangerous Persuaders: An exposé of gurus, personal
development courses and cults, and how they operate in
Australia*. Ringwood: Penguin, 1994.